UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

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

NOTICE OF FILING PUBLIC VERSION OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION AND APPOINTMENT OF CLASS COUNSEL [DKT. NO. 133]

On October 11, 2016, pursuant to the Court's August 25, 2016, Scheduling Order [Dkt. No. 262], the Parties filed a Notice of Documents Previously Filed Under Seal Agreed to Be Unsealed [Dkt. No. 266]. The parties are filing an updated Notice on October 14, 2016. Plaintiffs now file full versions of Plaintiffs' Motion for Class Certification and Appointment of Class Counsel and Memorandum in Support [Dkt. No. 133] previously filed entirely 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 unsealed copies of the corresponding exhibits as listed in Exhibit 1, to the October 14, 2016 Notice. Attached hereto as Exhibit 1 is an Index of Exhibits, including Plaintiffs' Motion for Class Certification and

Appointment of Class Counsel and Memorandum in Support [Dkt. No. 133] and corresponding exhibits.

Dated: October 14, 2016

Respectfully submitted,

/s/ Daniel C. Hedlund

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CERTIFICATE OF SERVICE

I hereby certify that on October 14, 2016, I electronically filed the foregoing document with the Clerk of the Court using the ECF system which will send notification of such filing to all filing users indicated on the Electronic Notice List through the Court's electronic filing system.

I also certify that I will serve copies via First Class U.S. Mail upon all other parties indicated on the Manual Notice List.

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INDEX OF EXHIBITS TO PLAINTIFFS' NOTICE OF FILING PUBLIC VERSION OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION AND APPOINTMENT OF CLASS COUNSEL [DKT. NO. 133]

Exhibit	Description
1.	Plaintiffs' Motion and Memorandum In Support of Class Certification and Appointment of Class Counsel [Dkt. 133]
2.	Exhibit A (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
3.	Exhibit D to Plaintiffs' Motion for Class Certification [Dkt. 133]
4.	Exhibit E to Plaintiffs' Motion for Class Certification [Dkt. 133]
5.	Exhibit H to Plaintiffs' Motion for Class Certification [Dkt. 133]
6.	Exhibit I to Plaintiffs' Motion for Class Certification [Dkt. 133]
7.	Exhibit J to Plaintiffs' Motion for Class Certification [Dkt. 133]
8.	Exhibit L to Plaintiffs' Motion for Class Certification [Dkt. 133]
9.	Exhibit M to Plaintiffs' Motion for Class Certification [Dkt. 133]
10.	Exhibit N to Plaintiffs' Motion for Class Certification [Dkt. 133]
11.	Exhibit O to Plaintiffs' Motion for Class Certification [Dkt. 133]
12.	Exhibit P to Plaintiffs' Motion for Class Certification [Dkt. 133]
13.	Exhibit Q to Plaintiffs' Motion for Class Certification [Dkt. 133]
14.	Exhibit R (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
15.	Exhibit S to Plaintiffs' Motion for Class Certification [Dkt. 133]

16.	Exhibit U (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
17.	Exhibit V (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
18.	Exhibit W to Plaintiffs' Motion for Class Certification [Dkt. 133]
19.	Exhibit X to Plaintiffs' Motion for Class Certification [Dkt. 133]
20.	Exhibit Y to Plaintiffs' Motion for Class Certification [Dkt. 133]
21.	Exhibit Z to Plaintiffs' Motion for Class Certification [Dkt. 133]
22.	Exhibit BB to Plaintiffs' Motion for Class Certification [Dkt. 133]
23.	Exhibit DD to Plaintiffs' Motion for Class Certification [Dkt. 133]
24.	Exhibit EE (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
25.	Exhibit FF to Plaintiffs' Motion for Class Certification [Dkt. 133]
26.	Exhibit GG to Plaintiffs' Motion for Class Certification [Dkt. 133]
27.	Exhibit HH to Plaintiffs' Motion for Class Certification [Dkt. 133]
28.	Exhibit II (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
29.	Exhibit JJ to Plaintiffs' Motion for Class Certification [Dkt. 133]
30.	Exhibit KK to Plaintiffs' Motion for Class Certification [Dkt. 133]
31.	Exhibit LL to Plaintiffs' Motion for Class Certification [Dkt. 133]
32.	Exhibit MM to Plaintiffs' Motion for Class Certification [Dkt. 133]
33.	Exhibit NN to Plaintiffs' Motion for Class Certification [Dkt. 133]
34.	Exhibit OO to Plaintiffs' Motion for Class Certification [Dkt. 133]
35.	Exhibit PP to Plaintiffs' Motion for Class Certification [Dkt. 133]
36.	Exhibit QQ (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
37.	Exhibit RR to Plaintiffs' Motion for Class Certification [Dkt. 133]
38.	Exhibit SS (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
39.	Exhibit TT (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
40.	Exhibit UU (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]
41.	Exhibit VV to Plaintiffs' Motion for Class Certification [Dkt. 133]
42.	Exhibit WW to Plaintiffs' Motion for Class Certification [Dkt. 133]
43.	Exhibit XX (portions thereof) to Plaintiffs' Motion for Class Certification [Dkt. 133]

44.	Exhibit KKK to Plaintiffs' Motion for Class Certification [Dkt. 133]
45.	Exhibit LLL to Plaintiffs' Motion for Class Certification [Dkt. 133]
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54.	Exhibit IIII to Plaintiffs' Motion for Class Certification [Dkt. 133]
55.	Exhibit JJJJ to Plaintiffs' Motion for Class Certification [Dkt. 133]
56.	Exhibit KKKK to Plaintiffs' Motion for Class Certification [Dkt. 133]
57.	Exhibit LLLL to Plaintiffs' Motion for Class Certification [Dkt. 133]

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN

THE SHANE GROUP, INC. ET AL.,

Plaintiffs, on behalf of themselves and all others similarly situated

vs.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Civil Action No. 2:10-cv-14360-DPH-MKM

Judge Denise Page Hood
Magistrate Judge Mona K. Majzoub

FILED UNDER SEAL

PLAINTIFFS' MOTION FOR CLASS CERTIFICATION AND APPOINTMENT OF CLASS COUNSEL

Plaintiff Michigan Regional Council of Carpenters Employee Benefits Fund, and proposed plaintiffs Patrice Noah and Susan Baynard, by their undersigned counsel, submit this Motion for Class Certification and Appointment of Class Counsel. In support of this motion, Plaintiffs rely upon the authorities and arguments set forth in the incorporated memorandum. Defendant does not consent to the relief sought.

Dated: October 21, 2013

Respectfully submitted,

/s/ Daniel A. Small_____

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UNITED STATES DISTRICT COURT
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THE SHANE GROUP, INC. ET AL., Plaintiffs, on behalf of themselves and all others similarly situated vs. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Civil Action No. 2:10-cv-14360-DPH-MKM Judge Denise Page Hood Magistrate Judge Mona K. Majzoub **FILED UNDER SEAL**

PLAINTIFFS' MEMORANDUM IN SUPPORT OF THEIR MOTION FOR CLASS CERTIFICATION AND APPOINTMENT OF CLASS COUNSEL

STATEMENT OF ISSUES PRESENTED

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

   Plaintiffs' Answer: Yes.

CONTROLLING OR APPROPRIATE AUTHORITY FOR RELIEF SOUGHT

Fed. R. Civ. P. 23

Amchem Prods., Inc. v. Windsor
521 U.S. 591 (1997)

Amgen, Inc. v. Conn. Retirement Plans and Trust Funds
133 S. Ct. 1184 (2013)

In re Cardizem CD Antitrust Litig.
200 F.R.D. 326 (E.D. Mich. 2001)

In re Foundry Resins Antitrust Litig.
242 F.R.D. 393 (S.D. Ohio 2007)

In re Scrap Metal Antitrust Litig.
527 F.3d 517 (6th Cir. 2008)

Messner v. Northshore Univ. HealthSystem
669 F.3d 802 (7th Cir. 2012)

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INTRODUCTION

By the mid-2000's, Blue Cross Blue Shield of Michigan ("BCBSM" or "Blue Cross") had been by far the dominant insurer in Michigan for years. However, its cost advantage over rival insurers that derived from the deeper discounts it received from hospitals had begun to erode. Instead of competing on the merits, BCBSM sought to halt the adverse trend by using its still powerful market clout to rig the rules of the game in its favor. Pursuant to an overarching scheme to protect its market dominance in Michigan, BCBSM began inserting anti-competitive "Most Favored Nation" ("MFN") provisions into its contracts with numerous hospitals. The MFNs kept rivals' costs for hospital care artificially high, thereby inflating the premiums they charged for health insurance, lowering their margins on health insurance sales, and diminishing their profits and resources to invest in aggressive competition with Blue Cross. In some cases, an MFN excluded a Blue Cross rival from a hospital altogether. Thus, the MFN scheme allowed BCBSM to maintain, if not enlarge, its dominance in Michigan. Plaintiffs seek certification of a class of those directly harmed by this practice, which is now banned by the State of Michigan in response to BCBSM's unlawful actions.

Insurers in Michigan negotiate formulas that determine the amount they will pay, or reimburse, hospitals for the healthcare services used by their insureds and self-insureds. BCBSM's "equal-to" MFNs forced hospitals to set the overall

annual reimbursement rate for the services covered by other commercial insurers as high or higher than BCBSM's overall annual reimbursement rate, and BCBSM's "MFN-plus" agreements required hospitals to set that rate a certain number of percentage points above BCBSM's rate. Thus the MFN scheme caused the reimbursement rates of BCBSM's rivals, including Priority Health, Health Alliance Plan ("HAP") and Aetna, to be artificially inflated, raising their costs, diminishing their competitive vigor and eliminating their ability to compete at certain hospitals.

The MFN scheme harmed these insurers as direct purchasers of hospital services, but they also harmed their insured and self-insured customers. Many of these customers were injured because they paid a portion of the price set by the insurer's reimbursement rate. Both the insurers and their insureds and self-insured entities paid higher prices for hospital healthcare services than they would have absent the MFN agreements. [redacted]

[redacted] Plaintiffs agree. Other insurers should have been able to compete without the anticompetitive constraint of BCBSM's MFN scheme.

In addition to harming other insurers and their insureds and self-insureds, BCBSM also protected itself from competition at the expense of its own customers. BCBSM frequently agreed to pay higher reimbursement rates to hospitals in Michigan as a quid pro quo for their agreement to the MFNs. For example, a BCBSM executive described a "strategic alliance" with the Beaumont hospitals "concerning their willingness to shut out competing plans that approach them for a greater discount, in exchange for an increase from BCBSM… I can't imagine this wouldn't be a fantastic long-term competitive advantage for us…" Ex. RR - M. Johnson Dep., DOJ Ex. 6 (BLUECROSSMI-99-051863 at -863).

As is plain, BCBSM benefitted from its practice of paying hospitals for MFNs. Even though BCBSM's costs increased, the scheme ensured that its rival insurers' costs were even higher and gave BCBSM an anti-competitive advantage over them. Instead of using its power to negotiate with hospitals for the best possible prices for the benefit of its own insureds, BCBSM offered increased reimbursement rates to obtain MFN provisions. The scheme protected BCBSM from competing insurers, but increased costs for its own customers.

In sum, BCBSM used its MFN scheme to raise its rivals' costs, and thereby unlawfully maintain, if not enhance, its position as the dominant commercial health insurer in Michigan. Its actions caused members of the proposed class to pay inflated prices for hospital services.

Plaintiff Michigan Regional Council of Carpenters Employee Benefits Fund ("Carpenters"), and proposed plaintiffs Patrice Noah and Susan Baynard[1] move the Court for certification of a class under Federal Rule of Civil Procedure 23 defined as all persons and entities who during the relevant time period (as listed below), alone or with a co-payor, directly paid a Michigan hospital (as listed below) for hospital healthcare services at the price provided in the provider agreement (as listed below).

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

[1] The Court has not ruled on the motion to add and drop plaintiffs. 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.

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

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.[2]

[2] Plaintiffs have been able to simplify and narrow the class definition alleged in the Consolidated Amended Complaint. (Consolidated Amended Compl. ("Compl.") (Dkt. 78), ¶ 26). 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. Specifically, the class is defined to include the persons and entities that directly paid for hospital healthcare services at prices set by certain provider agreements at thirteen Michigan hospitals (the "affected hospitals"). *See In re Foundry Resins Antitrust Litig.*, 242 F.R.D. 393, at 402-403 & n.6 (S.D. Ohio 2007) (approving class definition that was "a reply-memorandum modification of the definition presented in [plaintiffs'] actual motion" and noting that it "moots some of Defendants' objections"); *see also In re Domestic Air Transp. Antitrust Litig.*, 137 F.R.D. 677,

This proposed Class satisfies the requirements of Rule 23(a) and (b)(3). In that regard, this antitrust case is no different from many others. "[I]n antitrust cases, Rule 23, when applied vigorously, will frequently lead to certification." *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 815-16 (7th Cir. 2012) (alleging inflated prices for hospital healthcare services). The Court should grant Plaintiffs' motion and certify the proposed class.

STATEMENT OF FACTS

I. BCBSM is the Dominant Seller in the Michigan Commercial Health Insurance Market

Clearly, BCBSM is the dominant seller in the commercial health insurance market in Michigan. The most recent data shows Blue Cross controlling 69% of that market. Ex. D - *See* American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2012 Update* (2012). Blue Cross was unquestionably aware of its dominant market share vis-à-vis its

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683 n.5 (N.D. Ga. 1991) ("[t]he act of refining a class definition is a natural outcome of federal class action practice."). The definition excludes certain insureds—those who escaped injury because the amount they paid for their hospital services was unaffected by the overcharge (i.e., the additional amount charged due to an antitrust violation). An example of how an insured can escape injury is provided by the following hypothetical. Suppose the "allowed amount" for the hospital's services (i.e., the amount due under the reimbursement formula negotiated by the hospital and insurer) is $2,000, but would have been $1,600 absent the overcharge caused by the MFN scheme, and the insurance policy requires the insured to pay a flat co-pay of $200. The insurer would pay $200 whether the hospital charged the inflated amount ($2,000) or the proper amount ($1,600).

competitors. Ex. E - *See* Brown Dep., DOJ Ex. 25 (BLUECROSSMI-E-0126960) (BCBSM executive David Brown saying that "we [BCBSM] are the dominant carrier and just need to keep blocking and tackling and keep our eye on the ball"); Ex. F - Andreshak Dep. 197:5–9 (10/29/12) (BCBSM is the market leader in Michigan for group healthcare); Ex. G - 208:18–22 ("The market is dominated by Blue Cross/Blue Shield . . . with over 70% of commercial market share.").

BCBSM understood how its market dominance gave it negotiating power against the hospitals in its provider network. Ex. H - *See* Darland Dep. at 60:8–18 ("the bigger you are, the more leverage you have"); 60:24–61:12 ("hospitals, for all intents and purposes, couldn't survive . . . without Blue Cross . . . so being 50 percent of their commercial book of business, gave us leverage to say, you need us . . . . And so, that very need translates into them,… in many cases close to literally, having to take what we offer"); Ex. I - 124:25–125:14 ("We were, by far, for [PG 5] hospitals, especially even more so the largest commercial payor. And so, we had a lot of leverage that we could have imposed."); Ex. J - Milewksi Dep. 49:3–24 (10/11/12) (testifying that BCBSM had leverage because of its size).

[redacted]

[redacted] Ex. L - *see also* McGuire Dep. 65:18-69:20 (08/14/12) (CFO of St. John Providence Health System discussing internal Providence strategy document that states BCBSM has "ultimate leverage in our community," and interpreting that statement to refer to "the fact that Blue Cross has a significant percentage of the market and has significant market power when dealing with [the] hospital community."); Ex. M - Felbinger Dep. 33:14–21 (8/29/12) (CFO of Borgess Health stating that BCBSM has "a significant amount of power on rates and how they apply their rules and regulations."); Ex. N - AETNA-00575835 (hospital required an increase in Aetna's reimbursement rate because size of BCBSM's "business" and "the penalties for non-compliance [with the MFN agreement] are extensive to the point where we cannot afford to be out of compliance.").

II. BCBSM's Competitive Advantage Over Other Insurers in Discounts at Hospitals Began to Erode in the Mid-2000s

In the years before BCBSM introduced its MFNs, it believed its market share had begun to erode along with its advantage over competitors in terms of the large discounts that it could historically extract from hospitals. Ex. O - *See* Darland Dep., Ex. 44 (BLUECROSSMI-99-02467917) (email between BCBSM executives stating that it is likely that BCBSM's discount differential will erode, with Doug Darland stating that BCBSM could not "compete in the market if we had to pay what our competitors pay for hospital services"); Ex. P - Noxon Dep. 68:12 –

69:15 (BCBSM executive testifying that BCBSM's hospital discount advantage had been eroding over time); Ex. Q - *id.* at 234:1-8 (BCBSM's discount differential was eroding in part because other insurers were seeking better discounts); Ex. R - BLUECROSSMI-99-0317577 (internal BCBSM email stating that BCBSM's "absolute discounts slipped in 2008," and "discounts vs. competitors dropped in 2007"); Ex. S - BLUECROSSMI-99-01404334 (2007 BCBSM document stating that "[d]iscount advantage on inpatient has been eroded by other payors."); Ex. T - *see also* Expert Report of Dr. Christopher A. Vellturo ("Vellturo Report"), *Aetna v. Blue Cross Blue Shield of Mich.*, No. 11-cv-15346, at ¶ 594 (MFNs halted BCBSM's market share decline in the mid-2000s and stopped share gains by BCBSM's competitors).[3]

To shore up its dominance and hamstring the threat from stronger competition, Blue Cross adopted a practice of inserting MFN agreements in its hospital contracts as described above. This course of conduct sometimes even expressly sought to turn back the clock by mandating that hospitals revert back to the discount differential that Blue Cross had enjoyed over its competitors in an earlier period. Ex. U - *See, e.g.*, BLUECROSSMI-99-388498 at -500, -503 (2009

[3] Dr. Vellturo is Aetna's expert on "whether BCBSM's contracting conduct significantly reduced competition among suppliers of health insurance and related administrative services," in its parallel case against BCBSM. Dr. Vellturo is President and Founder of Quantitative Economic Solutions, LLC, and received his Ph.D. in economics from MIT, where he was a Bradley Fellow in public economics. Dr. Vellturo prepared a 244-page report in the Aetna case.

contract between BCBSM and Beaumont required Beaumont to attest that "the discount represented in the BCBSM/BCN payment rates exceed the discount offered to other non-governmental payors to the same degree as existed in February 2006").

III. Blue Cross Used Its Market Power to Impose Equal-To MFN and MFN-Plus Agreements in its Hospital Contracts Despite Hospitals' Resistance

BCBSM used its market power to impose MFNs on many Michigan hospitals through the contracting process even when hospitals protested. [redacted] Blue Cross intended for the PHA to govern its relationship with all hospitals in its network.[4] For its MFN scheme to succeed in materially raising its rivals' costs, BCBSM needed to secure MFN provisions at several, not just a few, of the hospitals in its network.

The PHA contains a "Most Favored Discount" section, which provides:

> Hospital will attest and commit that the payment rates which it has provided to BCBSM under this Agreement for non-Medicare members are at least as favorable as the rates which it has established

[4] The PHA did govern the relationship between BCBSM and its PG 5 hospitals, while PG 1-4 hospitals used the PHA as the starting point for further negotiations. Ex. W - *See* Schaal Dep. 69:6-9; Ex. X - 276:10-17 (10/08/12) (stating that the PHA binds all hospitals in Michigan, such that the PHA applied to a PG 1-4 hospital if the hospital's negotiated provider agreement expired and was not renegotiated).

> with all other non-governmental PPOs, non-governmental HMOs or other non-governmental commercial insurers.

Blue Cross was able to unilaterally impose this provision on the smallest hospitals in its network, the PG 5 hospitals.[5] [redacted]

These smaller hospitals were essentially at the mercy of BCBSM's market power. Larger hospitals did resist BCBSM's pursuit of MFNs—both individually and through their trade association—but did so without much success. The Michigan Hospital Association, a statewide association of nearly all of the hospitals in Michigan, resisted the insertion of the MFN into the PHA. Ex. Y - *See* Felbinger Dep. 146:19–149:17 (08/29/12) (hospital CFO stating that the MHA did not want the MFN agreement in PHA; the MHA did not want BCBSM to have more bargaining power than they already had, because that would "tie[] [hospital's] hands even tighter than they're already tied.").

Hospitals tried to resist because they and the medical community in general were concerned the MFN scheme would further entrench the dominance of

[5] Blue Cross organizes hospitals in Michigan into "peer groups" numbered one through five. These peer groups, often referred to with the short hand "PG," are comprised of hospitals of similar sizes (taking into account the number of licensed beds and number of admissions). PG 1-4 hospitals are larger hospitals; [redacted]

BCBSM in the Michigan health insurance market. Ex. Z - *See* Share Dep., Aetna Ex. 16 (BLUECROSSMI-99-03029350 at -351 (BCBSM email stating many physicians "do not want BCBSM to have more power. They very much fear that we abuse our already excessive market share.")); Ex. AA - Lantzy-Talpos Dep. 55:6–57:6 (11/13/12) (testifying that Michigan hospital told Aetna the hospital did not want to sign an MFN-plus with BCBSM). Many hospitals indicated that the MFNs would unfairly restrict their ability to contract with other providers, and heighten the competitive problems caused by Blue Cross's dominant market position. Ex. BB - *See* McGuire Dep., DOJ Ex. 3 (AHT-000443 at -445) (Ascension's "[g]oal should be to remove from contract language because MFN clause effectively neutralizes our ability to create leverage by developing other payer relationships."); Ex. CC - Longbrake Dep., DOJ Ex. 2 (BX-HRV-000069 at -070) (hospital requesting removal of MFN due to its "reluctance to be contractually obligated for an unspecified amount of time, to terms that constrain our strategic growth and may threaten our very survival in the market."). For some hospitals, the MFNs thwarted plans to move business away from BCBSM to other payors. For instance, Ascension Health wanted to diversify its payors to "reduce . . . long term dependence on BCBSM Michigan and create additional leverage with BCBS during the negotiating process." Ex. DD - *See* AH-000036 at -038

("Commercial Payer Diversification Strategy"). But hospitals' resistance often failed given BCBSM's market power.

IV. BCBSM Frequently Traded Higher Reimbursement Costs for Itself and its Insureds and Self-Insureds to Obtain MFNs that Protected BCBSM from Competition

Despite these concerns, Blue Cross aggressively inserted MFNs into hospital contracts in Michigan. If BCBSM was unable to insert the MFNs unilaterally, it made them the focal point of its contract negotiations with hospitals. Blue Cross executives repeatedly described the MFN agreements as "key" "required," "important" and "a cornerstone." *See* Ex. EE - BLUECROSSMI-02-001189; Ex. FF - Smith Dep., DOJ Ex.13 (BLUECROSSMI-99-407857 at -857, -858); Ex. GG - Longbrake Dep., DOJ Ex. 3 (BLUECROSSMI-99-01053141 at -141).

And Blue Cross was willing to pay the hospitals more through increased reimbursement rates (and sometimes lump sums) to implement its MFN scheme. BCBSM often specifically tied its willingness to increase rates to the hospital's acceptance of the MFN. *Id.*, Ex. EE (Blue Cross executive Doug Darland indicating in his contract negotiations with Allegan General Hospital that an MFN was "required" to consider a variance to the Peer Group 5 reimbursement model, and that a MFN with a differential was preferred); Ex. HH - BLUECROSSMI-99-176762 at -764; Ex. II - CIVLIT-BCBSM-00270479 at -481, -482, -483, -486

(BCBSM agreed to increase hospital's reimbursement rate for the 2009 fiscal year in part "in recognition of [hospital's] favored discount commitment)").

Frequently Blue Cross even made it clear that the larger the discount differential the hospital was willing to agree to, the larger the increase in reimbursement rates that BCBSM would provide. Ex. JJ- *See* Darland Dep. 47:1-16 (BCBSM should be able to afford "a more generous rate increase" if Beaumont kept discount differential at current levels); Ex. KK - Noxon Dep., DOJ Ex. 8 (BLUECROSSMI-10-009368 at -371) (BCBSM email to hospital chain stating that "BCBSM would be willing to consider a larger add on [i.e., higher reimbursement rate] if [Ascension Health] were willing to provide a larger point spread [i.e., a greater percentage point MFN differential]").

And there is no mystery to why BCBSM sought the MFNs so forcefully—it wanted to protect its advantage in hospital discounts and restrain other insurers' ability to compete. Blue Cross executives testified that the MFNs did nothing to reduce costs for their own customers or otherwise benefit them. Ex. LL - *See* Dallafior Dep. 305:6-8 (10/24/12) ("Q. Are you aware of Blue Cross's use of MFN clauses saving its customers any money? A. No."); Ex. MM - Schaal Dep. 222:1-4 (testifying that he could not think of any way that the MFN has benefited patients at hospitals with MFNs); Ex. NN - Sorget Dep. 37:24-38:14 (10/16/12). Indeed BCBSM executives confirmed that the MFNs led to higher rates for their

own customers. Ex. OO - Dallafior Dep., 183:18-186:18 (10/24/12) (paying Beaumont additional dollars would drive up BCN's rates to customers because "if we were to pay [Beaumont] more, that means those costs would be passed on, that portion, to the customer in either premium increases or in claims expense that they would incur for those claims that were - those claims that were incurred at the Beaumont Health System."). BCBSM's Douglas Darland confessed that he was not comfortable "pay[ing] more in exchange for an MFN or MFN plus" because it would not be "protecting the assets of our customers." Ex. PP - Darland Dep. 323:6 -324:18. But BCBSM did that very thing, at the expense of its customers who are members of the proposed class.

V. BCBSM Harmed Its Own Insureds and Self-Insureds as They Paid More for Hospital Services So BCBSM Could Avoid Competition through MFNs

Because BCBSM agreed to pay higher reimbursement rates to hospitals in exchange for MFN provisions, BCBSM increased its reimbursement rates at those hospitals above what they would have been absent the MFNs. These agreements to increase reimbursement rates also increased the cost of hospital services for many of BCBSM's insureds who pay a portion of the allowed amount. The higher reimbursement rates also increased the costs of employers and other organizations that self-insure and contract with BCBSM for access to BCBSM's provider

network at the rates negotiated by BCBSM, and that directly pay hospitals for much of the cost of their employees' or members' hospital healthcare services.

Examples of BCBSM reimbursement rate increases occurring as a quid pro quo for an MFN provision follow:

Beaumont Hospitals - Grosse Pointe, Troy, Royal Oak

- Blue Cross proposed to Beaumont a quid pro quo exchange of increased reimbursement rates for an MFN clause — with larger increases in reimbursement rates for larger discount differentials. Ex. QQ - Darland Dep., DOJ Ex. 5 (BLUECROSSMI-08-022036) (BCBSM should be able to afford "a more generous rate increase" if Beaumont kept discount differential at its current level); Ex. RR - M. Johnson Dep., DOJ Ex. 6 (BLUECROSSMI-99-051863 at -863) (discussing Beaumont "strategic alliance" wherein Beaumont would "shut out competing plans that approach them for a greater discount" in exchange for a substantial 7-8% rate increase from BCBSM). BCBSM estimated that its "upfront" cost of this rate increase would be $25 million. It thought this was "a fantastic long-term competitive advantage for us." Ex. U - *See* BLUECROSSMI-99-388498 at -498, -503; Ex. SS - BLUECROSSMI-99-194458 at -458, -459.

- Blue Cross called the MFN-plus it succeeded in buying from Beaumont a "mega most favored nation clause." Ex. TT - CIVLIT-BCBSM-00187609 at -610. The MFN-plus guaranteed Blue Cross a rate that was 10 percentage points better than any of its competitors. Ex. U - *See* BLUECROSSMI-99-388498 at -498, -503; Ex. UU - BLUECROSSMI-99-194458 at -458, -459.

St. John Hospital and Medical Center and Providence Park Hospital

- St. John Hospital and Medical Center and Providence Park Hospital, both part of the Ascension hospital system, entered into a MFN-plus agreement with BCBSM, effective no later than July 1, 2008, which guaranteed that BCBSM would have a 10% better discount than other insurers. Ex. GG - *See* CIVLIT-BCBSM-00270479 at -480, -483, -486. Additionally, Blue Cross paid $7,519,400.00 in lump sum payments to the Ascension hospitals for the contracts with MFN-plus clauses. Ex. II - Noxon Dep., DOJ Ex. 8 (BLUECROSSMI-10-009368 at -371).

- As it states in the contract, BCBSM agreed to increase the hospitals' reimbursement rate over and above the standard update "in recognition of [Ascension Health's] favored discount commitment." Ex. FF - BLUECROSSMI-99-176762 at -764; Ex. GG - CIVLIT-BCBSM-00270479 at -481, -482, -483, -486; Ex. VV - *see also* Sorget Dep. 178:13-179:10 (Sorget understood offer to Ascension to mean that increase in reimbursement was "dependent" on a commitment to provide a 10 percent most favored nation clause).

- Blue Cross was willing to pay even higher reimbursement rates in exchange for an MFN with a larger discount differential. Ex. WW - *See* Smith Dep., DOJ Ex. 9 (AHSJP-037045 at -045) (Blue Cross executive Gerald Noxon stating BCBSM's "willingness to pay a premium for a commitment on this. BCBSM is looking for a significant spread."). Blue Cross believed an MFN point spread greater than 20 points was worth a 1.5% rate increase, valued at "up to $7M" in additional revenue for Ascension. Ex. XX - Noxon Dep., DOJ Ex. 7 (BLUECROSSMI-10-009207 at -208) (BCBSM proposal for Ascension meeting including a $5 million one-time signing bonus payment and an MFN clause-related increase which BCBSM estimated would yield up to $7 million in additional payments to Ascension); Ex. II - *see also* Noxon Dep., DOJ Ex. 8 (BLUECROSSMI-10-009368 at -371) ("BCBSM would be willing to consider a larger add on [in rates] if AH were willing to provide a larger point spread").[6]

VI. BCBSM's MFNs Harmed Other Insurers and their Insureds and Self-Insureds by Forcing Them to Pay Higher Prices for Hospital Services

Blue Cross did not only harm its own customers through its use of the anticompetitive MFN scheme. Other insurers such as Priority, HAP and Aetna, were forced to increase their reimbursement rates or forego rate decreases they could have negotiated, due to hospitals' MFN obligations to BCBSM. The result

[6] Blue Cross occasionally internally estimated how much the MFN was worth to itself. Here Blue Cross estimated that the most favored nation discount advantage of 10 percentage points was "worth about 2.5 million a year" to it. Ex. YY - *See* Darland Dep. 418:15-419:10 (11/15/12); Ex. ZZ - Darland Dep., Ex. 45 (BLUECROSSMI-08-003819).

was that these insurers, their insureds and self-insureds paid more for hospital services than they would have absent the MFN agreements.[7] Ex. A - *See* Leitzinger Expert Report at ¶11, 45-46, 59, 65, 67, 72, 74; Ex. AAA - Darland Dep. 405:4-23 (MFNs maintain a "floor" differential—hospitals could not negotiate lower rates for other insurers).

[redacted]

[7] Plaintiffs have obtained and their expert, Dr. Jeffrey Leitzinger, has analyzed the claims data from BCBSM, Priority, HAP and Aetna, which collectively constitutes approximately 80 percent of the commercial health insurance market in Michigan. Ex. A - Leitzinger Rpt. at ¶ 25. These companies are four of the top six commercial health insurers in the state. Ex. A - *Id*. at Ex. 4. Other commercial health insurers each have a market share of three percent or less. Ex. A - *Id*.

Dr. Leitzinger is an economist and President of Econ One Research, Inc., an economic research and consulting firm. He has 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. His doctoral work concentrated on the field within economics known as industrial organization, which involves the study of markets, competition and antitrust. Ex. A - See *Id*. at ¶ 1.

[redacted] Ex. CCC - Andreshak Dep. 160:12–161:4 (testifying that Aetna would not even approach PG 5 hospitals to negotiate better discounts due to effects of MFN).

Examples of the adverse effect that BCBSM's MFNs had on other insurers and their insureds and self-insureds abound:

PRIORITY HEALTH

[redacted]

[redacted]

[redacted] Ex. KKK - *See also* Root Dep., DOJ Ex. 16 (BLUECROSSMI-99-03093188 at -189) (series of emails regarding the possible business that BCBSM could gain if the BCBSM MFN agreement caused Charlevoix to terminate Priority Health).

- Charlevoix CFO William Jackson testified that the hospital increased Priority's rates in order to make the insurer compliant with the Blue Cross MFN. Ex. LLL - *See* Jackson Dep. 79:1-80:6 (03/02/12)

[redacted]

- Priority knew that the MFN at Lakeshore would require them to increase their rates when negotiating the new contract and was willing to comply. Ex. QQQ - *See* HLH001685 ("Priority agrees we can adjust to assist Lakeshore with favored nation clause.").

[redacted]

[redacted]

HEALTH ALLIANCE PLAN (HAP)

Beaumont Hospitals – Royal Oak, Grosse Pointe, and Troy

- Beaumont Hospitals' MFNs with BCBSM (discussed *supra* at 16) required Beaumont to give Blue Cross at least a 10-percentage point advantage over other insurers.

[redacted]

- Laura Eory, a provider and hospital contracting executive at HAP, stated that it is fair to say that MFNs were harmful to HAP's ability to be competitive in the marketplace. Ex. WWW - Eory Dep. 180:6-181:1 (11/12/12). [redacted] (i.e., Garden City Hospital, [redacted] Ex. XXX - *See* Jodway Dep. 50:15-51:22 (09/07/12); [redacted]

AETNA

Bronson LakeView Hospital

- [redacted] Ex. CCCC - Hughes Dep., DOJ Ex. 11 (AETNA- 00071584 at -585).

- Helen Hughes, Director of Managed Care for Bronson Healthcare Group, testified that allowing Aetna's reimbursement rate to remain at 70%, where it was in 2007, would have violated the MFN and that she would "not do anything that specifically violates the agreement." Ex. DDDD - Hughes Dep. 294:5–295:1.

Three Rivers Health

- Three Rivers Health pursued reimbursement rate increases from Aetna in order to make its contract with Aetna compliant with the BCBSM MFN. Ex. EEEE - *See* Andrews Dep. 68:9–70:4 (11/02/11); Ex. FFFF - *see also* Andrews Dep., Ex. 11 (AE-0003311) (letter from Three Rivers to Cofinity (a health insurer) stating that the "Blue Cross contract is presenting challenges regarding the most favored nation clause" and that was one reason that Three Rivers needed "to get all of our payors near or at Blue Cross levels by the end of 2009.").

- Three Rivers Health and Aetna subsequently executed an amendment to the existing hospital agreement, effective January 1, 2009, which increased Aetna's reimbursement rate from 65% to 75% of charges beginning in 2010, when the MFN became effective. Ex. GGGG - *See* TRC-HC-0003777 at -778.

- The BCBSM MFN was the only reason Three Rivers Health gave to Aetna for refusing a lower reimbursement rate. Ex. HHHH - Winters Dep. 46:9–48:16 (10/09/12).

ARGUMENT

I. The Court Should Certify the Proposed Class of Purchasers of Hospital Healthcare Services.

Plaintiffs satisfy the applicable test for class certification, which requires meeting the four prongs of Federal Rule of Civil Procedure Rule 23(a) and at least one prong of Rule 23(b). As described below, Plaintiffs can use class-wide evidence to show that: BCBSM included MFN provisions in its provider agreements with the relevant hospitals; those provisions were anticompetitive; they resulted in artificially high reimbursement rates at those hospitals; Plaintiffs and the Class therefore paid artificially inflated prices for hospital healthcare services; and the amount of the overcharge on the payments made by Plaintiffs and the Class for hospital healthcare services.

A. The Proposed Class Meets the Standards of the Supreme Court and the Sixth Circuit

Courts are required to conduct a "rigorous analysis" at class certification. *Amgen, Inc. v. Conn. Retirement Plans and Trust Funds*, 133 S.Ct. 1184, 1194 (2013). "The proposed class must be 'sufficiently cohesive to warrant adjudication by representation.'" *In re: Scrap Metal Antitrust Litig.*, 527 F.3d 517 (6th Cir. 2008) (quoting *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 623 (1997)).

The analysis at this stage is focused on the Rule 23 requirements, not the

merits. The Supreme Court recently counseled in *Amgen*:

> Rule 23 grants courts no license to engage in free-ranging merits inquiries at the certification stage. Merits questions may be considered to the extent—but only to the extent—that they are relevant to determining whether the Rule 23 prerequisites for class certification are satisfied.

133 S.Ct. at 1194-1195.[8] An inquiry into the merits is often not necessary to determine whether a class should be certified. *See Wilkof v. Caraco Pharm. Labs., Ltd*., 280 F.R.D. 332, 338 (E.D. Mich. 2012). Plaintiffs are not required to prove their case at the class certification stage. *See Messner*, 669 F.3d at 811 ("[T]he court should not turn the class certification proceedings into a dress rehearsal for trial on the merits.")

"The Court should err in favor of certification when there is some doubt whether to certify the class." *Hyland v. Homeservices of Am., Inc*., 2008 U.S. Dist. LEXIS 90892, 30 (W.D. Ky. Nov. 6, 2008) (quoting *In re Foundry Resins Antitrust Litig.*, 242 F.R.D. 393, 402 (S.D. Ohio 2007)); *see In re Playmobil Antitrust Litig*., 35 F. Supp. 2d 231, 239 (E.D.N.Y. 1998) (citing *In re Control Data Corp. Sec. Litig*., 116 F.R.D. 216, 219 (D. Minn. 1986)) ("Because of the

[8] *Amgen* also cited *Wal-Mart v. Dukes*, 131 S.Ct. 2541, 2552, n.6 (2011): "(a district court has no ''authority to conduct a preliminary inquiry into the merits of a suit'' at class certification unless it is necessary 'to determine the propriety of certification' (quoting Eisen v. Carlisle & Jacquelin, 417 U.S. 156, … (1974)))" as well as the "Advisory Committee's 2003 Note on subd. (c)(1) of Fed. Rule Civ. Proc. 23, 28 U.S.C. App., p. 144 ('[A]n evaluation of the probable outcome on the merits is not properly part of the certification decision.')."

important role that class actions play in the private enforcement of antitrust actions, courts resolve doubts in favor of certifying the class.").

B. Antitrust Claims Are Well-Suited for Class Treatment

The Supreme Court has recognized that private antitrust actions critically complement public enforcement of the antitrust laws, and that class actions enhance the effectiveness of such private actions. *Hawaii v. Standard Oil Co. of Cal.*, 405 U.S. 251, 266 (1972) ("Congress has given private citizens rights of action for … damages for antitrust violations …. Rule 23 … provides for class actions that may enhance the efficacy of [such] private [antitrust] actions by permitting citizens to combine their limited resources to achieve a more powerful litigation posture."). The Supreme Court has also made clear that the Rule 23(b)(3) predominance requirement is "*readily met* in certain cases alleging . . . violations of the antitrust laws." *Amchem*, 521 U.S. at 625 (emphasis added). Courts have also found class actions to be particularly appropriate in antitrust cases challenging anticompetitive agreements. *See Cason-Merenda v. VHS of Michigan, Inc.*, No. 06-cv-15601, 2013 WL 5106520, *9 (E.D. Mich. Sept. 13, 2013) ("the Sixth Circuit has expressed a favorable view of class certification in antitrust conspiracy cases"). This Court, as well as others within the Sixth Circuit, have certified numerous classes in antitrust cases. *See, e.g., In re: Scrap Metal Antitrust Litig.*, 527 F.3d 517 (6th Cir. 2008); *Foundry Resins*, 242 F.R.D. 393; *In re*

Cardizem CD Antitrust Litig., 200 F.R.D. 326 (E.D. Mich. 2001).

C. The Class Satisfies the Requirements of Federal Rule of Civil Procedure 23(a)

Rule 23(a) requires that plaintiffs comply with four prerequisites: (1) numerosity of parties; (2) commonality of a factual or legal issue; (3) typicality of claims; and (4) adequacy of representation. Each is satisfied here.

i. The Class Easily Meets the Numerosity Requirement

To maintain a class action, "the class must be so numerous that joinder of all members is impracticable." Fed. R. Civ. P. 23(a)(1). "While no strict numerical test exists, 'substantial' numbers of affected consumers are sufficient to satisfy this requirement." *Young v. Nationwide Mut. Ins. Co.*, 693 F.3d 532, 541 (6th Cir. 2012). In a case such as this, where the class is made up of thousands of individuals and entities that made purchases from several hospitals over a multi-year time period, Ex. A - see Leitzinger Rpt. at ¶ 25, courts have not hesitated to find numerosity. Ex. A - *See id.* (numerosity satisfied when there were thousands of potential class members); *In re Aftermarket Auto. Lighting Prods. Antitrust Litig*., 276 F.R.D. 364, 375 (C.D. Cal. 2011) (finding numerosity satisfied when the class numbered "at least in the hundreds").

ii. The Existence and Effects of Blue Cross's MFN Clauses Create Factual and Legal Questions Common to the Class

The second requirement of Federal Rule of Civil Procedure 23(a) is that there is a factual or legal question common to the class. The Sixth Circuit has held

that "there need only be one question common to the class." *Sprague v. General Motors Corp.,* 133 F.3d 388, 397 (6th Cir. 1998). Plaintiffs demonstrate commonality if "resolution of [plaintiffs'] common conspiratorial allegations will advance this litigation." *Foundry Resins*, 242 F.R.D. at 405.

Among the factual and legal issues common to each class member's claim are:

- Whether BCBSM agreed to MFNs in its contracts with hospitals;
- Whether the use of MFNs by BCBSM is anticompetitive;
- Whether Defendant violated the Sherman Act through use of MFN contracts;
- Whether Defendant violated the Michigan Antitrust Reform Act through use of MFN contracts;
- Whether Defendant's actions caused injury to Plaintiffs and the Class in the form of inflated prices for hospital healthcare services; and
- The appropriate measure of damages.

Courts in this Circuit have repeatedly found such common questions sufficient to satisfy the commonality requirement. *See supra*; *Young v. Nationwide Mut. Ins. Co*., 693 F.3d 532, 543 (6th Cir. 2012) (plaintiffs satisfied the commonality requirement as there would be common proof of causation concerning whether the Defendant's actions caused the harms alleged).

Class members here all base their claims on Blue Cross's anticompetitive MFN scheme and thus their claims will all succeed or fail based on the

determination of whether this scheme existed, violated the antitrust laws and impacted the plaintiff class. Any of the legal and factual issues that underlie this central determination is enough to satisfy commonality.

iii. As Purchasers of Hospital Services, Plaintiffs' Claims are Typical of the Claims of the Class

"[A] plaintiff's claim is typical if it arises from the same event or practice or course of conduct that gives rise to the claims of other class members, and if his or her claims are based on the same legal theory." *Powers v. Hamilton County Pub. Defender Comm'n*, 501 F.3d 592, 618 (6th Cir. 2007) (quoting *In re Am. Med. Sys., Inc.*, 75 F.3d at 1082). The typicality requirement does not require that plaintiffs' claims be identical to or co-extensive with those of the class. *See National Constructors Ass'n v. National Electrical Contractors Ass'n*, 498 F. Supp. 510, 545 (D. Md. 1980). For example, plaintiff's claims are typical even if the plaintiff did not purchase all of the same price-fixed products as the class, *In re Vitamins Antitrust Litig.,* 209 F.R.D. 251, 261 (D.D.C. 2002) ("The typicality requirement does not mandate that products purchased, methods of purchase, or even damages of the named plaintiffs must be the same as those of the absent class members."), or even if the plaintiff was only directly affected by one of multiple acts making up an anticompetitive scheme. *Natchitoches Parish Hosp. Serv. Dist. v. Tyco Int'l, Ltd.*, 247 F.R.D. 253, 264-65 (D. Mass. 2008) (finding typicality where plaintiffs alleged defendant's anticompetitive scheme involved a number of agreements and

where named plaintiffs were not parties to all of the agreements). Courts tend to "liberally construe the typicality requirement." *Foundry Resins*, 242 F.R.D. at 405. In antitrust cases, "typicality is established when the named plaintiffs and all class members allege[] the same antitrust violation by defendants." *Cason-Merenda,* 2013 WL 5106520 at *8 (quoting *Foundry Resins*, 242 F.R.D. at 405).

The class representatives here all challenge the same course of conduct: the anticompetitive MFN scheme that Blue Cross implemented to maintain and enhance its domination of the Michigan commercial health insurance market by raising the hospital healthcare costs of its rivals and in some instances, excluding its rivals from a Michigan hospital. This practice inflated the reimbursement rates for healthcare services negotiated by both Blue Cross and its rivals at the affected hospitals and thus caused the class to pay inflated prices for those services.

Blue Cross employed this scheme as broadly as possible with the hospitals in its network, to maximize the scheme's impact on its rivals. BCBSM's succeeded in executing its plan in large part, with BCBSM imposing MFN provisions on all of its PG 5 hospitals and several of its larger hospitals. The scheme allowed BCBSM to maintain and enhance its market dominance.

This claim alleges exactly the same antitrust violation as the other class members advance and is based in the same facts and legal theory – Blue Cross's MFN scheme violates state and federal antitrust law and caused purchasers to pay

inflated prices for healthcare services at the affected hospitals. Thus the representatives' claims are typical of the class's claims.

iv. Named Plaintiffs Will Fairly and Adequately Protect the Interests of the Class

Rule 23(a)'s fourth requirement is that Plaintiffs will "fairly and adequately protect the interests of the class." "Adequate representation invokes two inquiries: (1) whether the class counsel are qualified, experienced and generally able to conduct the litigation and (2) whether the class members have interests that are antagonistic to the other class members." *Beattie v. CenturyTel, Inc*., 234 F.R.D. 160, 169 (E.D. Mich. 2006) (quoting *Stout v. Byrider*, 228 F.3d 709, 717 (6th Cir. 2000) (internal quotations omitted)).

(1) Named Plaintiffs Have the Same Interests as the Class

In evaluating adequacy of representation, courts seek to uncover any potential conflicts of interest between Class members. *See Amchem Prods. v. Windsor,* 521 U.S. 591, 625-26 (1997). Here, Plaintiffs have no conflicts with other class members. Rather, Plaintiffs' interests are aligned because they, like all other class members, have been injured by the same alleged conduct, and they, like other class members, "have the same interest in establishing liability, and that they all seek damages for overpayment." *Foundry Resins*, 242 F.R.D. at 407.

The named plaintiffs, just like the absent class members, were injured when they overpaid for hospital healthcare services as a result of BCBSM's MFN

scheme. Plaintiff Carpenters is a union health and welfare fund that self-insures its union members. It had a contract with both BCBSM and HAP during the relevant period to obtain access to their network of hospitals at the prices they negotiated. Carpenters paid for healthcare services received by its members at the artificially inflated prices determined by PPO and HMO provider agreements at *all* of the BCBSM and HAP affected hospitals.[9] Proposed plaintiffs Susan Baynard and Patrice Noah are individuals insured under Priority Health's HMO plan. They paid artificially inflated prices for healthcare services at Paul Oliver Memorial Hospital that were set by Priority's provider agreement with Paul Oliver.[10] These plaintiffs, no different from absent class members, were injured when they paid the inflated hospital healthcare prices caused by BCBSM's MFN scheme. They have the same interest as other class members in proving the unlawfulness of Blue Cross's scheme and recovering the damages caused thereby.

(2) Class Counsel Will Fairly and Adequately Represent the Class

To satisfy the adequacy requirement, class counsel must be able to vigorously prosecute the interests of a class. *Jackson's Five Star Catering, Inc. v. Beason*, No. 10-CV-10010, 2012 WL 3205526, *2 n.2 (E.D. Mich. July 26, 2012)

[9] Ex. A - *See* Leitzinger Rpt. at ¶ 76 n.160.

[10] If the Court grants Plaintiff's motion to add Noah and Baynard as named plaintiffs, Plaintiffs will immediately produce documents for them that will show their purchases at Paul Oliver Memorial Hospital during the class period while insured by Priority Health, and thus establish their standing.

(quoting *In re Am. Med. Sys., Inc.*, 75 F.3d 1069, 1083 (6th Cir. 1996)). This Court has already determined that the four undersigned firms it appointed as interim class counsel have the experience, knowledge and resources to adequately represent the class. Dkt. 69, Order for Appointment of Interim Class and Liaison Counsel (finding that the four firms "will fairly and adequately represent the interests of the putative class."); *see* Fed. R. Civ. P. 23(g)(1)(A). Class counsel's zealous prosecution of this case since their appointment by, for example, opposing the motion to dismiss, actively participating in a very full period of fact discovery, and now preparing this motion, confirms their adequacy. Accordingly, the Court should find the four firms adequate under Rule 23(a)(4), and appoint them class counsel under Rule 23(g)(1), to represent the proposed class.

D. The Class Satisfies the Requirements of Federal Rule of Civil Procedure 23(b)(3)

Rule 23(b)(3) requires that: (1) common questions of law or fact predominate over individual questions; and (2) a class action is superior to other available methods of adjudication. Both requirements are easily satisfied here.

i. Common Questions of Proof Predominate Over Individual Ones

The Supreme Court has made clear that the predominance requirement is "*readily met* in certain cases alleging . . . violations of the antitrust laws." *Amchem*, 521 U.S. at 625 (emphasis added). In *Amgen*, the Supreme Court recently

emphasized that "Rule 23(b)(3). . . does *not* require a plaintiff seeking class certification to prove that each 'elemen[t] of [her] claim [is] susceptible to class-wide proof" but rather that "common questions *predominate* over any questions affecting only individual [class] members." 133 S.Ct. 1184, 1196 (2013) (emphasis in original); *see also Scrap Metal* 527 F.3d at 535 (proof of an antitrust "conspiracy is a common question that is thought to predominate over the other issues of the case.").

Predominance is found when "common questions represent a significant aspect of [a] case and . . . can be resolved for all members of [a] class in a single adjudication." *Messner*, 669 F.3d at 815. "Or, to put it another way, common questions can predominate if a 'common nucleus of operative facts and issues' underlines the claims brought by the proposed class." *Id*. The standard is "met if a single factual or legal question is 'at the heart of the litigation.'" *Calloway v. Caraco Pharm. Labs, Ltd.*, 287 F.R.D. 402, 407 (E.D. Mich. 2012) (quoting *Powers*, 501 F.3d at 619). As long as common issues and evidence have central significance, the presence of some peripheral individual issues or evidence will not defeat a finding of predominance. *Scrap Metal*, 527 F.3d at 535; *Sterling*, 855 F.2d at 1196; *In re Telectronics Pacing Sys., Inc*., 172 F.R.D. 271, 287 (S.D. Ohio 1997) ("That common issues predominate over individual issues does not require that the class members' claims be proven by identical evidence or that

individualized proof cannot be introduced on some issues.").

The major factual issues in this case —the existence, scope and terms of BCBSM's MFN scheme, the scheme's effect on competition, whether the scheme inflated prices for healthcare services at the 13 affected hospitals, and the methodology to estimate the class's damages—are all common to the class. As is typical in antitrust class actions, the focus of the evidence will be squarely on BCBSM's conduct and its effect on the market and the class as a whole — not on matters pertaining to any individual class member. Thus, this is one of the many antitrust cases where, as the Supreme Court's has observed, the predominance requirement is "readily met." *Amchem*, 521 U.S. at 625.

"Considering whether questions of law or fact common to class members predominate begins . . . with the elements of the underlying causes of action." *Erica P. John Fund, Inc. v. Halliburton Co.,* 131 S. Ct. 2179, 2184 (2011). Here, Plaintiffs allege a violation of Section 1 of the Sherman Act, 15 U.S.C. § 1 and Section 2 of the Michigan Antitrust Reform Act. See Dkt. 78, CAC ¶ 117-127. To establish an antitrust claim for damages, a plaintiff must prove "(1) a violation of the anti-trust law, (2) direct injury (or impact) from the violation, and (3) damages." *Foundry Resins*, 242 F.R.D. at 408–09. As shown below, common

issues predominate for each of the elements[11] and Plaintiffs will introduce common evidence to establish each element at trial.

(1) Common Evidence Can Establish Blue Cross's Antitrust Violation

There can be no dispute that the first element of Plaintiff's Section 1 antitrust claim presents an entirely common issue[12] – and one that predominates over any individual issues regarding impact and damages. "[C]onspiracy is a common question that is thought to predominate over the other issues of the case." *Scrap Metal*, 527 F.3d at 535. In antitrust cases, "courts have consistently found that common issues regarding the existence and scope of the conspiracy predominate over questions affecting only individual members." *Foundry Resins*, 242 F.R.D. at 408). Significantly, therefore, proof of Blue Cross's conspiracy with the hospitals in its network is an issue of sufficient importance and magnitude that

[11] While common issues predominate for each element here, all that is required is that common issues predominate for the claim overall. *Amgen*, 133 S. Ct. at 1196 ("Rule 23(b)(3), however, does *not* require a plaintiff seeking class certification to prove that each element of her claim is susceptible to classwide proof." (emphasis in original) (internal citations and quotations omitted)). And indeed, in this Circuit, not only is the conspiracy issue common, it "is thought to predominate over other issues in the case and has the effect of satisfying the first prerequisite of Rule 23(b)(3)." *Scrap Metal*, 527 F.3d at 535.

[12] *See In re Titanium Dioxide Antitrust Litig.*, 284 F.R.D. 328, 344 (D. Md. 2012) (holding conspiracy capable of common proof because plaintiffs' allegations will focus on the actions of the defendants, and thus will not vary among class members); *In re Chocolate Confectionary Antitrust Litig.*, 289 F.R.D. 200, 219 n.23 (M.D. Pa. 2012) ("There is little doubt that the conspiracy element of the antitrust claims *sub judice* will be provable with evidence common to the class.").

it alone causes common issues to predominate under clear Sixth Circuit precedent.

The central issues for that element are the existence, scope and anticompetitive effect of BCBSM's MFN scheme. This scheme includes a series of anticompetitive MFN agreements between BCBSM and its network hospitals. Proof of this conspiracy and its effect on competition plainly "will not vary among class members." *In re NASDAQ Market-Makers Antitrust Litig.*, 169 F.R.D. 493, 518 (S.D.N.Y. 1996).[13]

(2) Antitrust Impact Can Be Established Through Evidence Common to the Class.

The second element of Plaintiffs' Section 1 claim is "antitrust impact, sometimes referred to as 'fact of damage,' which results from a violation of the antitrust laws. *Cason-Merenda,* 2013 WL 5106520at *9 (quoting *Messner*, 669 F.3d 802at 816). Antitrust injury requires a showing of "some damage" due to a defendant's antitrust violations. *See Zenith Radio Corp. v. Hazeltine Research*, 395 U.S. 100, 114 n.9 (1969). An overcharge, the additional amount paid for a product or service due to an antitrust violation, which is the type of harm the class suffered here, is a classic form of antitrust injury. *See Hanover Shoe, Inc. v. United Machinery Corp.*, 392 U.S. 481, 489 (1968) (proof of an overcharge "ma[k]e[s] out a prima facie case of injury and damage within the meaning of §

[13] Dr. Leitzinger found that economic issues associated with proof of violation will involve evidence that is common to class members. Ex. A - Leitzinger Rpt. at Sec. VI.

4"); *Cardizem CD*, 200 F.R.D. at 309 (proof of overcharges is "most common method for determining damages").

"Plaintiffs are not required to show that the fact of injury actually exists for each class member." *Cardizem CD*, 200 F.R.D. at 340; *see also In re K-Dur Antitrust Litig*., 686 F.3d 197, 222 (3d Cir. 2012) ("For certification plaintiff need not prove antitrust injury actually occurred."). They only need to show that they are capable of establishing injury to the class with common proof at trial; unsurprisingly, courts have long held that in antitrust conspiracy cases like this one, causation can be established on a class-wide basis at trial. *Foundry Resins*, 242 F.R.D. at 409. Further, plaintiffs need not show that every class member was injured; certification is appropriate if the injury to the class was widespread, i.e., "most" class members were harmed. *Messner*, 669 F.3d at 818. This Court and others in the Sixth Circuit agree that the possible inclusion of some uninjured members in the class does not "transform the common [impact] question into a multitude of individual ones." *Cardizem CD*, 200 F.R.D. at 320-21; *Cason-Merenda,* 2013 WL 5106520at *13, *21 (court certified class when plaintiffs' expert showed "*almost* all of the members of the class" were harmed); *J.B.D.L. Corp. v. Wyeth-Ayerst Labs. Inc.,* 225 F.R.D. 208, 218 (S.D. Ohio 2003).[14]

[14] *See also Blackie v. Barrack*, 524 F.2d 891, 906 n.22 (9th Cir. 1975); *Meijer, Inc. v. Warner Chilcott Holdings Co. III, LTD*., 246 F.R.D. 293, 309-10 (D.D.C. 2007); *In re Sugar Indus. Antitrust Litig*., 73 F.R.D. 322, 347 (E.D. Pa. 1976). "[A]

Plaintiffs can submit two types of common proof at trial showing that the class was injured by Blue Cross's MFN scheme: (1) testimony and documents from Defendant's executives and those of hospitals and other insurers; and (2) expert testimony concerning accepted economic and econometric analyses. The availability of this common evidence satisfies Rule 23's predominance requirement. *See In re Linerboard Antitrust Litig.*, 305 F.3d 145, 153 (3rd Cir. 2002) (lesser showing was "belt and suspenders" proof under Rule 23).

Discovery has revealed testimony and documents, all of which are part of the proof of the MFN scheme's impact on the class, in which BCBSM's executives themselves noted that the MFNs would impact all of the prices class members paid for hospital services. For example, BCBSM executives have confirmed that the inflation in reimbursement rates negotiated by BCBSM to get the MFNs inflated the charges paid by all its insureds and self-insureds in the same manner.[15] When asked "is it the case, sir, that when hospital reimbursement rates increase, that self-funded customers pay those increases," a BCBSM hospital contracting executive

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class will often include persons who have not been injured by the [defendants'] conduct," but that does not defeat certification. *Id*. at 823 (quoting *Kohen*, 571 F.3d at 677). Only when it is apparent that a great many persons have not been impacted should a court deny class certification. *Kohen*, 571 F.3d at 677.

[15] Ex. IIII - Schaal Dep. 42:2-16; Ex. JJJJ - 75:7-18 ("Q: [D]oes that [model reimbursement] rate differ for inpatient or outpatient? A: No. Q: So the model sets out one reimbursement rate for traditional, TRUST, and BCN at a Peer Group 5 hospital? A: Yes.")

stated: "Somebody is going to pay for it," and then clarified that those paying for it "would be *all customers* in some shape or form or other." Ex. KKKK - Sorget Dep. 28:20-29:4 (emphasis added). He also stated that BCBSM's "level of discounts" in terms of their reimbursement rates would affect "the cost factor to what customers have to pay." Ex. LLLL - Sorget Dep. 246:7-8. Admissions like these are strong proof of causation that all or nearly all class members were injured. *See Blood Reagents*, 283 F.R.D. at 238-39 (evidence stating price increases affected all customers "lend support to a finding of predominance"); *Urethane*, 251 F.R.D. at 638-39 (crediting "documents from the defendants showing that the defendants viewed their price increase … to be successful").

Blue Cross's admissions that inflated reimbursement rates affected all purchasers of hospital services is not the only common evidence that class members were harmed by the MFN scheme. In addition, common evidence, much of it detailed in Sections V and VI of the Statement of Facts above, provides consistent, clear and direct proof that BCBSM's MFN scheme inflated reimbursement rates at the 13 affected hospitals. Numerous hospital and insurer executives, along with BCBSM's own personnel, ascribe increased reimbursement rates for Priority, HAP and Aetna directly to the requirements of BCBSM's MFN agreements. [redacted]

[redacted] BCBSM executives described how BCBSM increased its own reimbursement rates to obtain MFNs from hospitals. For example, BCBSM formed a "strategic alliance" with Beaumont wherein Beaumont would "shut out competing plans that approach them for a greater discount" in exchange for a substantial reimbursement rate increase from BCBSM. Ex. PP - M. Johnson Dep., DOJ Ex. 6 (BLUECROSSMI-99-051863 at -863). This evidence, common to the class, shows how BCBSM MFNs injured class members.

Moreover, Plaintiffs can present class-wide economic expert testimony at trial that corroborates what the lay evidence shows—all or nearly all of the class members were impacted by the MFN scheme. Plaintiffs retained Dr. Leitzinger to evaluate whether economic evidence that is common to members of the proposed class can be used at trial to corroborate the evidence in the discovery record that shows that class members were impacted at the 13 affected hospitals. Dr. Leitzinger has concluded that such economic evidence is available in the form of the analysis described below. Ex. A - *Id.* at Sec. VI.

Dr. Leitzinger statistically examined impact upon purchasers of healthcare services at the 13 hospitals where documents and testimony show that the MFN scheme inflated their payments to the hospital by raising the reimbursement rate of their insurer (or provider of their administrative services contract, if self-insured) .

Ex. A - *Id.* at Sec. VI(B). First, Dr. Leitzinger examined how the applicable reimbursement rate at the 13 hospitals changed after the MFN went into effect (or, in the case of Priority, HAP and Aetna, how the reimbursement rate changed after both the MFN became effective and these insurers then negotiated new reimbursement rates). Ex. A - Leitzinger Rpt. at ¶ 47-50.

Second, for Priority, HAP and Aetna, he compared their new, post-MFN reimbursement rates to Blue Cross's reimbursement rate to see whether their new rates brought them into compliance with the MFN. Ex. A - *Id.*

Third, he used a difference-in-differences (DID) regression analysis, which compared the actual annual reimbursement rate resulting from the applicable reimbursement formula in the provider agreement at the 13 hospitals with the actual reimbursement rates paid by the same insurance companies at similar hospitals in Michigan (the "benchmark" hospitals) under contracts without an MFN provision using the same "before and after" time periods as for the 13 hospitals.[16] In his regression, he included variables to control for variation among

[16] Courts have approved the use of DID regression analyses to assess antitrust impact and damages. *Messner, 669 F.3d at 810*; *In re Reformulated Gasoline (RFG) Antitrust & Patent Litig.*, No. CV-05-01671, 2007 WL 8056980, *8–10 (C.D. Cal. Mar. 27, 2007) (granting plaintiffs' motion for class certification where plaintiffs' expert offered difference-in-differences regression as one method to measure impact); *see also* authority crediting regression analyses for common proof of antitrust impact and damages: *Conwood Co., L.P. v. U.S. Tobacco Co.*, 290 F.3d 768, 793 (6th Cir. 2002) (describing regression analysis as a "generally accepted method[] of proving antitrust damages"); *Foundry Resins*, 242 F.R.D. at

hospitals in such characteristics as complexity of care, costs, insurers' billed amounts, and location. Ex. A - *Id.* at ¶ 51-57.

With DID regression analysis, he compared the change in reimbursement rates at the 13 hospitals with the change in reimbursement rates at the benchmark hospitals to see whether the MFN caused any of the 13 hospitals to have greater increases (or smaller decreases) in reimbursement rates than the benchmark hospitals experienced. The specific comparison was between a given MFN hospital (i.e., one of the 13) and the benchmark hospitals in Michigan within the same Peer Group. For example, if the MFN hospital was a PG 1 hospital, Dr. Leitzinger used all PG 1 hospitals in Michigan with no MFN agreement with claims present in both the pre- and post-MFN time periods as the benchmark.[17] He

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411 ("[C]ourts have recognized that [regression] analyses are acceptable, generalized methods for assessing damages on a class-wide basis."); *In re High Fructose Corn Syrup Antitrust Litig.*, 295 F.3d at 660-61 (7th Cir. 2002) (same); *TFT-LCD*, 265 F.R.D. at 313 (N.D. Cal. 2010) ("courts have accepted multiple regression and correlation analyses as means of proving antitrust injury and damages on a class-wide basis"); *see also Scrap Metal*, 527 F.3d at 532-34 (approving multiple regression as a standard acceptable scientific method); *Realcomp II, Ltd. v. F.T.C.*, 635 F.3d 815, 834 (6th Cir. 2011) (finding that an expert's "benchmark, and statistical-regression analyses thus provide substantial evidence in support of . . . anticompetitive effects"); *Chocolate Confectionary*, 289 F.R.D. at 220 (regression analysis "is the comparing of variables to determine the influence that one variable, the independent or explanatory variable, has on another variable, the dependent variable."); *In re Ethylene Propylene Diene Monomer (EPDM) Antitrust Litig.*, 256 F.R.D. 82, 95 (D Conn. 2009) (plaintiffs commonly use regression analyses in antitrust cases).

[17] The exception was for PG 5 hospitals. Because all such hospitals in Michigan had MFN agreements, there obviously were no PG 5 hospitals that could

concluded that the MFN scheme inflated the reimbursement rate at any MFN hospital that had greater increases or smaller decreases in reimbursement rates compared to the benchmark hospitals. Ex. A – *Id.* at ¶ 57. Using this methodology, which is common to the class, Dr. Leitzinger's analysis shows that reimbursement rates were inflated at the 13 hospitals due to the MFN scheme.

After determining that such reimbursement rates were inflated, Dr. Leitzinger next examined whether these inflated rates caused the payments by class members for the covered healthcare services also to be inflated.[18] He used another

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serve as a benchmark. Dr. Leitzinger thus used the most comparable benchmark hospitals available: PG 4 hospitals in Michigan without an MFN agreement. Differences between PG 4 and PG 5 hospitals are generally limited to the number of beds. Ex. A - Leitzinger Rpt. at ¶ 54.

[18] Dr. Leitzinger described the process in this manner, Ex. A - *id* at ¶ 58-59:

> 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 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.
>
> 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

set of common evidence to discern that all such payments contained an overcharge: the reimbursement methodologies contained in Priority, HAP, Aetna and BCBSM's contracts with the affected hospitals and other relevant documents. Ex. A - *Id.* at Sec. VI(C). All four insurers utilized reimbursement formulas that. if reimbursement rates were inflated, then the reimbursement rates for all claims employing that formula would be inflated, or resulted in the same degree of rate inflation from pre- to post-MFN across all covered services whether the insurer had a single reimbursement formula for all services or different formulas for different types of services (e.g., inpatient v. outpatient). Ex. A - *Id.* at Sec. VI(C)(1)-(4). These methodologies thus confirm that inflation in the overall reimbursement rate caused inflation in the payments made by class members to the affected hospitals. Ex. A - *Id.* Thus the analysis is additional common evidence that is available to prove at trial that the MFN scheme injured all or nearly all class members. The second element of plaintiffs' case, antitrust injury, can be proved with common evidence.

In *Messner*, an antitrust damages class action claiming that a hospital merger resulted in inflated prices for hospital healthcare services, the Seventh Circuit explained why the same type of DID regression analysis used here can be applied to show common impact. The plaintiff's expert, Dr. Dranove, proposed using a

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insurer/hospital Provider Agreements constitutes evidence that is common to Class members.

"differences-in-differences" method whereby he would compare "the percentage change in [defendant's] prices between the pre- and post-merger periods . . . to the percent change in prices at a control group of local hospitals during the same period." *Id.* at 810. The difference in magnitude between the price changes of the merged hospital and the price changes of the control group would estimate the overcharge imposed on the defendant's patients due to its exercise of increased market power after the merger. *Id.* at 817.

The district court denied class certification, finding fault with Dranove's methodology. *Id.* The Seventh Circuit, however, vacated, stating:

> Dranove claimed that he could use common evidence—the post-merger price increases Northshore negotiated with insurers—to show that *all or most* of the insurers and individuals who received coverage through those insurers *suffered some antitrust injury* as a result of the merger. That was *all that was necessary to show predominance* for purposes of Rule 23(b)(3).

Id. at 818 (citing *Hydrogen Peroxide*, 552 F.3d at 311-12) (internal cites omitted; emphasis added). The Seventh Circuit also concluded that although uniform price increases would simplify the analysis:

> [A] lack of uniformity would only require [Dranove] to do more [differences-in-differences] analyses for each contract—one analysis for each individual non-uniform price increase imposed in the contract being analyzed. . . . In a more complex world, multiple analyses would be needed to show more accurately a contract's precise impact on class members. That need does not change the fact that those analyses all rely on common evidence—the contract setting out the non-uniform price increases—and a common methodology to show that impact. *Id.* at 819.

Here, Dr. Leitzinger likewise can use common evidence—the inflated reimbursement rates and the resulting inflated prices for hospital healthcare services caused by the MFN scheme, as well as his common methodology—to show that all or nearly all purchasers of those services paid some overcharge and thus suffered some antitrust injury. Applying the same methodology multiple times for the different provider agreements at issue does not change the fact that the methodology is common to all class members. A finding of predominance is as warranted here as it was in *Messner*.

(3) A Reliable Method of Proving Class-wide Damages Exists

"[P]laintiffs meet their burden if they show that they can use recognized and reliable methodologies to prove damages on a class-wide basis."[19] *Foundry Resins*, 242 F.R.D. at 410 (citing *Carbon Black*, 2005 WL 102966 at *19-20 (D. Mass. 2005)). The Sixth Circuit has "never required a precise mathematical calculation of damages before deeming a class worthy of certification." *Scrap Metal*, 527 F.3d

[19] Of course, even if there were a need to determine damages individually, that would not pose an obstacle to class certification. *See Scrap Metal*, 527 F.3d at 535 ("the court found that the 'fact of damages' was a question common to the class even if the amount of damages sustained by each individual class member varied.") (citing *CenturyTel, Inc.*, 511 F.3d at 564); *Olden v. LaFarge Corp.*, 383 F.3d 495, 508 (6th Cir. 2004) ("individual *damage* determinations might be necessary, but the plaintiffs have raised common allegations which would likely allow the court to determine liability (including causation) for the class as a whole") (emphasis in original).

at 535 (citation omitted).[20] This relaxed standard is due to the long-standing antitrust doctrine that "a defendant whose wrongful conduct has rendered difficult the ascertainment of the precise damages suffered by the plaintiff is not entitled to complain that they cannot be measured with the same exactness and precision as would otherwise be possible." *Eastman Kodak Co.v. Southern Photo Materials Co.,* 273 U.S. 359, 379 (1927).[21]

In this case, Dr. Leitzinger has concluded that there is a workable, formulaic approach to estimating the amount of the class's damages in the form of overcharges paid for hospital healthcare services. Ex. A - Leitzinger Rpt. at ¶ 11, 75. He used the same DID regression methodology described above that has been commonly used by economists analyzing the impact of competition on hospital reimbursement and adopted by courts analyzing damages in antitrust class actions.[22] Dr. Leitzinger concluded that the percent of inflation in reimbursement

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[20] *See also Blood Reagents*, 283 F.R.D. at 240 (as to the expert's methodology for measuring damages at trial, the court noted that at the class certification stage, it need only "find that the model 'could evolve to become admissible evidence,' but the model need not be 'perfect.'" (citations omitted)).

[21] *See also Texaco, Inc. v. Hasbrouck*, 496 U.S. 543, 573, n. 31 (1990) (standard not rigorous); *Rossi v. Standard Roofing, Inc.,* 156 F.3d 452, 484 (3d Cir. 1998) (a "reasonable estimate" sufficient).

[22] *See supra*; *Conwood*, 290 F.3d at 793; *Foundry Resins*, 242 F.R.D. at 411 (recognizing that multiple regression models are "reasonable damages methodologies"); *Chocolate Confectionary*, 289 F.R.D. at 212 n.14 (noting multiple regression analyses "have been accepted by many courts as reasonable and reliable methods of proving class-wide damages"); *Flat Glass*, 191 F.R.D. at

revealed through the DID regression analysis can be applied to the total reimbursement dollars received by the hospital under the applicable provider agreement and during the applicable time period – totals that are readily calculable from the data provided through discovery in this case – in order to determine the aggregate overcharge for the class. Ex. A - *Id.* at ¶ 11, 65, 75. Dr. Leitzinger's standard, reliable formulaic calculation would provide the amount by which class members overpaid for hospital services as a result of Blue Cross's MFN scheme. Ex. A - *Id.* at ¶ 75. As this damages analysis is common to the class, there can be no doubt that plaintiffs can prove their antitrust claims with common evidence that predominates over any individual evidence.

ii. Class Action Treatment is Superior to Other Methods of Adjudication

The "superiority" requirement ensures that resolution by class action will "achieve economies of time, effort, and expense, and promote … uniformity of

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475-87 (holding that multiple regression analysis is one of most common ways to estimate damages in antitrust cases; "There is no dispute that when used properly multiple regression analysis is one of the mainstream tools in economic study and it is an accepted method of determining damages in antitrust litigation."); *In re Sulfuric Acid Antitrust Litig.*, No. 03-C-4576, 2007 WL 898600, at *7 (N.D. Ill. March 21, 2007) (noting multiple regression analysis has "been found to be [an] acceptable mechanism[] on which to base a class action"); *DRAM*, 2006 WL 1530166, at *10 ("other courts have already upheld" multiple regression models "as valid means for proving damages on a class-wide basis, and this court has found no reason to reject them at this stage of the proceedings"); *In re Bulk (Extruded) Graphite Products Antitrust Litig.*, 2006 WL 891362, at *15 (D.N.J. April 4, 2006) (noting multiple regression "methods are widely accepted").

decision as to persons similarly situated, without sacrificing procedural fairness or bringing about other undesirable results." *Amchem*, 521 U.S. at 615.[23] "If common questions are found to predominate," then courts also generally have found the superiority requirement satisfied. *Carbon Black,* 2005 WL 102966 at *21. "Courts are generally loath to deny class certification based on speculative problems with case management." *In re NASDAQ Market-Makers Antitrust Litig.*, 169 F.R.D. 493, 528 (S.D.N.Y. 1996). Courts have noted that "[a]ntitrust class actions are expensive endeavors and joining forces with other similarly situated plaintiffs is often the only way to effectuate a case." *Carbon Black*, 2005 WL 102966, *22.

Trying this case as a class action would be "superior to other available methods." A class action here would avoid repetitive adjudications; prevent possible inconsistent results; and allow class members an opportunity for redress they would otherwise be denied. Class members' individual recoveries would not warrant their own suits. *See Kinder v. United Bancorp, Inc.*, No. 11-cv-10440, 2012 U.S. Dist. LEXIS 140567, at *16 (E.D. Mich. 2012) (finding superiority; as"[i]ndividual recovery [wa]s limited to $1000," it was "unlikely that prospective

[23] *See also Sterling v. Velsicol Chem.*, 855 F.2d 1188, 1196 (6th Cir. 1988)("The procedural device of a Rule 23(b)(3) class action was designed not solely as a means for assuring legal assistance in the vindication of small claims but, rather, to achieve the economies of time, effort, and expense.") (citations omitted); *Cardizem*, 200 F.R.D. at 351 ("proceeding with this consolidated multi-district litigation as a class action will achieve economies of both the litigants' and the Court's time, efforts and expense").

plaintiffs would take on the expense of counsel"). The presence of large claimants, like businesses and unions, does not militate against certification. *Paper Systems, Inc. v. Mitsubishi*, 193 F.R.D. 601, 605 (E.D. Wis. 2000).[24] In sum, a single class-wide adjudication would be more efficient than thousands of individual actions litigating the same issues with the same proof, and more fair than the more likely alternative—no individual suits at all. *See, e.g.*, *Cardizem*, 200 F.R.D. at 350 - 351; *Urethane*, 237 F.R.D. at 453.

CONCLUSION

In sum, the Court should grant the motion, certify the proposed class and appoint the undersigned firms as co-lead counsel for the proposed class.

[24] There are currently no individual cases pending against Blue Cross seeking recovery of overcharges despite the fact that the Department of Justice and the State of Michigan publicly challenged the lawfulness of the MFN agreements in a lawsuit in this Court. This supports the conclusion that individual actions are not a viable alternative to a class action. *See Riordan v. Smith Barney*, 113 F.R.D. 60, 66 (N.D. Ill. 1986) (finding superiority in part because "no other actions against defendants arising out of the transaction at issue are currently pending").

Dated: October 21, 2013

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on October 21, 2013, I electronically filed *under seal* Plaintiffs' Motion for Class Certification and Appointment of Class Counsel and Supporting Memorandum with the Clerk of the Court using the ECF, who in turn sent notice to the following:

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/s/ Brent W. Johnson_____
Brent W. Johnson

Exhibit A

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]

[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]

[redacted]

[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

[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.

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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

Developments in Antitrust Cases Alleging Delayed Generic Competition in the Pharmaceutical Industry, *American Antitrust Institute,* 5th Annual Future of Private Antitrust Enforcement Conference, December 2011.

Class Certification and Calculation of Damages, *American Bar Association*, Section of Antitrust Law and *International Bar Association*, 8th International Cartel Workshop, February 2010.

Class Certification Discussion and Demonstration, *American Bar Association,* Section of Antitrust Law, The Antitrust Litigation Course, October 2007.

Antitrust Injury and the Predominance Requirement in Antitrust Class Actions, *American Bar Association*, Houston Chapter, April 2007.

Class Certification Discussion and Demonstration, *American Bar Association,* Section of Antitrust Law, The Antitrust Litigation Course, October 2005.

What Can an Economist Say About The Presence of Conspiracy?, *American Bar Association,* Antitrust Law, The Antitrust Litigation Course, October 2003.

Lessons From Gas Deregulation, *International Association for Energy Economics,* Houston Chapter*,* December 2002.

A Retrospective Look at Wholesale Gas Industry Restructuring, *Center for Research in Regulated Industries*, 20th Annual Conference of the Advanced Workshop in Regulation and Competition, May 2001.

The Economic Analysis of Intellectual Property Damages, *American Conference Institute,* 6th National Advanced Forum, January 2001.

Law and Economics of Predatory Pricing Under Federal and State Law, *Golden State Antitrust and Unfair Competition Law Institute*, 8th Annual Meeting, October 2000.

Non-Price Predation--Some New Thinking About Exclusionary Behavior*, Houston Bar Association*, Antitrust and Trade Regulation Section, October 2000.

After the Guilty Plea: Does the Defendant Pay the Price in the Civil Damage Action, *American Bar Association*, Section of Antitrust Law, 48th Annual Spring Meeting, April 2000.

Economics of Restructuring in Gas Distribution, *Center for Research in Regulated Industries*, 12th Annual Western Conference, July 1999.

A Basic Speed Law for the Information Superhighway, *California State Bar Association*, December 1998.

INVITED PRESENTATIONS (cont'd.)

Innovation in Regulation, *Center for Research in Regulated Industries*, 11th Annual Western Conference, July/September 1998.

Electric Industry Deregulation: What Does The Future Hold?, *Los Angeles Headquarters Association,* November 1996.

Why Deregulate Electric Utilities?, *National Association of Regulatory Utility Commissioners*, November 1995.

Restructuring U.S. Power Markets: What Can the Gas Industry's Experience Tell Us?, *National Association of Regulatory Utility Commissioners*, July 1995.

Natural Gas Restructuring: Lessons for Electric Utilities and Regulators, *International Association for Energy Economics*, May 1995.

Techniques in the Direct and Cross-Examination of Economic, Financial, and Damage Experts*, The Antitrust and Trade Regulation Law Section of the State Bar of California and The Los Angeles County Bar Association*, 2nd Annual Golden State Antitrust and Trade Regulation Institute, October 1994.

Demonstration: Deposition of Expert Witnesses and Using Legal Technology, *National Association of Attorneys General*, 1994 Antitrust Training Seminar, September 1994.

Direct and Cross Examination of Financial, Economic, and Damage Experts, *The State Bar of California, Antitrust and Trade Regulation Law Section,* May 1994.

Price Premiums in Gas Purchase Contracts, *International Association for Energy Economics,* October 1992.

Valuing Water Supply Reliability, *Western Economic Association,* Natural Resources Section*,* July 1992.

Transportation Services After Order 636: "Back to the Future" for Natural Gas, Seminar sponsored by Jones, Day, Reavis & Pogue, May 1992.

The Cost of An Unreliable Water Supply for Southern California, Forum presented by Micronomics, Inc., May 1991.

Market Definition: It's Time for Some "New Learning", *Los Angeles County Bar Association,* Antitrust and Corporate Law Section, December 1989.

Market Definition in Antitrust Cases: Some New Thinking, *Oregon State Bar,* Antitrust Law Section*,* March 1987.

INVITED PRESENTATIONS (cont'd.)

Future Directions for Antitrust Activity in the Natural Gas Industry, *International Association of Energy Economists*, February 1987.

Information Externalities in Oil and Gas Leasing, *Western Economic Association Meetings*, Natural Resources Section, July 1983.

Economic Analysis of Offshore Oil and Gas Leasing, *Western States Land Commissioners Association*, December 1982.

PUBLISHED ARTICLES

"The Predominance Requirement for Antitrust Class Actions--Can Relevant Market Analysis Help?," American Bar Association, Section of Antitrust Law, *Economics Committee Newsletter*, Volume 7, No. 1, Spring 2007.

"Gas Line Economic?," *Petroleum News, Volume 11, No. 25,* June 2006.

"A Retrospective Look at Wholesale Gas: Industry Restructuring," *Journal of Regulatory Economics,* January 2002.

"Balance Needed in Operating Agreements as Industry's Center of Gravity Shifts to State Oil Firms," *Oil & Gas Journal*, October 2000.

"What Can We Expect From Restructuring In Natural Gas Distribution?" *Energy Law Journal*, January 2000.

"Gas Experience Can Steer Power Away from Deregulation Snags," *Oil & Gas Journal,* August 1996.

"Anatomy of FERC Order 636: What's out, What's in," *Oil & Gas Journal*, June 1992.

"Antitrust II – Future Direction for Antitrust in the Natural Gas Industry," *Natural Gas*, November 1987.

"Information Externalities in Oil and Gas Leasing," *Contemporary Policy Issues*, March 1984.

"Regression Analysis in Antitrust Cases: Opening the Black Box," *Philadelphia Lawyer*, July 1983.

"Foreign Competition in Antitrust Law," *The Journal of Law & Economics*, April 1983.

REGULATORY SUBMISSIONS

In the Matter of the Application of Southern California Gas Company Regarding Year Six (1999-2000) Under its Experimental Gas Cost Incentive Mechanism and Related Gas Supply Matters; A.00-06-023, Public Utilities Commission of the State of California, November 2001.

Sempra Energy and KN Energy, Incorporation; Docket No. EC99-48-000 (Affidavit and Verified Statement), Federal Energy Regulatory Commission, March/May 1999.

Rulemaking on the Commission's Own Motion to Assess and Revise the Regulatory Structure Governing California's Natural Gas Industry (Market Conditions Report), Public Utilities Commission of the State of California, July 1998.

In the Matter of the Application of Pacific Enterprises, Enova Corporation, et al. for Approval of a Plan of Merger Application No. A. 96-10-038, Public Utilities Commission of the State of California, August/October 1997.

In re: Koch Gateway Pipeline Company; Docket No. RP 97-373-000, Federal Energy Regulatory Commission, May/October 1997 and February 1998.

In the Matter of the Application of Sadlerochit Pipeline Company for a Certificate of Public Convenience and Necessity; Docket No. P-96-4, Alaska Public Utilities Commission, May 1996.

Public Funding of Electric Industry Research, Development, and Demonstration (RD&D) Under Partial Deregulation, California Energy Commission, January 1995.

NorAm Gas Transmission Company; Docket No. RP94-343-000, Federal Energy Regulatory Commission, August 1994/June 1995.

Natural Gas Vehicle Program; Investigation No. 919-10-029, California Public Utilities Commission, July 1994.

Transcontinental Gas Pipe Line Corporation; Docket No. RP93-136-000 (Proposed Firm-to-the-Wellhead Rate Design), Federal Energy Regulatory Commission, January 1994.

In re: Sierra Pacific's Proposed Nomination for Service on Tuscarora Gas Pipeline; Docket No. 93-2035, The Public Service Commission of Nevada, July 1993.

Employment Gains in Louisiana from Entergy-Gulf States Utilities Merger, Louisiana Public Utilities Commission, December 1992.

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Employment Gains to the Beaumont Area from Entergy-Gulf States Utilities Merger, Texas Public Utilities Commission, August 1992.

Transcontinental Gas Pipe Line Corporation; Docket No. RS 92-86-000 (Affidavit regarding Transco's Proposed IPS Service), Federal Energy Regulatory Commission, June 1992.

In Re: Pipeline Service Obligations; Docket No. RM91-11-000; Revisions to Regulations Governing Self-Implementing Transportation Under Part 284 of the Commission's Regulations; Docket No. RM91-3-000; Revisions to the Purchased Gas Adjustment Regulations; Docket No. RM90-15-000, Federal Energy Regulatory Commission, May 1991.

In the Matter of Natural Gas Pipeline Company of America; Docket No. CP89-1281 (Gas Inventory Charge Proposal), Federal Energy Regulatory Commission, January 1990.

In the Matter of United Gas Pipeline Company, UniSouth, Cypress Pipeline Company; Docket No. CP89-2114-000 (Proposed Certificate of Storage Abandonment by United Gas Pipeline Company), Federal Energy Regulatory Commission, December 1989.

In the Matter of Tennessee Gas Pipeline Company; Docket No. CP89-470 (Gas Inventory Charge Proposal), Federal Energy Regulatory Commission, July 1989.

In the Matter of Take-Or-Pay Allocation Proposed by Mississippi River Transmission Corporation, Federal Energy Regulatory Commission, March 1988.

In the Matter of Natural Gas Pipeline Company of America: Docket No.RP87-141-000 (Gas Inventory Charge Proposal), Federal Energy Regulatory Commission, December 1987.

In the Matter of Application of Wisconsin Gas Company for Authority to Construct New Pipeline Facilities; 6650-CG-104, Public Service Commission, State of Wisconsin, August 1987.

Trans-Alaska Pipeline System: Docket Nos. OR 78-1-014 and OR 78-1-016 (Phase 1 Remand), Federal Energy Regulatory Commission, October 1983.

Dr. Jeffrey Leitzinger
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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October 2009 – September 2013

	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.
DOJ BCBSM EDW Questions, November 19, 2012.
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

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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
02245412 - 02245426
02279582 - 02279585
02280185
02984062 - 02984066
03785568
06233228 - 06233239

CAH prefix

000457 - 000494

CIVLIT prefix

00361349
00270479 - 00270489

HAP-DOJ prefix

002872 - 002887
002911
003072 - 003080
003099 - 003109
003114
003875 - 003898
003911

NPI prefix

1023193901
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1538195409
1568739423
1578501367
1639186521
1750694790

PH-DOJ prefix

0001423
0001440
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0001464
0001480
0001489
0001638
0001642

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0001647
0001650
0001890
0001894
0001899
0001902
0002047
0002195
0002199
0002204
0002207
0002420
0002437
0002468
0003526 - 0003589

SHCH-DOJ prefix
004904

SHER prefix
06041 - 06052
09416 - 09433

SHS prefix
001191
001194

SHS-KMAT prefix
000000661
000003625

SHVN prefix
1988 - 1989

BI EDW Documentation
BI EDW Medical Claims Logical Data Model
BI EDW Medical Claims Physical Data Model
BI EDW Medical Claims Table Column Report
BI EDW Customer Subject Area Logical Data Model
BI EDW Customer Subject Area Model
BI EDW Customer Subject Area Physical Data Model
BI EDW Customer Subject Area Table Column Report

AHA Documentation
AHA Data Layout from 2005, AHA Survey Database File Layout, 2005
AHA Data Layout from 2006, AHA Survey Database File Layout, 2006
AHA Data Layout from 2007, AHA Survey Database File Layout, 2007
AHA Data Layout from 2008, AHA Survey Database File Layout, 2008
AHA Data Layout from 2009, AHA Survey Database File Layout, 2009
AHA Data Layout from 2010, AHA Survey Database File Layout, 2010
AHA Data Layout from 2011, AHA Survey Database File Layout, 2011
AHA Guide from 2012, Michigan 2012 AHA Guide

HAP Documentation
DOJ_DATA_DICTIONARY_FINAL.xlsx

Priority Health Documentation
DOJ_Fields_Documentation.xlsx
Provider_type_description.xlsx
PH Hospital Contracting Data Compilation.xlsx

Data

AHA Data
AHA Data from 2005 AHA Survey Database, 2005
AHA Data from 2006 AHA Survey Database, 2006
AHA Data from 2007 AHA Survey Database, 2007
AHA Data from 2008 AHA Survey Database, 2008
AHA Data from 2009 AHA Survey Database, 2009
AHA Data from 2010 AHA Survey Database, 2010
AHA Data from 2011 AHA Survey Database, 2011

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BCBSM Corporate Crosswalk produced at Byrnes Deposition
PDNP0000 XWALK Data 11192012 Files

BCN Data
CMC_CDML_CL_LINE_H1.dat
CMC_CDML_CL_LINE_H1.sql
CMC_CLCL_CLAIM_H1.dat
CMC_CLCL_CLAIM_H1.sql
CMC_PRPR_PROV_H1.dat
CMC_PRPR_PROV_H1.sql

BI EDW Data
BI_EDW_STAGE.PROVDB2_TPPOFAC
BI_EDW_STAGE.PROVDB2_TPROV
BI_EDW_STAGE.PROVDB2_TADR
BI_EDW_HIST.CD_MAPNG
BI_EDW_HIST.MED_CLM_BILL_PROV_HSTY, 2005-2012
BI_EDW_HIST.MED_CLM_HSTY, 2005-2012
BI_EDW_HIST.MED_SRVLN_HSTY, 2005-2012
BI_EDW_HIST.GRP_SEG_HSTY
BI_EDW_CONF.GRP_SEG_DMNS.S_CURR
BI_EDW_CONF.GRP_SEG_DMNS.S_PREV
BI_EDW_HIST.MED_SRVLN_CUST_HSTY, 2005-2012
BI_EDW_HIST.GRP_SEG_RISK_CELL_HSTY
BI_EDW_HIST.RISK_CELL_HSTY

HAP Data
doj_2005_2006.txt
doj_2007_2008.txt
doj_2009_2010.txt
doj_2011_2012.txt
doj_membership.txt

Priority Data
USDOJ_Medical_Claims_2005.TXT
USDOJ_Medical_Claims_2006.TXT
USDOJ_Medical_Claims_2007.TXT
USDOJ_Medical_Claims_2008.TXT
USDOJ_Medical_Claims_2009.TXT
USDOJ_Medical_Claims_2010.TXT
USDOJ_Medical_Claims_2011.TXT
USDOJ_Medical_Claims_2012.TXT

OFIR Data
OFIR Data 2003
OFIR Data 2004
OFIR Data 2005
OFIR Data 2006
OFIR Data 2007
OFIR Data 2008
OFIR Data 2009
OFIR Data 2010
OFIR Data 2011

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1982 Merger Guidelines.
Allen, Mark A., Hall, Robert E., Lazear, Victoria A., Reference Guide on Estimation of Economic Damages, Reference Guide on Estimation of Economic Damages, Reference Manual on Scientific Evidence Third Edition, 2011.
Angrist, Joshua D., Krueger, Alan B., Does Compulsory School Attendance Affect Schooling and Earnings? Quarterly Journal of Economics, November 1991.
Bell, Jacqueline, "Blue Cross Michigan Hit With 'Most Favored Action'," Law 360, www.law360.com, November 1, 2010.
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Borenstein, Severin, Airline Mergers, Airport Dominance, and Market Power, The American Economic Review, May 1990.
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Card, David, Krueger, Alan B., Minimum Wages and Employment: A Case Study of the Fast-Food Industry in New Jersey and Pennsylvanis: Reply The American Economic Review, December 2000.
Carroll, John D. and Ball, Kate, "Antitrust Issues in Bilateral Monopolies," Law 360, www.law360.com, November 8, 2011.
Dennis, Anthony J., Potential Antocompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts, Annals of Health Law, 1995.
Dennison, Mike, "New West Must Sell Large Share of Business to Oregon Insurer in Antitrust Deal,Missoulian, www.Missoulian.com, November 9, 2011.

Exhibit 2
In re: The Shane Group, Inc., et al. v. Blue Cross Blue Shield of Michigan
List of Materials Reviewed

Eames, Jessica M. and Sullivan, Kevin, "DOJ brings suit against Blue Cross Blue Shield of Michigan," Association of Corporate Counsel Lexology, www.lexology.com, October 25, 2010.
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Graybeal, John, "Most Favored Nations Clauses: Has a Tortured Past Produced a Settled Future?" www.antitrustandtraderegulationlaw.ncbar.org, August 22, 2011.
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Hastings, Justine S., Vertical Relationships and Competition in Retail Gasoline Markets: Empirical Evidence from Contract Changes in Southern California, The American Economic Review, March 2004.
Horizontal Merger Guidelines, U.S. Department of Justice and the Federal Trade Commission, August 19, 2010.
Justice Department Requires Divestiture to Preserve Health-Insurance Competition in Montana, Department of Justice, www.justice.gov, November 8, 2011.
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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.

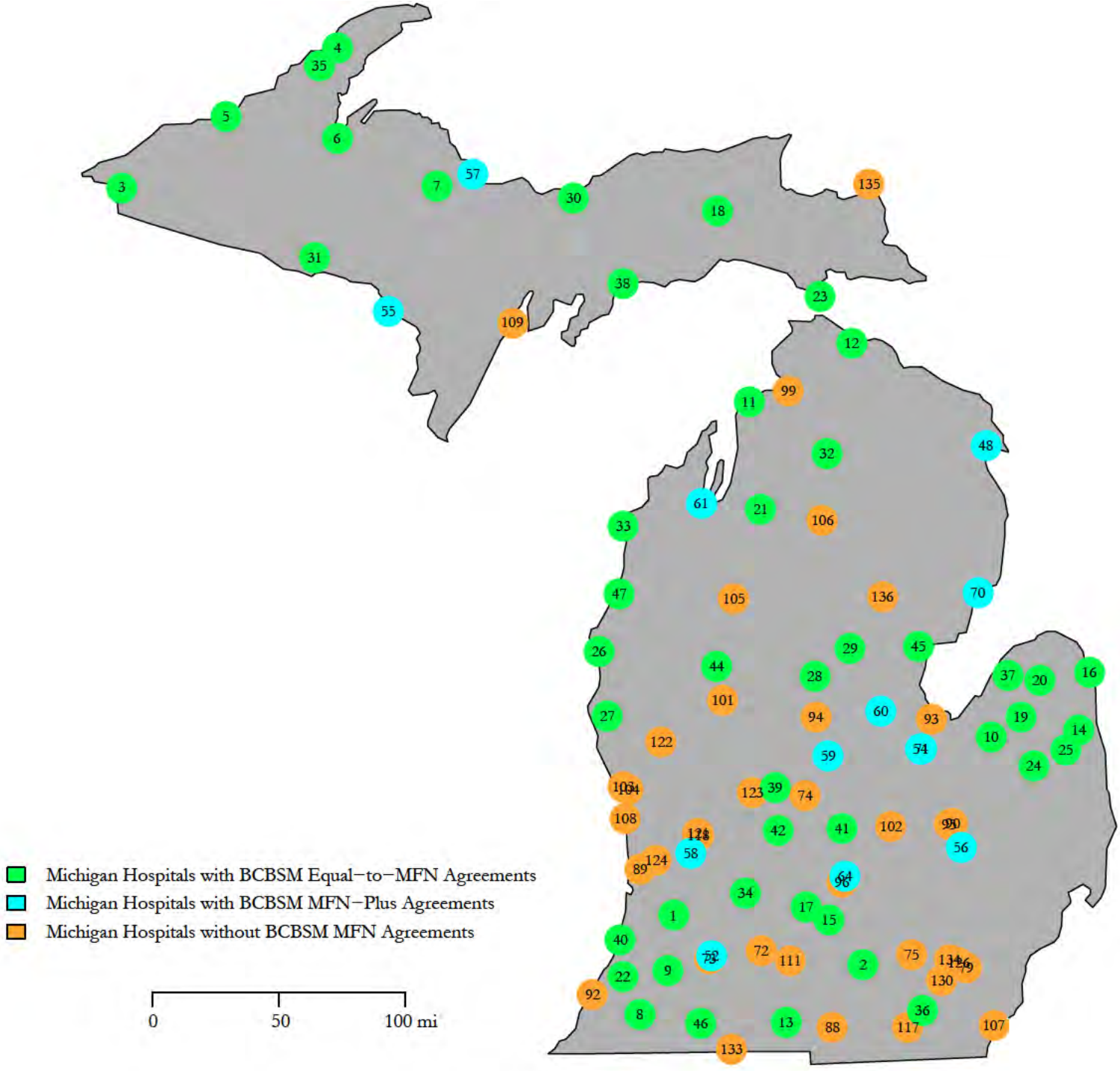
Cols. (7) & (8): U.S. Census Bureau Metropolitan and Micropolitan Delineation Files, Core based statistical areas (CBSAs) and combined statistical areas (CSAs), Feb. 2013, at http://www.census.gov/population/metro/data/def.html. Last accessed May 16, 2013.
U.S. Census Bureau Population Estimates, Metropolitan 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

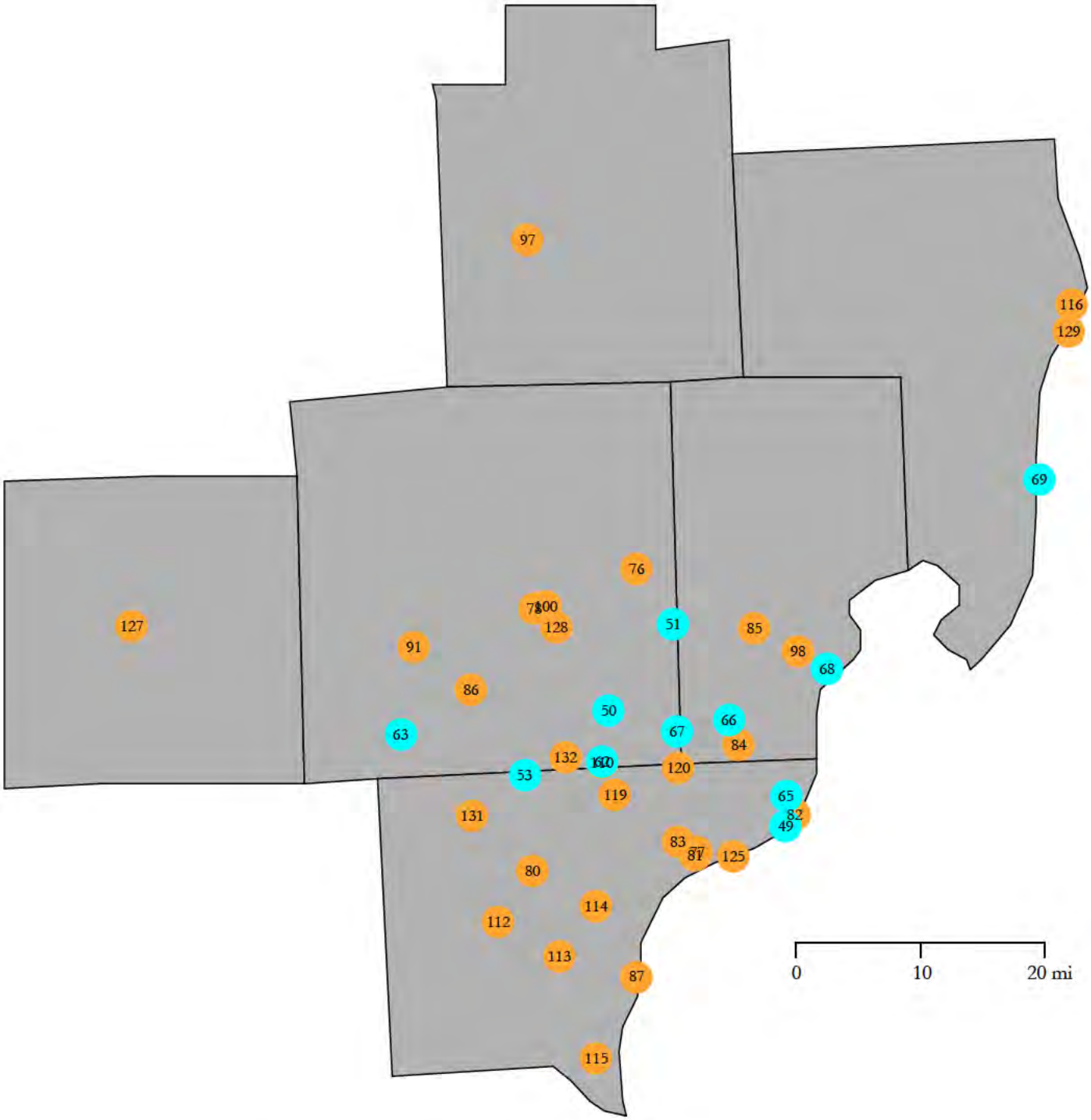
Source: Michigan Office of Financial and Insurance Regulation (OFIR).

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



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

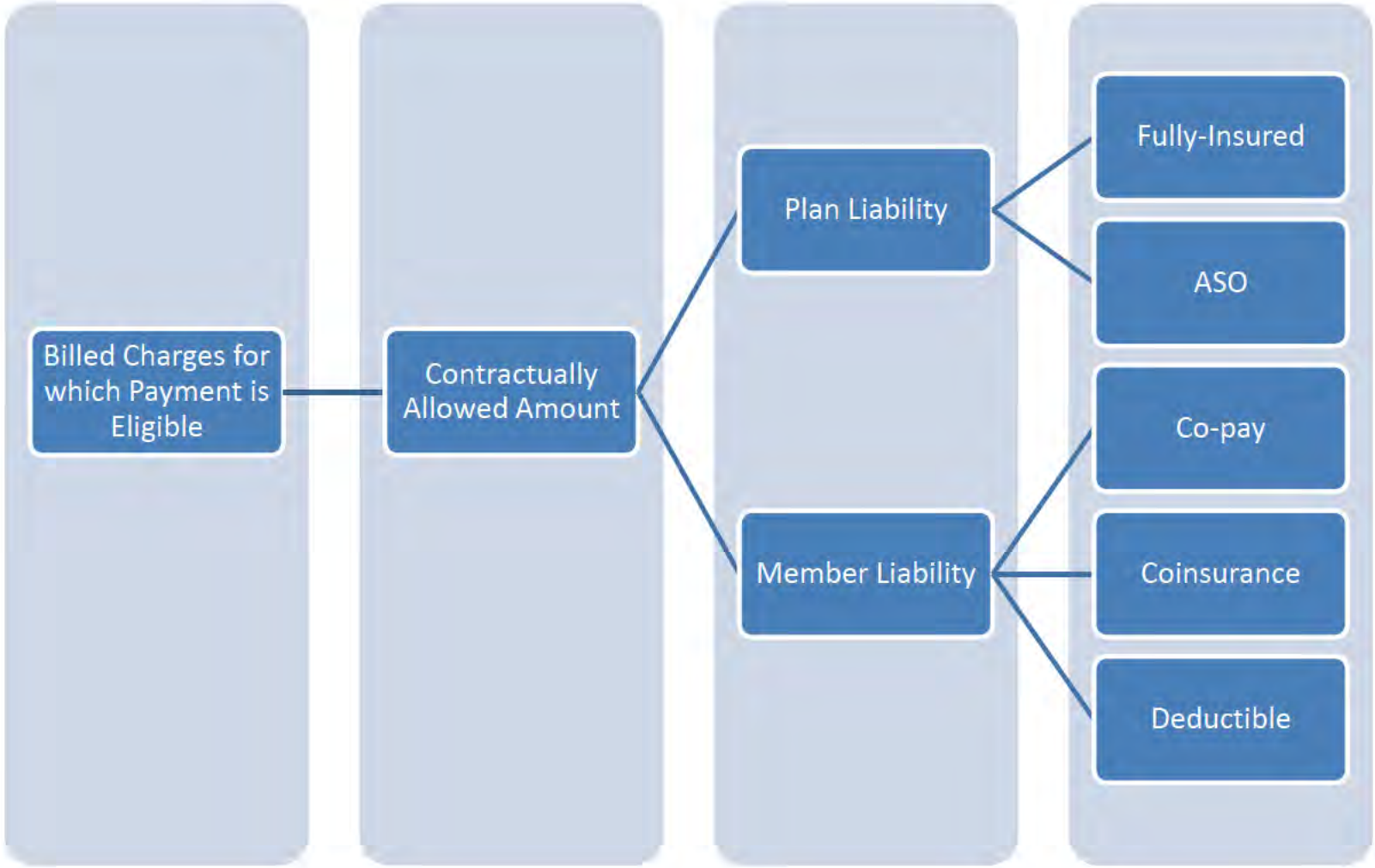


Exhibit 5: Counts and Shares of Acute Care Hospitals and Beds by Peer Group, 2011

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).

Exhibit D

2012 update

Competition in health insurance

A comprehensive study of U.S. markets

AMA

Competition in health insurance

A comprehensive study of U.S. markets | 2012 update

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2012 update

Competition in health insurance

A comprehensive study of U.S. markets

AMA

Table of contents

I. Introduction and background

This is the 11th edition of the American Medical Association's "Competition in health insurance: A comprehensive study of U.S. markets." This report presents new data on the degree of competition in health insurance markets across the country. It is intended to help researchers, policymakers, and federal and state regulators identify markets where consolidation among health insurers may cause competitive harm to consumers and providers of care.

This study addresses the following questions: Are health insurance markets competitive or do health insurers possess and exercise market power? Are proposed mergers between insurers likely to maintain, enhance or create such power? These are important policy questions because the use of market power harms society whether used in an output setting or input setting. When an insurer exercises market power in its *output* market (the sale of insurance coverage), premiums faced by consumers are higher than in a competitive market. When an insurer exercises market power in its *input* market (physician services and hospital care), payments to health care providers are below competitive levels. In both settings, the insurer reduces the quantity of coverage to levels below those produced in a competitive market. In short, when market power is exercised by health insurers, it adversely affects health insurance coverage and health care.

A first step in assessing the existence of or the potential for market power is to examine market concentration, as high concentration facilitates market power. Market concentration is an integral component of antitrust analysis. The U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) consider post-merger market concentration as well as the increase in concentration in their evaluation of proposed horizontal mergers between firms.[1] Thus, it is critical to develop credible estimates of the degree of concentration in different markets. In this study, we present new information on market concentration in the health insurance industry. Using 2010 data from HealthLeaders-InterStudy (HLIS), the most comprehensive source of data on enrollment in health maintenance organization (HMO), preferred provider organization (PPO) and point-of-service (POS) plans, we report commercial market shares and Herfindahl-Hirschman Indices (HHIs) for 385 metropolitan areas (MSAs)[2], the 50 states and the District of Columbia (DC).[3]

Three significant changes are reflected in this edition of the study. First, it now includes enrollment in POS plans. This means that the data for the combined product market (HMO+PPO+POS) from this year's analysis are not perfectly comparable to those from earlier editions since those were limited to HMO+PPO enrollment. Specifically, the addition of POS to the HMO+PPO category lowers the percentage of markets that are classified as highly concentrated. More importantly, however, the addition of POS allows for a more complete picture of health insurance markets.

Second, due to a recategorization of product types by HLIS and UnitedHealthcare (UnitedHealth), there was a very large shift in UnitedHealth's reported enrollment from PPO to POS between Jan. 1, 2009 (2011 edition) and Jan. 1, 2010 (this edition). Consequently, whereas previously UnitedHealth was among the largest PPO insurers in many geographic areas, in this edition it is among the largest insurers in many POS markets. We found it necessary to validate UnitedHealth's enrollment reported to HLIS, and had it verified by both HLIS and UnitedHealth staff.

Finally, this study includes enrollment in consumer-driven health plans (CDHP). HLIS clarified for us that their HMO, PPO and POS data include CHDP enrollments. Those lives are not reported as a separate plan type, rather they are *bolted on* to other product types, most frequently to PPO plans. Research by America's Health Insurance Plans (AHIP) found that, among CDHP, 89 percent of individual enrollees, 81 percent of small-group enrollees and 93 percent of large-group enrollees were in PPO products, respectively.[4] In sum, this edition includes enrollment in CDHP plans which are distributed among the HMO, POS and especially the PPO product.

Key findings in this edition are that, based on the DOJ/FTC Horizontal Merger Guidelines, 70 percent of the 385 MSAs studied were highly concentrated (HHI>2,500). Additionally, in 89 percent of MSAs, at least one insurer held a commercial market share of 30 percent or greater.

1. U.S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines. Issued August 19, 2010.

2. The "MSAs" are mostly metropolitan statistical areas, as well as a few metropolitan divisions, metropolitan New England city town and areas (NECTAs), and NECTA divisions. All of these definitions are from the U.S. Office of Management and Budget. For convenience, they are referred to as MSAs throughout the report.

3. For convenience, the District of Columbia (D.C.) is classified as a "state" for purposes of this report; this helps distinguish the state-level data (D.C.) from the MSA-level data (Washington, DC MSA).

4. America's Health Insurance Plans, Center for Policy and Research. *AHIP HSA January 2012 Census, May 2012.* www.ahip.org/hsacensus/. Accessed July 18, 2012.

High concentration levels in health insurance markets are largely the result of consolidation, which can lead to the exercise of market power and, in turn, harm to consumers and providers of care. Past and future consolidation of health insurers should raise serious antitrust concerns. Conceptually, consolidation can have both beneficial and harmful effects on consumers. However, only the latter has been observed. Specifically, it appears that consolidation has resulted in the possession and exercise of health insurer *monopoly power*—the ability to raise and maintain premiums above competitive levels—instead of passing any benefits of consolidation such as lower premiums from efficiency gains on to consumers. Research supports this observation. Although there has been year-to-year growth in the largest health insurers' profitability (e.g., premium revenues, operating earnings margins, return on equity and stock price growth),[5] premiums and cost-sharing levels faced by consumers have also been increasing.[6] Other research has found that consolidation in health insurance markets leads to higher premiums.[7] This supports an earlier finding that HMO premiums were higher in less competitive markets—i.e., those with fewer HMOs.[8] Finally, there is evidence that health insurers possess and exercise market power in an increasing number of geographic markets.[9]

High barriers to entry into health insurance markets also enable insurers to exercise market power.[10] Examples of such barriers include state regulatory requirements, the cost of developing a provider network and the development of sufficient business to permit the spreading of risk. Evaluating entry barriers is critical to antitrust analysis. If entry were easy, neither high market shares nor high concentration would necessarily translate into higher premiums because potential entry would force insurers to keep premiums in check. However, barriers to entry allow insurers with market power to charge premiums above competitive levels for an extended period of time.

Health insurer consolidation can lead to the exercise of another type of market power that can also cause competitive harm to consumers and providers of care. Where health insurers have market power in their output market (i.e., monopoly power), it is very likely they also have market power in their input market (e.g., in the purchasing of physician services). This is because, geographically, these markets roughly coincide.[11] Market power in input markets is known as *monopsony power*, which is the ability to reduce and maintain input prices (e.g., physician payments) below competitive levels. The exercise of monopsony power would also reduce the quantity (or quality) of health care below competitive levels and thus harm consumers. Recent research finds evidence that insurer consolidation leads to the exercise of monopsony power vis-à-vis physicians—i.e., lower physician earnings and employment.[12] For these reasons, proposed mergers that create or increase insurers' monopsony power should also raise antitrust concerns.[13]

In fact, the DOJ challenged two health insurer mergers based in part on the merged entity's potential to exercise monopsony power over physicians.[14] The DOJ focused on the increased difficulty a physician practice could face in replacing business should the merged insurer terminate its contract. In its analyses, the DOJ considered two "buy-side" shares—the share of individual practice revenue accounted for by the merging insurers, and those insurers' locality-wide post-merger share of patients.[15] A high post-merger share of physician practice revenue contributes to the merged entity's monopsony power by making it more costly for the practice to replace lost patients. This effect is reinforced in markets with a high post-merger share of patients as it would shrink the pool of potential replacement patients in the event of a contract termination. Our study strongly suggests that most markets are characterized by insurers with high market shares of patients, which increases the risk of the exercise of monopsony power.

Another factor that increases this risk is that, in most markets, a significant share of physicians work in small practices. Almost half of patient care physicians are in

5. Robinson J. Consolidation and the transformation of competition in health insurance. *Health Aff.* 2004;31(6):12–24.
6. The Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits 2011 Annual Survey. ehbs.kff.org/. Accessed July 18, 2012.
7. Dafny L., Duggan, M., Ramanarayanan, S. Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry. *Am Econ Rev.* 2012;102(2):1161–1185.
8. Christianson JB, Feldman R, Wholey D. HMO mergers: Estimating impact on premiums and costs. Health Aff. 1997;16:133–141. And: Wholey D, Feldman R, Christianson JB. The effect of market structure on HMO premiums. *J Health Economics.* 1995;14:81–105.
9. Dafny L. Are Health Insurance Markets Competitive? *Am Econ Rev.* 2010;100(4):1399–1431.
10. Robinson J. Consolidation and the transformation of competition in health insurance. *Health Aff.* 2004;31(6):12–24.
11. See e.g., Capps, C. Buyer power in health plan mergers. *J Comp Law and Econ.* 2009;6:375–391.
12. Dafny L., Duggan, M., Ramanarayanan, S. Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry. *Am Econ Rev.* 2012;102(2):1161–1185.
13. Schwartz, M. Buyer Power Concerns and the Aetna-Prudential Merger. Fifth Annual Health Care Antitrust Forum, Northwestern University School of Law, Chicago, IL, October 1999. www.justice.gov/atr/public/speeches/3924.pdf. Accessed July 18, 2012.
14. See Complaint, *U.S. v. Aetna Inc.* (ND TX, June 21, 1999) (Aetna Complaint) and *U.S. v. UnitedHeath Group Inc.* (DDC Dec. 20, 2005) (UnitedHealth Complaint). Both of these challenges required the health insurers to divest business in a few markets. In the Aetna matter, Aetna was required to divest business in Dallas and Houston. In the UnitedHealth Group matter, PacifiCare was required to divest business in Tucson, Ariz., and Boulder, Colo.
15. Capps, C. Buyer power in health plan mergers. *J Comp Law and Econ.* 2009;6:375–391.

practices with fewer than five physicians.[16] And, under current antitrust law, physicians cannot negotiate with insurers collectively across practices. This imbalance in relative size results in physicians having a weak bargaining position relative to health insurers.

In 2010 the DOJ announced that it would file an antitrust lawsuit to block Blue Cross Blue Shield of Michigan from acquiring Physicians Health Plan of Mid-Michigan. As a result, the companies abandoned the acquisition. One of the reasons given by the DOJ for its proposed challenge was that the merger would have given the merged entity the ability to control physician reimbursement rates in a way that would lower the quality of health care. It would have given the merged entity close to a 90 percent share of the commercial health insurance market in Lansing, Mich., which would have led to higher premiums, fewer choices and lower quality of health plans.[17]

In sum, the majority of health insurance markets in the United States are highly concentrated. Coupled with the concomitant large increases in premiums, insurer profitability, lower scope of benefits and high barriers to entry, this strongly suggests that health insurers are exercising market power in many parts of the country and in turn causing competitive harm to consumers and providers of care.

16. Kane CK. The Practice Arrangements of Patient Care Physicians, 2007–2008. Policy Research Perspectives, 2009-6. ama-assn.org/ama1/pub/upload/mm/363/prp-200906-phys-prac-arrange.pdf. Published December 2009. Accessed July 18, 2012.

17. Department of Justice. Press release. March 8, 2010. Justice.gov/atr/public/press_releases/2010/256259.htm. Accessed July 18, 2012.

II. Data and methodology

A. Product and geographic market definition

In order to calculate firms' market shares, it is necessary to define the market in which competition takes place. Markets are characterized by two aspects: a product market and a geographic market. A *product market* is a product or group of products for which there are no adequate substitutes. In a health insurance setting, traditional products include PPO, HMO and POS. Because it is an empirical question and it is not clear whether they are substitutes, we examine those products separately in addition to a combined HMO+PPO+POS product market.

The other dimension that needs to be defined is the relevant *geographic market*. The geographic market is the area within which consumers can turn to alternative producers in response to an increase in price. In determining the extent of the market for health insurance, distance is a critical consideration. The local nature of the delivery of health care, as well as the marketing and other business practices of health insurers strongly suggest that health insurance markets are local. This is because consumers buy coverage that serves them close to where they work and live. Thus, this study reports data at the metropolitan area (MSA) level as well as the state level.

B. Data

The data used for this study were obtained from the HealthLeaders-InterStudy (HLIS) Managed Market Surveyor from Jan. 1, 2010. HLIS collects enrollment data from managed care organizations (MCO) through its National Managed Care Census. On the HLIS survey instrument, MCOs are asked to report their national-level enrollment. Then they are asked to report their enrollment at the county level. If the sum of the county-level enrollment is equal to the national total, it is aggregated to the MSA and state levels. If an MCO cannot report the county-level lives, it is asked to report them at the state level. In this case the covered lives in the state are used to estimate county-level enrollment, which is then aggregated to the MSA level.[18]

Our objective is to present data on concentration in commercial health insurance markets. Accordingly, we report market shares and HHIs for the combined HMO+PPO+POS commercial product market as well as for HMO, PPO and POS markets separately. By definition, the commercial market excludes enrollees in public programs (e.g., Medicare, Medicaid and the State Children's Health Insurance Program) but includes public employees with employer-sponsored coverage (e.g., Federal Employees Health Benefits Program).

This is the first edition of this report that includes enrollment in POS plans. Those data recently became available as a separate category. This means that the data for the combined product market (HMO+PPO+POS) from this year's analysis are not perfectly comparable to those from earlier editions since they excluded POS. More importantly, however, the addition of POS enrollment allows for a more complete picture of health insurance markets.

As discussed above, the HMO, PPO and POS data include consumer-driven health plans (CDHP). CDHP covered lives are not reported as a separate category, but are rather *bolted on* to the other product types, most frequently to PPO. In sum, this edition includes commercial enrollment in HMO, PPO and POS, with enrollment of CHDP distributed among those products.

The key variables we use from the HLIS Managed Market Surveyor to obtain the information for this study are:

- Commercial HMO enrollment
- Commercial PPO enrollment
- Commercial POS enrollment

For each MSA and state, we use enrollment in these products to calculate:

- Health insurer market shares
- Herfindahl-Hirschman Indices (HHIs)

It should be noted that due to a recategorization of product types by HLIS and UnitedHealth, there was a very large shift in UnitedHealth's reported enrollment from PPO to POS between Jan. 1, 2009 (2011 edition) and Jan. 1, 2010 (this edition). In 2009 approximately 70 percent of UnitedHealth's reported commercial enrollment was in PPO; however, in 2010 nearly 70 percent was in POS. Consequently, whereas UnitedHealth was previously

18. HLIS uses the insurer's reported service area to allocate the state-level reported enrollment to each county. If the insurer reported county-level enrollment in the prior year, HLIS uses the prior-year proportions of its reported state-level enrollment to allocate current county-level enrollment. Otherwise, HLIS uses the county's proportion of the total privately insured population in the state.

among the largest PPO insurers in many geographic areas, in this study it is among the largest insurers in many POS markets.

Our aim is to calculate market shares and HHIs based on enrollment in fully and self-insured plans. To do so, however, we do not use the entire database as provided by HLIS; certain MCOs and geographic areas are excluded. Self-insured employers typically use third-party administrators (TPA) to administer their benefits. If the TPAs are also risk-bearing insurers, they are included in this study. There are other non-risk-bearing MCOs—typically known as "PPO rental networks"—whose enrollment is also sometimes reported in the HLIS raw data. To avoid double-counting them, we exclude those entities. It should be noted that these exclusions have a negligible impact on our market shares and HHIs since there was only a handful (six) of such entities in the raw HLIS data.

Second, with two exceptions, we exclude insurers' enrollment from states where they are not licensed to sell health insurance. Blue Cross Blue Shield Association (BCBS) companies that use the Blue brand do not compete with one another. Yet some BCBS insurers report enrollment in states where they are not licensed to operate.[19] We exclude that enrollment to avoid double-counting lives and because branded companies do not compete with one other.

The two exceptions to those exclusions are as follows. In other cases, a Blue company (e.g., WellPoint) may own a subsidiary that does not use the Blue brand. An example of an unbranded company is UniCare, which is owned by WellPoint. One of the states where UniCare operates is Illinois—a state whose market is dominated by BCBS of Illinois; here, BCBS of Illinois and UniCare can be competitors. In short, there could be competition among branded and unbranded companies. In these cases, we do not exclude the unbranded company's enrollment. Finally, we also do not exclude enrollment of *non*-BCBS insurers in states adjacent to the license-state because the state reported in the data is where enrollees live.[20]

Third, we only present market shares and HHIs for areas where the enrollment data plausibly capture a reasonable fraction of the insured population. Specifically, we calculate the ratio of total commercial enrollment reported by all health insurers in an area to an *estimate* of the commercially-insured population, and only present areas where this is at least 30 percent and fewer than 150 percent.[21] In this edition, five MSAs are excluded because of this criterion.[22] The data perform well in the remaining areas. On average, the state- and MSA-level data capture 79 percent and 77 percent of the commercially-insured populations, respectively.[23]

Finally, we only present data for a product when there are at least 5,000 reported enrollees in that product among all insurers. Accordingly, we do not present HMO data for Alaska, Mississippi and 105 MSAs, nor do we report POS data for Hawaii and 47 MSAs because each of those areas had fewer than 5,000 reported enrollees in those products. We nonetheless present the data for the combined HMO+PPO+POS and the PPO product markets in those geographic areas because they exceed the threshold of 5,000 enrollees.

C. Market share and HHI calculations

This study reports health insurers' market shares for four product markets (HMO+PPO+POS, HMO, PPO, and POS). For each product market, we calculate the market share in a geographic area by dividing an insurer's enrollment by the sum of all insurers' enrollment and multiplying the result by 100.

The HHI is a measure of market concentration, which is a useful indicator of market power and serves as a signal of the likely impact of a merger on competition. The DOJ and FTC use the HHI as an aid in assessing the potential for anti-competitive effects when evaluating proposed horizontal mergers. Higher HHIs indicate greater concentration.

19. This is due to the BlueCard® program, which enables members of one BCBS company to get health care while traveling or living in another BCBS company's service area. The program is designed for members who have a child attending an out-of-state school, have family members living in different service areas, have a long-term work assignment in another state, or are retirees with dual residence. Source: www.bcbs.com/already-a-member/coverage-home-and-away.html. Accessed July 18, 2012.

20. An insurance company may operate in New York, for example, but also report enrollees in New Jersey. Enrollees in New Jersey would be kept in the data because they may work in New York but live in New Jersey. We do not include the enrollments of BCBS insurers in neighboring states because their reported enrollment in those states is often too large to plausibly represent enrollees residing outside the state of license.

21. The commercially-insured population (INS) was calculated as: INS = POP – UNINS – (MEDICARE + MEDICAID – DUAL), where POP is population, UNINS is number of uninsured persons, MEDICARE is number of Medicare beneficiaries, MEDICAID is the number of Medicaid eligibles, and DUAL is persons who receive both a Medicare and a Medicaid benefit.

22. Four MSAs had percentages less than 30%: Great Falls, MT; Jacksonville, NC; Fayetteville, NC; Lawton, OK; and Rochester, MN's percentage was 151%.

23. The distributions of these proportions are as follows. States: 12 percent of states, >= 0.30 and < 0.50; 18 percent of states, ≥ 0.50 and < 0.70; 49 percent of states ≥ 0.70 and < 0.90, and 22 percent of states >= 0.90. MSAs: Eight percent of MSAs, >= 0.30 and < 0.50; 29 percent of MSAs, ≥ 0.50 and < 0.70; 35 percent of MSAs ≥ 0.70 and < 0.90, and 27 percent of MSAs >= 0.90.

The HHI is the sum of the squared market shares of all firms in a market. To illustrate, suppose a market consisted of four firms and that each one held a 25 percent share. The HHI for that market would be 2,500:

$25^2 + 25^2 + 25^2 + 25^2 = 2{,}500$

If the number of firms in a market increased, the HHI would generally decrease, and vice versa. The largest value the HHI can reach is 10,000, which is obtained when there is a single firm in the market.

D. DOJ/FTC merger guidelines

In evaluating horizontal mergers, the DOJ and FTC consider both the post-merger market concentration and the increase in concentration resulting from a merger.[24] Markets are classified into three types:

- Unconcentrated markets: HHI below 1,500
- Moderately concentrated markets: HHI between 1,500 and 2,500
- Highly concentrated markets: HHI above 2,500

Additionally, the DOJ and FTC employ the following standards in assessing the degree of competition:

Small change in concentration: Mergers involving an increase in the HHI of less than 100 points are unlikely to have adverse competitive effects and ordinarily require no further analysis.

Unconcentrated markets: Mergers resulting in unconcentrated markets are unlikely to have adverse competitive effects and ordinarily require no further analysis.

Moderately concentrated markets: Mergers resulting in moderately concentrated markets that involve an increase in the HHI of more than 100 points potentially raise significant competitive concerns and often warrant scrutiny.

Highly concentrated markets: Mergers resulting in highly concentrated markets that involve an increase in the HHI of between 100 points and 200 points potentially raise significant competitive concerns and often warrant scrutiny. Mergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power. The presumption may be rebutted by persuasive evidence showing that the merger is unlikely to enhance market power.

24. See Section 5.3 of the Department of Justice and Federal Trade Commission Horizontal Merger Guidelines. Issued August 19, 2010.

III. Summary of findings and conclusion

The results are presented in Section IV. Table 1 pertains to the combined HMO+PPO+POS product market. For each state and MSA, Table 1 reports the HHI and the market shares of the two largest insurers. Tables 2, 3 and 4 present similar information for the HMO, PPO and POS product markets, respectively. Note that the data are rounded. As a result in a few markets where the second largest insurer has very few covered lives (Table 2), the market share appears as zero. However, the actual, unrounded shares are just above 0 percent. Finally, Table 5 reports the HHIs by product for all states and MSAs. All the data are from Jan. 1, 2010.

After implementing the restrictions discussed in Section II.B, the numbers of states and MSAs for which we report data differ by product market. Data for the combined HMO+PPO+POS markets and the PPO markets are reported for 385 MSAs and 51 states, HMO data are reported for 280 MSAs and 49 states, and POS data are presented for 338 MSAs and 50 states.

In this section we summarize the findings. The summary focuses on MSAs because, in general, they more closely approximate relevant antitrust markets in the health insurance industry, though the state-level statistics also portray an industry in need of regulatory oversight.

A. Market concentration (HHI)

In terms of market concentration (HHI), we found the following:

- Seventy percent (268) of the combined HMO+PPO+POS markets are highly concentrated (HHI>2,500).
- Ninety-four percent (264) of the HMO markets are highly concentrated (HHI>2,500).
- Ninety-five percent (365) of the PPO markets are highly concentrated (HHI>2,500).
- Ninety-nine percent (335) of the POS markets are highly concentrated (HHI>2,500).

B. Market share

In terms of market shares, we found the following:

HMO+PPO+POS product market

- In 89 percent (342) of the MSAs, at least one insurer had a combined HMO+PPO+POS market share of 30 percent or greater.
- In 38 percent (146) of the MSAs, at least one insurer had a combined HMO+PPO+POS market share of 50 percent or greater.
- In 9 percent (36) of the MSAs, one insurer had a combined HMO+PPO+POS market share of 70 percent or greater.

HMO product market

- In 99 percent (277) of the MSAs, at least one insurer had an HMO market share of 30 percent or greater.
- In 67 percent (188) of the MSAs, at least one insurer had an HMO market share of 50 percent or greater.
- In 33 percent (93) of the MSAs, one insurer had an HMO market share of 70 percent or greater.

PPO product market

- In 98 percent (379) of the MSAs, at least one insurer had a PPO market share of 30 percent or greater.
- In 68 percent (260) of the MSAs, at least one insurer had a PPO market share of 50 percent or greater.
- In 36 percent (140) of the MSAs, one insurer had a PPO market share of 70 percent or greater.

POS product market

- In 99 percent (336) of the MSAs, at least one insurer had a POS market share of 30 percent or greater.
- In 68 percent (229) of the MSAs, at least one insurer had a POS market share of 50 percent or greater.
- In 17 percent (59) of the MSAs, one insurer had a POS market share of 70 percent or greater.

C. Conclusion

In this study, we presented data on competition in health insurance markets across the United States. Specifically, we reported market share and concentration (HHI) data for 51 states (including the District of Columbia) and 385 MSAs. This study presented the most complete picture of commercial health insurance markets to date. Our data, which are based on both fully and self-insured plans, are based on HMO, PPO and POS commercial enrollments and include participation in consumer-driven health plans.

We found that the majority of commercial health insurance markets in the United States are highly concentrated. These markets are ripe for the exercise of health insurer market power, which is detrimental to society. The results of this study should prompt federal and state antitrust authorities to more vigorously examine the anti-competitive effects of proposed mergers between health insurers.

After years of largely unchallenged consolidation in the health insurance industry, two recent attempts to consolidate received closer scrutiny than similar ones in the past. As a result, a merger between Independence Blue Cross and Highmark proposed in 2007 was called off by those companies in 2009 because the Pennsylvania Insurance Department insisted that one of the companies drop its Blues brand. The companies refused and instead called off the merger. Then in 2010, Blue Cross Blue Shield of Michigan called off its proposed acquisition of Physicians Health Plan of Mid-Michigan because the DOJ announced that it would file an antitrust lawsuit to block the acquisition.

Although those recent efforts at consolidation received more antitrust scrutiny than previous ones, most health insurance markets are nonetheless already highly concentrated. Thus, another line of research for regulators to pursue is to examine the impact of prior market consolidation on premiums.[25] Such retrospective studies would complement the present methodology of predicting merger effects at the time of announcement and in turn help guide merger enforcement policy.

25. Ashenfelter, O.C., Hosken D., Weinberg M. Generating Evidence to Guide Merger Enforcement. National Bureau of Economic Research Working Paper 14798; March 2009.

IV. State and MSA tables

Table 1. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010
Combined HMO+PPO+POS (total) product markets

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	7712	BCBS AL	88	UnitedHlthcare	5
Anniston-Oxford, AL	8085	BCBS AL	90	Triton (Viva Hlth)	3
Auburn-Opelika, AL	7991	BCBS AL	89	UnitedHlthcare	6
Birmingham-Hoover, AL	7292	BCBS AL	85	UnitedHlthcare	7
Decatur, AL	8561	BCBS AL	92	UnitedHlthcare	4
Dothan, AL	8326	BCBS AL	91	UnitedHlthcare	5
Florence, AL	8279	BCBS AL	91	Cigna	5
Gadsden, AL	8848	BCBS AL	94	UnitedHlthcare	3
Huntsville, AL	7819	BCBS AL	88	UnitedHlthcare	3
Mobile, AL	7070	BCBS AL	84	UnitedHlthcare	6
Montgomery, AL	8029	BCBS AL	89	UnitedHlthcare	4
Tuscaloosa, AL	8333	BCBS AL	91	Triton (Viva Hlth)	3
Alaska	4413	Premera	62	Aetna	21
Anchorage, AK	3997	Premera	56	Aetna	26
Fairbanks, AK	5965	Premera	76	Aetna	10
Arizona	2224	BCBS AZ	29	UnitedHlthcare	27
Flagstaff, AZ	3203	BCBS AZ	48	Aetna	26
Phoenix-Mesa-Scottsdale, AZ	2270	BCBS AZ	29	UnitedHlthcare	25
Prescott, AZ	3345	BCBS AZ	52	UnitedHlthcare	20
Tucson, AZ	2564	UnitedHlthcare	42	Cigna	16
Yuma, AZ	4797	BCBS AZ	68	Cigna	8
Arkansas	2428	BCBS AR	39	UnitedHlthcare	22
Fayetteville-Springdale-Rogers, AR-MO	1836	BCBS AR	26	Cigna	23
Fort Smith, AR-OK	1943	UnitedHlthcare	29	BCBS AR	25
Hot Springs, AR	2553	BCBS AR	41	UnitedHlthcare	24
Jonesboro, AR	3499	BCBS AR	55	UnitedHlthcare	16
Little Rock-North Little Rock, AR	2474	BCBS AR	34	UnitedHlthcare	32
Pine Bluff, AR	3026	BCBS AR	49	Cigna	16
California	2051	WellPoint	29	Kaiser	29
Bakersfield, CA	2905	WellPoint	45	Kaiser	24
Chico, CA	3919	WellPoint	47	BS of CA	40
El Centro, CA	4449	WellPoint	60	BS of CA	29
Fresno, CA	2686	WellPoint	43	BS of CA	21
Hanford-Corcoran, CA	4446	WellPoint	61	BS of CA	26
Los Angeles-Long Beach-Glendale, CA	2142	WellPoint	31	Kaiser	28
Madera, CA	3211	WellPoint	49	BS of CA	22
Merced, CA	3960	WellPoint	59	BS of CA	20
Modesto, CA	2406	Kaiser	34	WellPoint	29

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Napa, CA	3458	WellPoint	42	Kaiser	41
Oakland-Fremont-Hayward, CA	2738	Kaiser	46	WellPoint	19
Oxnard-Thousand Oaks-Ventura, CA	2311	WellPoint	41	Kaiser	15
Redding, CA	4426	WellPoint	60	BS of CA	29
Riverside-San Bernardino-Ontario, CA	2079	Kaiser	33	WellPoint	24
Sacramento-Arden-Arcade-Roseville, CA	2346	Kaiser	40	WellPoint	19
Salinas, CA	4964	WellPoint	68	BS of CA	14
San Diego-Carlsbad-San Marcos, CA	1649	Kaiser	26	WellPoint	21
San Francisco-San Mateo-Redwood City, CA	2021	Kaiser	33	WellPoint	22
San Jose-Sunnyvale-Santa Clara, CA	2061	Kaiser	34	WellPoint	23
San Luis Obispo-Paso Robles, CA	4534	WellPoint	62	BS of CA	26
Santa Ana-Anaheim-Irvine, CA	1936	WellPoint	33	Kaiser	19
Santa Barbara-Santa Maria, CA	2838	WellPoint	45	BS of CA	21
Santa Cruz-Watsonville, CA	2857	WellPoint	47	BS of CA	19
Santa Rosa-Petaluma, CA	3306	Kaiser	51	WellPoint	21
Stockton, CA	2515	Kaiser	41	WellPoint	24
Vallejo-Fairfield, CA	3402	Kaiser	52	WellPoint	24
Visalia-Porterville, CA	3993	WellPoint	58	BS of CA	23
Yuba City-Marysville, CA	5321	WellPoint	72	BS of CA	10
Colorado	1809	WellPoint	22	Cigna	21
Boulder, CO	1961	WellPoint	25	UnitedHlthcare	23
Colorado Springs, CO	1750	WellPoint	22	Cigna	21
Denver-Aurora, CO	1882	Kaiser	24	UnitedHlthcare	21
Fort Collins-Loveland, CO	2323	WellPoint	31	Cigna	25
Grand Junction, CO	2017	WellPoint	30	Cigna	24
Greeley, CO	2116	Cigna	29	WellPoint	26
Pueblo, CO	2134	WellPoint	33	UnitedHlthcare	21
Connecticut	2560	WellPoint	40	UnitedHlthcare	21
Bridgeport-Stamford-Norwalk, CT	2531	WellPoint	37	UnitedHlthcare	22
Danbury, CT	2479	WellPoint	36	UnitedHlthcare	22
Hartford-West Hartford-East Hartford, CT	2514	WellPoint	40	Aetna	19
New Haven-Milford, CT	3139	WellPoint	50	Aetna	16
Waterbury, CT	3169	WellPoint	50	Aetna	16
Delaware	4818	BCBS DE	66	Aetna	19
Dover, DE	5836	BCBS DE	75	Aetna	10
Wilmington, DE-MD-NJ	3642	BCBS DE	54	Aetna	25
District of Columbia	5305	CareFirst	72	Aetna	9
Washington-Arlington-Alexandria, DC-VA-MD-WV	1966	CareFirst	33	Aetna	17
Florida	2054	BCBS FL	31	UnitedHlthcare	23
Cape Coral-Fort Myers, FL	2557	BCBS FL	35	UnitedHlthcare	25
Deltona-Daytona Beach-Ormond Beach, FL	2763	BCBS FL	42	UnitedHlthcare	24

Table 1. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
Combined HMO+PPO+POS (total) product markets

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1604	UnitedHlthcare	23	Aetna	20
Fort Walton Beach-Crestview-Destin, FL	3881	BCBS FL	59	UnitedHlthcare	14
Gainesville, FL	4205	BCBS FL	63	AvMed Hlth Plan	10
Jacksonville, FL	2303	BCBS FL	30	Aetna	29
Lakeland-Winter Haven, FL	2186	UnitedHlthcare	28	BCBS FL	22
Miami-Miami Beach-Kendall, FL	1629	UnitedHlthcare	27	Aetna	17
Naples-Marco Island, FL	2968	BCBS FL	46	UnitedHlthcare	20
Ocala, FL	3553	BCBS FL	55	UnitedHlthcare	20
Orlando-Kissimmee, FL	2387	UnitedHlthcare	31	Cigna	27
Palm Bay-Melbourne-Titusville, FL	2030	Cigna	26	UnitedHlthcare	25
Panama City-Lynn Haven, FL	5020	BCBS FL	69	UnitedHlthcare	9
Pensacola-Ferry Pass-Brent, FL	3400	BCBS FL	49	UnitedHlthcare	29
Port St. Lucie-Fort Pierce, FL	3094	BCBS FL	48	Cigna	21
Punta Gorda, FL	2365	BCBS FL	31	Aetna	25
Sarasota-Bradenton-Venice, FL	2429	BCBS FL	33	Aetna	28
Tallahassee, FL	6956	BCBS FL	83	UnitedHlthcare	6
Tampa-St. Petersburg-Clearwater, FL	2199	UnitedHlthcare	32	Aetna	23
Vero Beach, FL	4087	BCBS FL	60	UnitedHlthcare	17
West Palm Beach-Boca Raton-Boynton Beach, FL	2046	BCBS FL	26	UnitedHlthcare	24
Georgia	2200	WellPoint	33	UnitedHlthcare	27
Albany, GA	3447	WellPoint	48	UnitedHlthcare	32
Athens-Clarke County, GA	2920	WellPoint	44	UnitedHlthcare	26
Atlanta-Sandy Springs-Marietta, GA	2011	WellPoint	29	UnitedHlthcare	25
Augusta-Richmond County, GA-SC	2239	WellPoint	29	UnitedHlthcare	29
Brunswick, GA	3526	WellPoint	44	UnitedHlthcare	38
Columbus, GA-AL	2892	WellPoint	46	UnitedHlthcare	23
Dalton, GA	3787	Cigna	52	WellPoint	30
Gainesville, GA	2168	WellPoint	34	UnitedHlthcare	27
Hinesville-Fort Stewart, GA	3864	WellPoint	57	UnitedHlthcare	21
Macon, GA	2546	WellPoint	40	UnitedHlthcare	26
Rome, GA	2410	WellPoint	36	UnitedHlthcare	27
Savannah, GA	2439	WellPoint	33	UnitedHlthcare	29
Valdosta, GA	3809	WellPoint	50	UnitedHlthcare	34
Warner Robins, GA	3874	WellPoint	58	UnitedHlthcare	19
Hawaii	5298	HMSA (BCBS HI)	69	Kaiser	22
Honolulu, HI	5491	HMSA (BCBS HI)	71	Kaiser	20
Idaho	2763	BC of ID	47	Regence	16
Boise City-Nampa, ID	3402	BC of ID	53	Regence	19
Coeur d'Alene, ID	3633	Group Hlth Cooperative	55	BC of ID	22
Idaho Falls, ID	2843	BC of ID	44	Aetna	24
Lewiston, ID-WA	2905	BC of ID	38	Regence	34
Pocatello, ID	3713	BC of ID	56	Regence	20

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Illinois	3385	HCSC (BCBS)	55	UnitedHlthcare	12
Bloomington-Normal, IL	2973	HCSC (BCBS)	47	Hlth Alliance Med Plans	20
Champaign-Urbana, IL	3212	Hlth Alliance Med Plans	53	HCSC (BCBS)	13
Chicago-Naperville-Joliet, IL	4218	HCSC (BCBS)	63	UnitedHlthcare	10
Danville, IL	2343	Hlth Alliance Med Plans	33	HCSC (BCBS)	30
Davenport-Moline-Rock Island, IA-IL	2735	UnitedHlthcare	45	HCSC (BCBS)	21
Decatur, IL	3597	HCSC (BCBS)	57	UnitedHlthcare	14
Kankakee-Bradley, IL	2734	HCSC (BCBS)	48	Cigna	12
Lake County-Kenosha County, IL-WI	2770	HCSC (BCBS)	46	UnitedHlthcare	19
Peoria, IL	2823	UnitedHlthcare	38	HCSC (BCBS)	35
Rockford, IL	3723	HCSC (BCBS)	58	WellPoint	10
Springfield, IL	2471	HCSC (BCBS)	36	Hlth Alliance Med Plans	29
Indiana	3438	WellPoint	56	UnitedHlthcare	12
Anderson, IN	4840	WellPoint	68	UnitedHlthcare	9
Bloomington, IN	3898	WellPoint	59	Aetna	16
Columbus, IN	4158	WellPoint	61	SE IN Hlth Org	16
Elkhart-Goshen, IN	4142	WellPoint	63	Cigna	8
Evansville, IN-KY	2636	WellPoint	44	Welborn Hlth Plans	18
Fort Wayne, IN	3262	WellPoint	53	Aetna	15
Gary, IN	2997	WellPoint	48	UnitedHlthcare	20
Indianapolis, IN	3776	WellPoint	59	UnitedHlthcare	12
Kokomo, IN	3630	WellPoint	57	Advantage Hlth Solutions	13
Lafayette, IN	2570	WellPoint	40	UnitedHlthcare	27
Michigan City-La Porte, IN	4003	WellPoint	61	UnitedHlthcare	11
Muncie, IN	4414	WellPoint	65	UnitedHlthcare	9
South Bend-Mishawaka, IN-MI	2436	WellPoint	42	BCBS MI	20
Terre Haute, IN	5580	WellPoint	73	Cigna	10
Iowa	3302	Wellmark	49	UnitedHlthcare	27
Ames, IA	3359	Wellmark	50	Aetna	22
Cedar Rapids, IA	3671	Wellmark	56	UnitedHlthcare	19
Davenport-Moline-Rock Island, IA-IL	2735	UnitedHlthcare	45	HCSC (BCBS)	21
Des Moines, IA	3083	Wellmark	41	UnitedHlthcare	33
Dubuque, IA	4305	Wellmark	50	UnitedHlthcare	42
Iowa City, IA	5862	Wellmark	75	UnitedHlthcare	15
Sioux City, IA-NE-SD	2839	Wellmark	48	UnitedHlthcare	19
Waterloo-Cedar Falls, IA	4205	UnitedHlthcare	52	Wellmark	38
Kansas	2362	BCBS KS	43	UnitedHlthcare	12
Lawrence, KS	4034	BCBS KS	61	Coventry	11
Topeka, KS	5047	BCBS KS	69	UnitedHlthcare	11
Wichita, KS	3033	BCBS KS	46	Preferred Hlth Systems	27
Kentucky	3139	WellPoint	40	Humana	37
Bowling Green, KY	3823	WellPoint	57	Humana	19
Elizabethtown, KY	3562	WellPoint	44	Humana	39
Lexington-Fayette, KY	2899	Humana	38	WellPoint	35

Table 1. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
Combined HMO+PPO+POS (total) product markets

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Louisville, KY-IN	2766	WellPoint	43	Humana	26
Owensboro, KY	4911	WellPoint	67	Humana	15
Louisiana	2954	LA Hlth Serv & Ind (BCBS)	48	UnitedHlthcare	20
Alexandria, LA	2640	LA Hlth Serv & Ind (BCBS)	39	Humana	24
Baton Rouge, LA	2043	UnitedHlthcare	27	LA Hlth Serv & Ind (BCBS)	27
Houma-Bayou Cane-Thibodaux, LA	3250	LA Hlth Serv & Ind (BCBS)	49	UnitedHlthcare	23
Lafayette, LA	3474	LA Hlth Serv & Ind (BCBS)	53	UnitedHlthcare	19
Lake Charles, LA	2194	LA Hlth Serv & Ind (BCBS)	33	UnitedHlthcare	23
Monroe, LA	2449	UnitedHlthcare	32	Humana	28
New Orleans-Metairie-Kenner, LA	2115	LA Hlth Serv & Ind (BCBS)	31	UnitedHlthcare	26
Shreveport-Bossier City, LA	2042	LA Hlth Serv & Ind (BCBS)	35	UnitedHlthcare	17
Maine	3462	WellPoint	53	Aetna	20
Bangor, ME	3827	WellPoint	56	Cigna	19
Lewiston-Auburn, ME	3793	WellPoint	55	Aetna	23
Portland-South Portland, ME	3578	WellPoint	54	Aetna	19
Maryland	3087	CareFirst	49	UnitedHlthcare	18
Baltimore-Towson, MD	3798	CareFirst	58	UnitedHlthcare	15
Bethesda-Gaithersburg-Frederick, MD	2529	CareFirst	38	UnitedHlthcare	25
Cumberland, MD-WV	2796	UnitedHlthcare	38	CareFirst	33
Hagerstown-Martinsburg, MD-WV	1975	UnitedHlthcare	29	CareFirst	22
Salisbury, MD	3075	CareFirst	45	UnitedHlthcare	28
Massachusetts	2930	BCBS MA	48	Harvard Pilgrim	19
Barnstable Town, MA	3240	BCBS MA	46	Harvard Pilgrim	28
Boston-Cambridge-Quincy, MA	2872	BCBS MA	46	Harvard Pilgrim	22
Brockton-Bridgewater-Easton, MA	3199	BCBS MA	47	Harvard Pilgrim	27
Framingham, MA	3081	BCBS MA	48	Harvard Pilgrim	20
Haverhill-North Andover-Amesbury, MA-NH	2060	BCBS MA	33	WellPoint	21
Lawrence-Methuen-Salem, MA-NH	2463	BCBS MA	42	Harvard Pilgrim	16
Leominster-Fitchburg-Gardner, MA	2775	BCBS MA	46	Harvard Pilgrim	18
Lowell-Billerica-Chelmsford, MA-NH	2761	BCBS MA	45	Harvard Pilgrim	20
Lynn-Peabody-Salem, MA	3474	BCBS MA	53	Tufts	19
New Bedford, MA	3292	BCBS MA	49	Harvard Pilgrim	23
Pittsfield, MA	4683	BCBS MA	66	Hlth New England	13
Springfield, MA	2447	BCBS MA	44	Tufts	14
Taunton-Norton-Raynham, MA	3288	BCBS MA	49	Harvard Pilgrim	23
Worcester, MA-CT	2339	BCBS MA	41	Harvard Pilgrim	16
Michigan	4900	BCBS MI	69	Priority Hlth	9
Ann Arbor, MI	5481	BCBS MI	73	Priority Hlth	9
Battle Creek, MI	6153	BCBS MI	78	UnitedHlthcare	10
Bay City, MI	6057	BCBS MI	77	HealthPlus MI	12
Detroit-Livonia-Dearborn, MI	3656	BCBS MI	56	Hlth Alliance Plan	21
Flint, MI	5275	BCBS MI	71	HealthPlus MI	16
Grand Rapids-Wyoming, MI	3794	BCBS MI	44	Priority Hlth	42
Holland-Grand Haven, MI	3758	Priority Hlth	49	BCBS MI	36

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Jackson, MI	5473	BCBS MI	72	Priority Hlth	18
Kalamazoo-Portage, MI	4969	BCBS MI	68	UnitedHlthcare	15
Lansing-East Lansing, MI	4651	BCBS MI	63	Sparrow Hlth Sys	24
Monroe, MI	4943	BCBS MI	69	Hlth Alliance Plan	9
Muskegon-Norton Shores, MI	4256	BCBS MI	58	Priority Hlth	28
Niles-Benton Harbor, MI	6725	BCBS MI	81	Aetna	9
Saginaw-Saginaw Township North, MI	5903	BCBS MI	75	HealthPlus MI	15
Warren-Farmington Hills-Troy, MI	5201	BCBS MI	71	Hlth Alliance Plan	10
Minnesota	3241	BCBS MN	46	Medica	29
Duluth, MN-WI	2739	BCBS MN	42	Medica	26
Minneapolis-St. Paul-Bloomington, MN-WI	2883	BCBS MN	43	Medica	27
St. Cloud, MN	3513	BCBS MN	48	Medica	30
Mississippi	3025	BCBS MS	47	UnitedHlthcare	19
Gulfport-Biloxi, MS	2727	BCBS MS	45	Cigna	15
Hattiesburg, MS	3543	BCBS MS	44	UnitedHlthcare	37
Jackson, MS	3053	BCBS MS	49	UnitedHlthcare	18
Pascagoula, MS	3422	BCBS MS	50	UnitedHlthcare	24
Missouri	1649	WellPoint	26	UnitedHlthcare	22
Columbia, MO	2399	Coventry	40	UnitedHlthcare	17
Jefferson City, MO	2312	WellPoint	35	UnitedHlthcare	25
Joplin, MO	1887	WellPoint	32	UnitedHlthcare	21
Kansas City, MO-KS	1854	BCBS KS City	32	UnitedHlthcare	19
Springfield, MO	1842	Sisters of Mercy	31	UnitedHlthcare	21
St. Joseph, MO-KS	4188	BCBS KS City	62	WellPoint	14
St. Louis, MO-IL	2095	UnitedHlthcare	31	WellPoint	29
Montana	3042	Cigna	45	BCBS MT	28
Billings, MT	2596	Cigna	35	BCBS MT	31
Missoula, MT	3401	Cigna	52	BCBS MT	20
Nebraska	3634	BCBS NE	55	UnitedHlthcare	19
Lincoln, NE	4037	BCBS NE	60	UnitedHlthcare	17
Omaha-Council Bluffs, NE-IA	2529	BCBS NE	39	UnitedHlthcare	26
Nevada	2613	UnitedHlthcare	43	Cigna	17
Carson City, NV	2290	Renown Health	31	WellPoint	31
Las Vegas-Paradise, NV	3412	UnitedHlthcare	53	Cigna	18
Reno-Sparks, NV	1861	WellPoint	26	Renown Health	22
New Hampshire	3352	WellPoint	51	Harvard Pilgrim	20
Manchester, NH	3027	WellPoint	45	Harvard Pilgrim	25
Nashua, NH-MA	2666	WellPoint	42	Harvard Pilgrim	25
Portsmouth, NH-ME	3299	WellPoint	51	Harvard Pilgrim	21
Rochester-Dover, NH	3870	WellPoint	57	Cigna	17
New Jersey	2440	Aetna	31	Horizon BCBS	28
Atlantic City, NJ	4387	Horizon BCBS	63	Cigna	14
Camden, NJ	3221	Aetna	49	Horizon BCBS	25
Edison, NJ	2599	Aetna	32	Horizon BCBS	29

Table 1. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
Combined HMO+PPO+POS (total) product markets

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Newark-Union, NJ-PA	2526	Aetna	31	Horizon BCBS	28
Ocean City, NJ	4039	Horizon BCBS	60	Aetna	16
Trenton-Ewing, NJ	2960	Aetna	45	Horizon BCBS	21
Vineland-Millville-Bridgeton, NJ	3447	Horizon BCBS	45	Aetna	36
New Mexico	2392	HCSC (BCBS)	35	Presbyterian HC Services	28
Albuquerque, NM	2212	Presbyterian HC Services	34	HCSC (BCBS)	23
Farmington, NM	2043	Presbyterian HC Services	32	Cigna	19
Las Cruces, NM	3635	HCSC (BCBS)	57	Presbyterian HC Services	14
Santa Fe, NM	2949	HCSC (BCBS)	42	Presbyterian HC Services	30
New York	1886	WellPoint	29	UnitedHlthcare	24
Albany-Schenectady-Troy, NY	2028	Capital District Phy. Hlth.	31	WellPoint	21
Binghamton, NY	2819	Lifetime Hlthcare	45	UnitedHlthcare	23
Buffalo-Cheektowaga-Tonawanda, NY	3036	HealthNow NY (BCBS)	48	Independent Hlth	19
Elmira, NY	3558	Lifetime Hlthcare	51	UnitedHlthcare	28
Glens Falls, NY	2200	WellPoint	37	MVP Hlth Care	16
Ithaca, NY	2672	Aetna	42	UnitedHlthcare	21
Kingston, NY	2148	WellPoint	31	UnitedHlthcare	23
New York-White Plains-Wayne, NY-NJ	2151	WellPoint	30	UnitedHlthcare	24
Poughkeepsie-Newburgh-Middletown, NY	2177	WellPoint	32	UnitedHlthcare	26
Rochester, NY	3304	Lifetime Hlthcare	43	MVP Hlth Care	36
Suffolk County-Nassau County, NY	2882	WellPoint	39	UnitedHlthcare	31
Syracuse, NY	2725	Lifetime Hlthcare	45	UnitedHlthcare	21
Utica-Rome, NY	2118	Lifetime Hlthcare	27	UnitedHlthcare	26
North Carolina	3054	BCBS NC	48	UnitedHlthcare	18
Asheville, NC	3284	BCBS NC	48	UnitedHlthcare	22
Burlington, NC	3151	BCBS NC	47	UnitedHlthcare	26
Charlotte-Gastonia-Concord, NC-SC	2158	BCBS NC	33	Aetna	19
Durham, NC	2941	BCBS NC	46	Coventry	20
Goldsboro, NC	5816	BCBS NC	75	Cigna	11
Greensboro-High Point, NC	3245	BCBS NC	45	UnitedHlthcare	32
Greenville, NC	5906	BCBS NC	75	Cigna	15
Hickory-Morganton-Lenoir, NC	4530	BCBS NC	64	Cigna	15
Raleigh-Cary, NC	3309	BCBS NC	51	Cigna	18
Rocky Mount, NC	4907	BCBS NC	66	Cigna	22
Wilmington, NC	3349	BCBS NC	44	UnitedHlthcare	33
Winston-Salem, NC	2925	BCBS NC	44	UnitedHlthcare	21
North Dakota	4271	BCBS ND	60	Aetna	26
Bismarck, ND	5058	Aetna	65	BCBS ND	27
Fargo, ND-MN	2355	BCBS ND	31	BCBS MN	29
Grand Forks, ND-MN	2557	BCBS ND	32	BCBS MN	31
Ohio	1812	WellPoint	27	Medical Mutual	23
Akron, OH	1911	Medical Mutual	30	WellPoint	23
Canton-Massillon, OH	1662	Medical Mutual	24	WellPoint	23
Cincinnati-Middletown, OH-KY-IN	2584	WellPoint	39	Humana	23

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Cleveland-Elyria-Mentor, OH	2316	Medical Mutual	39	WellPoint	19
Columbus, OH	2221	Medical Mutual	28	UnitedHlthcare	25
Dayton, OH	2437	WellPoint	35	UnitedHlthcare	29
Lima, OH	1802	WellPoint	28	Medical Mutual	21
Mansfield, OH	2514	WellPoint	38	Medical Mutual	29
Sandusky, OH	2546	Medical Mutual	36	WellPoint	32
Springfield, OH	2012	UnitedHlthcare	24	Humana	24
Toledo, OH	2457	Medical Mutual	41	WellPoint	19
Weirton-Steubenville, WV-OH	1640	WellPoint	28	Coventry	18
Youngstown-Warren-Boardman, OH-PA	1848	WellPoint	31	Medical Mutual	20
Oklahoma	2803	HCSC (BCBS)	45	Aetna	19
Oklahoma City, OK	3215	HCSC (BCBS)	48	Aetna	22
Tulsa, OK	2419	HCSC (BCBS)	38	UnitedHlthcare	19
Oregon	1201	Regence	20	Kaiser	18
Bend, OR	1478	Regence	24	PacificSource	21
Corvallis, OR	1712	Regence	29	UnitedHlthcare	21
Eugene-Springfield, OR	2541	PacificSource	45	Regence	19
Medford, OR	1508	Regence	26	Aetna	16
Portland-Vancouver-Beaverton, OR-WA	1517	Kaiser	28	Regence	17
Salem, OR	1590	Kaiser	27	Regence	22
Pennsylvania	1709	Highmark	27	Independence BC	24
Allentown-Bethlehem-Easton, PA-NJ	1629	Highmark	26	Capital BC	18
Altoona, PA	5407	Highmark	73	Geisinger	6
Erie, PA	4794	Highmark	66	Coventry	19
Harrisburg-Carlisle, PA	2673	Highmark	40	Capital BC	28
Johnstown, PA	5943	Highmark	76	UPMC Hlth System	10
Lancaster, PA	2008	Highmark	30	Capital BC	21
Lebanon, PA	2834	Highmark	40	Capital BC	28
Philadelphia, PA	4538	Independence BC	60	Aetna	30
Pittsburgh, PA	3545	Highmark	55	UPMC Hlth System	19
Reading, PA	2138	Highmark	33	Capital BC	23
Scranton--Wilkes-Barre, PA	4097	BC of N.E. PA	59	Geisinger	21
State College, PA	3272	Highmark	47	Capital BC	29
Williamsport, PA	3907	BC of N.E. PA	58	Coventry	16
York-Hanover, PA	2586	Highmark	40	Capital BC	28
Rhode Island	3998	BCBS RI	55	UnitedHlthcare	30
Norwich-New London, CT-RI	3270	WellPoint	51	UnitedHlthcare	23
Providence-Fall River-Warwick, RI-MA	2547	BCBS RI	42	UnitedHlthcare	23
South Carolina	4031	BCBS SC	60	Cigna	15
Anderson, SC	4292	BCBS SC	61	Cigna	19
Charleston-North Charleston, SC	4234	BCBS SC	62	Cigna	14
Columbia, SC	4087	BCBS SC	61	Cigna	12
Florence, SC	4313	BCBS SC	63	UnitedHlthcare	12
Greenville, SC	3622	BCBS SC	53	Cigna	21

Table 1. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
Combined HMO+PPO+POS (total) product markets

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Myrtle Beach-Conway-North Myrtle Beach, SC	4536	BCBS SC	65	UnitedHlthcare	14
Spartanburg, SC	4451	BCBS SC	64	Cigna	15
Sumter, SC	5471	BCBS SC	73	UnitedHlthcare	9
South Dakota	2438	Wellmark	39	Dakotacare	25
Rapid City, SD	2645	Wellmark	43	Dakotacare	23
Sioux Falls, SD	2309	Wellmark	40	Avera Hlth	16
Tennessee	2988	BCBS TN	46	Cigna	24
Chattanooga, TN-GA	2807	BCBS TN	46	UnitedHlthcare	17
Clarksville, TN-KY	2063	BCBS TN	31	WellPoint	22
Cleveland, TN	3248	BCBS TN	50	Cigna	22
Jackson, TN	3744	BCBS TN	53	Cigna	28
Johnson City, TN	2800	BCBS TN	41	UnitedHlthcare	28
Kingsport-Bristol, TN-VA	2249	Cigna	30	BCBS TN	27
Knoxville, TN	2702	BCBS TN	39	Cigna	24
Memphis, TN-MS-AR	2492	Cigna	39	BCBS TN	21
Morristown, TN	3300	BCBS TN	50	Cigna	22
Nashville-Davidson--Murfreesboro, TN	3282	BCBS TN	51	Cigna	21
Texas	2262	HCSC (BCBS)	35	Aetna	22
Abilene, TX	3592	HCSC (BCBS)	54	Humana	24
Amarillo, TX	2168	HCSC (BCBS)	32	Humana	21
Austin-Round Rock, TX	2751	HCSC (BCBS)	42	UnitedHlthcare	23
Beaumont-Port Arthur, TX	3237	HCSC (BCBS)	49	Aetna	19
Brownsville-Harlingen, TX	3435	HCSC (BCBS)	53	Aetna	15
College Station-Bryan, TX	3581	HCSC (BCBS)	56	Scott & White Hlth	17
Corpus Christi, TX	3222	HCSC (BCBS)	45	UnitedHlthcare	29
Dallas-Plano-Irving, TX	2300	HCSC (BCBS)	29	Aetna	25
El Paso, TX	2302	Aetna	30	HCSC (BCBS)	27
Fort Worth-Arlington, TX	2040	Aetna	26	HCSC (BCBS)	24
Houston-Sugar Land-Baytown, TX	2157	Aetna	27	HCSC (BCBS)	27
Killeen-Temple-Fort Hood, TX	2694	Scott & White Hlth	41	HCSC (BCBS)	25
Laredo, TX	4936	HCSC (BCBS)	68	UnitedHlthcare	11
Longview, TX	3693	HCSC (BCBS)	54	UnitedHlthcare	21
Lubbock, TX	3709	HCSC (BCBS)	57	Humana	17
McAllen-Edinburg-Mission, TX	3784	HCSC (BCBS)	57	UnitedHlthcare	15
Midland, TX	4034	HCSC (BCBS)	60	UnitedHlthcare	15
Odessa, TX	4537	HCSC (BCBS)	65	UnitedHlthcare	10
San Angelo, TX	5446	HCSC (BCBS)	72	Aetna	12
San Antonio, TX	2358	HCSC (BCBS)	33	Aetna	25
Sherman-Denison, TX	3140	HCSC (BCBS)	46	UnitedHlthcare	23
Texarkana, TX-AR	2455	HCSC (BCBS)	43	UnitedHlthcare	15
Tyler, TX	4419	HCSC (BCBS)	62	UnitedHlthcare	17
Victoria, TX	3563	HCSC (BCBS)	53	Aetna	22
Waco, TX	2558	HCSC (BCBS)	40	Scott & White Hlth	26
Wichita Falls, TX	5700	HCSC (BCBS)	74	Aetna	13

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Utah	2330	Intermountain Hlth	40	Regence	17
Logan, UT-ID	2768	Intermountain Hlth	46	UnitedHlthcare	17
Ogden-Clearfield, UT	2365	Intermountain Hlth	38	Coventry	24
Provo-Orem, UT	2981	Intermountain Hlth	50	UnitedHlthcare	13
Salt Lake City, UT	2226	Intermountain Hlth	38	Regence	17
St. George, UT	2548	Intermountain Hlth	42	Coventry	20
Vermont	3482	BCBS VT	41	Cigna	41
Burlington-South Burlington, VT	3432	BCBS VT	41	Cigna	40
Virginia	2431	WellPoint	44	Aetna	12
Blacksburg-Christiansburg-Radford, VA	6289	WellPoint	79	Aetna	7
Charlottesville, VA	2934	WellPoint	40	Coventry	35
Danville, VA	7302	WellPoint	85	Piedmont (Centra)	4
Harrisonburg, VA	4564	WellPoint	64	Coventry	18
Lynchburg, VA	4368	WellPoint	63	Piedmont (Centra)	16
Richmond, VA	3292	WellPoint	53	Cigna	14
Roanoke, VA	5070	WellPoint	69	UnitedHlthcare	10
Virginia Beach-Norfolk-Newport News, VA-NC	3467	WellPoint	51	Optima Hlth (Sentara)	28
Winchester, VA-WV	3590	WellPoint	57	Optima Hlth (Sentara)	12
Washington	1942	Regence	28	Premera	26
Bellingham, WA	2487	Regence	35	Group Hlth Cooperative	29
Bremerton-Silverdale, WA	2854	Group Hlth Cooperative	45	Premera	23
Kennewick-Richland-Pasco, WA	2329	Premera	39	Group Hlth Cooperative	20
Longview-Kelso, WA	3345	Kaiser	53	Premera	20
Mount Vernon-Anacortes, WA	2523	Regence	35	Group Hlth Cooperative	28
Olympia, WA	2506	Group Hlth Cooperative	41	Premera	19
Seattle-Bellevue-Everett, WA	2050	Regence	28	Premera	27
Spokane, WA	2381	Premera	34	Group Hlth Cooperative	30
Tacoma, WA	2177	Regence	33	Premera	23
Wenatchee, WA	4623	Premera	65	Regence	16
Yakima, WA	2504	Premera	36	Regence	26
West Virginia	2362	Highmark	42	Aetna	13
Charleston, WV	2505	Highmark	40	Aetna	20
Huntington-Ashland, WV-KY-OH	1756	WellPoint	29	Humana	19
Morgantown, WV	3206	Highmark	52	Hlth Plan Upper Ohio	14
Parkersburg-Marietta-Vienna, WV-OH	1774	WellPoint	29	Highmark	18
Wheeling, WV-OH	2162	Hlth Plan Upper Ohio	37	WellPoint	19
Wisconsin	1362	UnitedHlthcare	28	WellPoint	15
Appleton, WI	2189	UnitedHlthcare	38	Humana	19
Eau Claire, WI	1811	Security HP of WI	26	Humana	23
Fond du Lac, WI	1534	UnitedHlthcare	22	Humana	19
Green Bay, WI	2616	UnitedHlthcare	44	Humana	18
Janesville, WI	1410	Dean Hlth Plan	21	Humana	17
La Crosse, WI-MN	1176	Hlth Tradition HP	18	BCBS MN	14

Table 1. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
Combined HMO+PPO+POS (total) product markets

State and MSAs	Total HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Madison, WI	1898	Dean Hlth Plan	29	Phys Plus Ins Corp	24
Milwaukee-Waukesha-West Allis, WI	3042	UnitedHlthcare	49	WellPoint	18
Oshkosh-Neenah, WI	1992	UnitedHlthcare	31	Humana	22
Racine, WI	3738	UnitedHlthcare	58	WellPoint	13
Sheboygan, WI	2452	UnitedHlthcare	41	Humana	17
Wausau, WI	2485	Security HP of WI	37	WellPoint	26
Wyoming	3656	Cigna	55	UnitedHlthcare	21
Casper, WY	5513	Cigna	70	UnitedHlthcare	23
Cheyenne, WY	3605	Cigna	49	Winhealth	32

Notes:

1. Data source: Managed Market Surveyor, ©2010 HealthLeaders-InterStudy. All rights reserved. Managed Market Surveyor data may not be reproduced, distributed, displayed or modified, in whole or in part, by any means, without the prior written consent of HLI.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the combined HMO+PPO+POS (TOTAL) product market are reported.
3. These data are based on enrollments in both fully and self-insured health plans.

Table 2. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010 HMO product markets

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	9270	Triton (Viva Hlth)	96	UnitedHlthcare	1
Birmingham-Hoover, AL	9373	Triton (Viva Hlth)	97	HealthSpring	3
Mobile, AL	9623	Triton (Viva Hlth)	98	HealthSpring	1
Montgomery, AL	9901	Triton (Viva Hlth)	100	HealthSpring	0
Arizona	2552	Aetna	43	Health Net	16
Phoenix-Mesa-Scottsdale, AZ	3136	Aetna	51	BCBS AZ	13
Tucson, AZ	2383	Health Net	27	Aetna	27
Arkansas	7507	BCBS AR	86	UnitedHlthcare	12
Little Rock-North Little Rock, AR	6948	BCBS AR	81	UnitedHlthcare	18
California	3498	Kaiser	56	WellPoint	12
Bakersfield, CA	3650	Kaiser	55	WellPoint	21
Chico, CA	4980	BS of CA	62	WellPoint	33
El Centro, CA	3587	BS of CA	51	WellPoint	29
Fresno, CA	3154	WellPoint	43	Kaiser	33
Hanford-Corcoran, CA	3348	BS of CA	43	WellPoint	36
Los Angeles-Long Beach-Glendale, CA	3499	Kaiser	56	WellPoint	12
Madera, CA	3276	Kaiser	47	WellPoint	26
Merced, CA	2753	WellPoint	42	Kaiser	23
Modesto, CA	4492	Kaiser	65	WellPoint	11
Napa, CA	7068	Kaiser	83	WellPoint	11
Oakland-Fremont-Hayward, CA	5616	Kaiser	74	Health Net	8
Oxnard-Thousand Oaks-Ventura, CA	2557	Kaiser	41	WellPoint	22
Redding, CA	8161	WellPoint	90	Kaiser	8
Riverside-San Bernardino-Ontario, CA	3480	Kaiser	56	BS of CA	12
Sacramento-Arden-Arcade-Roseville, CA	3993	Kaiser	60	BS of CA	14
Salinas, CA	9170	WellPoint	96	Kaiser	3
San Diego-Carlsbad-San Marcos, CA	2587	Kaiser	46	UnitedHlthcare	12
San Francisco-San Mateo-Redwood City, CA	4163	Kaiser	62	BS of CA	13
San Jose-Sunnyvale-Santa Clara, CA	5149	Kaiser	71	WellPoint	9
San Luis Obispo-Paso Robles, CA	4499	BS of CA	60	WellPoint	28
Santa Ana-Anaheim-Irvine, CA	2455	Kaiser	43	WellPoint	14
Santa Barbara-Santa Maria, CA	2186	BS of CA	27	Aetna	25
Santa Cruz-Watsonville, CA	2147	BS of CA	31	Health Net	24
Santa Rosa-Petaluma, CA	6352	Kaiser	79	WellPoint	9
Stockton, CA	4651	Kaiser	67	BS of CA	10
Vallejo-Fairfield, CA	5282	Kaiser	71	WellPoint	12
Visalia-Porterville, CA	2907	BS of CA	42	WellPoint	30
Yuba City-Marysville, CA	3909	Kaiser	49	WellPoint	38
Colorado	5012	Kaiser	69	WellPoint	14
Boulder, CO	5323	Kaiser	70	WellPoint	18
Colorado Springs, CO	4874	Kaiser	67	WellPoint	14
Denver-Aurora, CO	5508	Kaiser	73	WellPoint	12
Fort Collins-Loveland, CO	2629	Kaiser	36	Rocky Mountain	31

Table 2. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
HMO product markets

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Greeley, CO	4159	Kaiser	61	WellPoint	15
Pueblo, CO	4255	Kaiser	53	WellPoint	38
Connecticut	2490	WellPoint	31	EmblemHealth	27
Bridgeport-Stamford-Norwalk, CT	2539	WellPoint	38	Aetna	20
Danbury, CT	2499	WellPoint	37	EmblemHealth	21
Hartford-West Hartford-East Hartford, CT	3075	EmblemHealth	42	WellPoint	32
New Haven-Milford, CT	2969	WellPoint	40	EmblemHealth	32
Waterbury, CT	2951	WellPoint	39	EmblemHealth	33
Delaware	3793	BCBS DE	53	Aetna	27
Dover, DE	3964	BCBS DE	57	Coventry	19
Wilmington, DE-MD-NJ	3345	BCBS DE	42	Aetna	37
District of Columbia	4046	CareFirst	58	Kaiser	20
Washington-Arlington-Alexandria, DC-VA-MD-WV	2472	Kaiser	35	CareFirst	27
Florida	1867	Aetna	32	AvMed Hlth Plan	17
Cape Coral-Fort Myers, FL	4605	Aetna	63	BCBS FL	23
Deltona-Daytona Beach-Ormond Beach, FL	3470	BCBS FL	51	Aetna	22
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	2001	Coventry	30	Aetna	23
Gainesville, FL	3974	AvMed Hlth Plan	58	Humana	21
Jacksonville, FL	3700	Aetna	56	Humana	15
Lakeland-Winter Haven, FL	3208	Aetna	49	Humana	23
Miami-Miami Beach-Kendall, FL	2069	AvMed Hlth Plan	36	UnitedHlthcare	19
Ocala, FL	2461	Humana	37	AvMed Hlth Plan	27
Orlando-Kissimmee, FL	3604	Aetna	55	UnitedHlthcare	15
Palm Bay-Melbourne-Titusville, FL	3287	Health First Hlth	45	Aetna	27
Pensacola-Ferry Pass-Brent, FL	3761	BCBS FL	48	Coventry	34
Port St. Lucie-Fort Pierce, FL	3165	Aetna	50	BCBS FL	17
Punta Gorda, FL	5909	Aetna	74	BCBS FL	19
Sarasota-Bradenton-Venice, FL	4270	Aetna	60	BCBS FL	22
Tallahassee, FL	8301	BCBS FL	91	Coventry	7
Tampa-St. Petersburg-Clearwater, FL	3294	Aetna	52	Humana	18
West Palm Beach-Boca Raton-Boynton Beach, FL	2586	Aetna	45	AvMed Hlth Plan	12
Georgia	2277	WellPoint	32	Kaiser	29
Athens-Clarke County, GA	3535	Athens Hlth Plan	51	WellPoint	29
Atlanta-Sandy Springs-Marietta, GA	2486	Kaiser	37	WellPoint	24
Augusta-Richmond County, GA-SC	5885	WellPoint	75	UnitedHlthcare	13
Columbus, GA-AL	6118	WellPoint	77	UnitedHlthcare	12
Dalton, GA	5251	Alliant Hlth Plans	64	WellPoint	35
Gainesville, GA	2603	WellPoint	43	Kaiser	16
Macon, GA	2612	WellPoint	42	Humana	20
Rome, GA	3090	WellPoint	45	Humana	28
Savannah, GA	4017	WellPoint	54	Aetna	32
Warner Robins, GA	5681	WellPoint	74	Aetna	11

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Hawaii	5001	HMSA (BCBS HI)	51	Kaiser	49
Honolulu, HI	5027	HMSA (BCBS HI)	54	Kaiser	46
Idaho	6539	Group Hlth Cooperative	80	Intermountain Hlth	14
Coeur d'Alene, ID	9946	Group Hlth Cooperative	100	Regence	0
Illinois	4338	HCSC (BCBS)	64	Hlth Alliance Med Plans	12
Bloomington-Normal, IL	8883	Hlth Alliance Med Plans	94	WellPoint	4
Champaign-Urbana, IL	6831	Hlth Alliance Med Plans	81	Coventry	17
Chicago-Naperville-Joliet, IL	6512	HCSC (BCBS)	80	Humana	13
Danville, IL	6779	Hlth Alliance Med Plans	81	Coventry	16
Davenport-Moline-Rock Island, IA-IL	6566	UnitedHlthcare	80	Wellmark	11
Kankakee-Bradley, IL	2357	Coventry	36	HCSC (BCBS)	21
Lake County-Kenosha County, IL-WI	4433	HCSC (BCBS)	64	Humana	17
Peoria, IL	2896	Hlth Alliance Med Plans	45	HCSC (BCBS)	23
Rockford, IL	4404	HCSC (BCBS)	55	Coventry	36
Springfield, IL	3992	Hlth Alliance Med Plans	56	Coventry	23
Indiana	2685	Advantage Hlth Solutions	38	Physicians Hlth Plan	23
Elkhart-Goshen, IN	5482	Physicians Hlth Plan	70	WellPoint	24
Evansville, IN-KY	6140	Welborn Hlth Plans	77	WellPoint	13
Fort Wayne, IN	5974	Physicians Hlth Plan	72	WellPoint	27
Gary, IN	2894	Advantage Hlth Solutions	40	Aetna	26
Indianapolis, IN	5130	Advantage Hlth Solutions	68	WellPoint	22
Kokomo, IN	5406	Advantage Hlth Solutions	70	Physicians Hlth Plan	19
Lafayette, IN	4050	Physicians Hlth Plan	49	Advantage Hlth Solutions	38
Muncie, IN	4012	Advantage Hlth Solutions	52	Physicians Hlth Plan	34
South Bend-Mishawaka, IN-MI	2749	Advantage Hlth Solutions	35	Physicians Hlth Plan	29
Iowa	3125	UnitedHlthcare	43	Wellmark	32
Ames, IA	4606	Wellmark	61	UnitedHlthcare	29
Cedar Rapids, IA	3382	Wellmark	41	UnitedHlthcare	32
Davenport-Moline-Rock Island, IA-IL	6566	UnitedHlthcare	80	Wellmark	11
Des Moines, IA	3358	Coventry	37	Wellmark	34
Dubuque, IA	5479	UnitedHlthcare	66	Wellmark	34
Iowa City, IA	5614	Wellmark	68	UnitedHlthcare	31
Sioux City, IA-NE-SD	4375	Wellmark	63	Dakotacare	13
Waterloo-Cedar Falls, IA	6502	UnitedHlthcare	78	Wellmark	21
Kansas	3137	Preferred Hlth Systems	43	BCBS KS City	29
Wichita, KS	8402	Preferred Hlth Systems	91	Coventry	9
Kentucky	5132	Humana	69	WellPoint	15
Lexington-Fayette, KY	3879	Humana	57	UnitedHlthcare	19
Louisville, KY-IN	3916	Humana	54	WellPoint	29
Louisiana	4482	LA Hlth Serv & Ind (BCBS)	65	Humana	10
Baton Rouge, LA	5777	LA Hlth Serv & Ind (BCBS)	75	Vantage Hlth	10
New Orleans-Metairie-Kenner, LA	6425	LA Hlth Serv & Ind (BCBS)	79	UnitedHlthcare	7
Shreveport-Bossier City, LA	3609	LA Hlth Serv & Ind (BCBS)	47	Hlth Plus of Louisiana	37

Table 2. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
HMO product markets

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Maine	4335	WellPoint	59	Aetna	21
Bangor, ME	6057	WellPoint	75	Aetna	19
Lewiston-Auburn, ME	4536	WellPoint	61	Aetna	25
Portland-South Portland, ME	3508	WellPoint	45	Harvard Pilgrim	30
Maryland	2552	CareFirst	36	Kaiser	25
Baltimore-Towson, MD	2562	CareFirst	39	Kaiser	19
Bethesda-Gaithersburg-Frederick, MD	2620	CareFirst	38	Kaiser	28
Hagerstown-Martinsburg, MD-WV	3062	UnitedHlthcare	44	CareFirst	29
Salisbury, MD	3134	Coventry	42	CareFirst	27
Massachusetts	2999	BCBS MA	45	Harvard Pilgrim	24
Barnstable Town, MA	3647	BCBS MA	43	Harvard Pilgrim	38
Boston-Cambridge-Quincy, MA	3501	BCBS MA	47	Harvard Pilgrim	31
Brockton-Bridgewater-Easton, MA	3609	BCBS MA	47	Harvard Pilgrim	33
Framingham, MA	3360	BCBS MA	47	Harvard Pilgrim	29
Haverhill-North Andover-Amesbury, MA-NH	2679	BCBS MA	38	Harvard Pilgrim	24
Lawrence-Methuen-Salem, MA-NH	3090	BCBS MA	46	Harvard Pilgrim	23
Leominster-Fitchburg-Gardner, MA	2898	BCBS MA	43	Harvard Pilgrim	23
Lowell-Billerica-Chelmsford, MA-NH	3406	BCBS MA	46	Harvard Pilgrim	30
Lynn-Peabody-Salem, MA	3824	BCBS MA	54	Harvard Pilgrim	22
New Bedford, MA	3835	BCBS MA	54	Harvard Pilgrim	22
Pittsfield, MA	5698	BCBS MA	70	Hlth New England	28
Springfield, MA	2966	BCBS MA	47	Hlth New England	19
Taunton-Norton-Raynham, MA	3821	BCBS MA	53	Harvard Pilgrim	23
Worcester, MA-CT	2752	BCBS MA	41	Harvard Pilgrim	22
Michigan	3108	BCBS MI	44	Priority Hlth	24
Ann Arbor, MI	3902	BCBS MI	50	Priority Hlth	34
Battle Creek, MI	8663	BCBS MI	93	Priority Hlth	6
Bay City, MI	4908	BCBS MI	56	HealthPlus MI	42
Detroit-Livonia-Dearborn, MI	4235	Hlth Alliance Plan	46	BCBS MI	45
Flint, MI	4160	HealthPlus MI	46	BCBS MI	45
Grand Rapids-Wyoming, MI	6962	Priority Hlth	81	BCBS MI	18
Holland-Grand Haven, MI	7538	Priority Hlth	86	BCBS MI	14
Jackson, MI	4963	BCBS MI	59	Priority Hlth	39
Kalamazoo-Portage, MI	7468	BCBS MI	85	Priority Hlth	14
Lansing-East Lansing, MI	4726	BCBS MI	49	Sparrow Hlth Sys	49
Monroe, MI	3625	BCBS MI	46	Hlth Alliance Plan	37
Muskegon-Norton Shores, MI	5481	Priority Hlth	66	BCBS MI	34
Saginaw-Saginaw Township North, MI	4726	BCBS MI	52	HealthPlus MI	44
Warren-Farmington Hills-Troy, MI	4071	BCBS MI	50	Hlth Alliance Plan	39
Minnesota	2793	HealthPartners	37	BCBS MN	29
Duluth, MN-WI	2389	Security HP of WI	36	GHC of Eau Claire	22
Minneapolis-St. Paul-Bloomington, MN-WI	2724	HealthPartners	40	BCBS MN	24
St. Cloud, MN	3499	HealthPartners	47	BCBS MN	33

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Missouri	2383	Sisters of Mercy	34	BCBS KS City	30
Kansas City, MO-KS	5035	BCBS KS City	68	Coventry	20
Springfield, MO	7112	Sisters of Mercy	84	WellPoint	5
St. Joseph, MO-KS	7087	BCBS KS City	84	WellPoint	6
St. Louis, MO-IL	3313	Sisters of Mercy	52	WellPoint	15
Montana	5262	New West	62	BCBS MT	37
Missoula, MT	6864	New West	81	BCBS MT	19
Nebraska	6950	Coventry	82	Dakotacare	16
Omaha-Council Bluffs, NE-IA	5477	Coventry	68	Wellmark	30
Nevada	6465	UnitedHlthcare	80	Renown Health	8
Las Vegas-Paradise, NV	8757	UnitedHlthcare	93	Aetna	3
Reno-Sparks, NV	2968	Renown Health	43	Saint Mary's HlthFirst	25
New Hampshire	5396	WellPoint	66	Harvard Pilgrim	33
Manchester, NH	4871	Harvard Pilgrim	50	WellPoint	48
Nashua, NH-MA	4035	WellPoint	45	Harvard Pilgrim	44
Portsmouth, NH-ME	5254	WellPoint	66	Harvard Pilgrim	30
Rochester-Dover, NH	6122	WellPoint	75	Harvard Pilgrim	23
New Jersey	3629	Aetna	52	Horizon BCBS	23
Atlantic City, NJ	3231	Horizon BCBS	46	Aetna	26
Camden, NJ	5142	Aetna	69	Horizon BCBS	16
Edison, NJ	3556	Aetna	47	Horizon BCBS	31
Newark-Union, NJ-PA	3896	Aetna	54	Horizon BCBS	26
Ocean City, NJ	4032	Horizon BCBS	57	Aetna	21
Trenton-Ewing, NJ	5503	Aetna	72	Horizon BCBS	15
Vineland-Millville-Bridgeton, NJ	4591	Aetna	63	Horizon BCBS	23
New Mexico	4639	Presbyterian HC Services	61	Lovelace	27
Albuquerque, NM	4598	Presbyterian HC Services	61	Lovelace	28
Farmington, NM	4835	Presbyterian HC Services	50	Lovelace	49
Las Cruces, NM	4292	Presbyterian HC Services	54	Lovelace	37
Santa Fe, NM	5602	Presbyterian HC Services	71	Lovelace	22
New York	1342	EmblemHealth	22	MVP Hlth Care	17
Albany-Schenectady-Troy, NY	4928	Capital District Phy. Hlth.	64	MVP Hlth Care	29
Binghamton, NY	5231	Lifetime Hlthcare	67	MVP Hlth Care	26
Buffalo-Cheektowaga-Tonawanda, NY	6264	HealthNow NY (BCBS)	75	Independent Hlth	25
Elmira, NY	9816	Lifetime Hlthcare	99	MVP Hlth Care	1
Glens Falls, NY	4624	MVP Hlth Care	60	Capital District Phy. Hlth.	30
Kingston, NY	5416	MVP Hlth Care	72	WellPoint	8
New York-White Plains-Wayne, NY-NJ	2500	EmblemHealth	39	Aetna	23
Poughkeepsie-Newburgh-Middletown, NY	3005	MVP Hlth Care	48	Aetna	16
Rochester, NY	5556	MVP Hlth Care	68	Lifetime Hlthcare	31
Suffolk County-Nassau County, NY	3336	EmblemHealth	50	UnitedHlthcare	20
Syracuse, NY	5376	Lifetime Hlthcare	65	MVP Hlth Care	33
Utica-Rome, NY	4864	MVP Hlth Care	58	Lifetime Hlthcare	39

Table 2. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
HMO product markets

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
North Carolina	2105	Coventry	33	BCBS NC	25
Charlotte-Gastonia-Concord, NC-SC	3333	Aetna	51	Coventry	21
Durham, NC	7129	Coventry	84	BCBS NC	8
Greensboro-High Point, NC	2931	BCBS NC	32	UnitedHlthcare	31
Hickory-Morganton-Lenoir, NC	7028	BCBS NC	83	Cigna	8
Raleigh-Cary, NC	2446	Coventry	36	BCBS NC	26
Winston-Salem, NC	5039	BCBS NC	67	UnitedHlthcare	23
North Dakota	6211	Medica	77	Dakotacare	13
Ohio	1699	Aetna	25	Humana	19
Akron, OH	3232	Kaiser	48	Aetna	26
Canton-Massillon, OH	5407	Aultman Hlth	72	Kaiser	11
Cincinnati-Middletown, OH-KY-IN	5249	Humana	70	WellPoint	16
Cleveland-Elyria-Mentor, OH	4060	Kaiser	58	Aetna	24
Columbus, OH	6383	Aetna	78	WellPoint	14
Dayton, OH	5588	Humana	72	WellPoint	15
Springfield, OH	6389	Humana	79	Aetna	11
Toledo, OH	3351	ProMedica	47	Medical Mutual	26
Weirton-Steubenville, WV-OH	5199	Hlth Plan Upper Ohio	68	Coventry	22
Youngstown-Warren-Boardman, OH-PA	2294	Aetna	34	Highmark	23
Oklahoma	3703	CommunityCare	54	Aetna	22
Oklahoma City, OK	3163	Aetna	45	UnitedHlthcare	27
Tulsa, OK	5876	CommunityCare	75	Aetna	11
Oregon	5182	Kaiser	63	Providence Hlth	35
Bend, OR	8632	Providence Hlth	93	Kaiser	5
Eugene-Springfield, OR	8864	Providence Hlth	94	Kaiser	4
Portland-Vancouver-Beaverton, OR-WA	5686	Kaiser	70	Providence Hlth	29
Salem, OR	6424	Kaiser	77	Providence Hlth	22
Pennsylvania	2264	Aetna	32	Independence BC	32
Allentown-Bethlehem-Easton, PA-NJ	3348	Independence BC	46	Aetna	33
Altoona, PA	5368	Highmark	71	Geisinger	13
Erie, PA	5377	Highmark	71	UPMC Hlth System	15
Harrisburg-Carlisle, PA	3163	Capital BC	39	Coventry	33
Johnstown, PA	5129	Highmark	66	UPMC Hlth System	27
Lancaster, PA	4196	Independence BC	61	Capital BC	16
Lebanon, PA	3385	Capital BC	46	Coventry	26
Philadelphia, PA	4941	Aetna	51	Independence BC	49
Pittsburgh, PA	3970	UPMC Hlth System	56	Highmark	26
Reading, PA	3964	Independence BC	54	Aetna	28
Scranton--Wilkes-Barre, PA	4274	BC of N.E. PA	46	Geisinger	46
State College, PA	3212	Geisinger	41	Highmark	30
Williamsport, PA	4678	BC of N.E. PA	62	Geisinger	29
York-Hanover, PA	3119	Capital BC	46	Coventry	24

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Rhode Island	9849	UnitedHlthcare	99	Aetna	1
Norwich-New London, CT-RI	3850	WellPoint	57	EmblemHealth	20
Providence-Fall River-Warwick, RI-MA	2654	BCBS MA	40	UnitedHlthcare	21
South Carolina	3889	BCBS SC	58	Cigna	19
Columbia, SC	4542	BCBS SC	60	Medical Mutual	30
South Dakota	5125	Dakotacare	67	Sanford	24
Rapid City, SD	5847	Dakotacare	71	Sanford	29
Sioux Falls, SD	3904	Dakotacare	51	Sanford	31
Tennessee	3742	UnitedHlthcare	55	Aetna	17
Chattanooga, TN-GA	2867	UnitedHlthcare	41	Cigna	24
Clarksville, TN-KY	6832	Humana	81	WellPoint	14
Johnson City, TN	8062	UnitedHlthcare	89	Humana	11
Kingsport-Bristol, TN-VA	7261	UnitedHlthcare	84	WellPoint	9
Knoxville, TN	6890	UnitedHlthcare	81	Humana	16
Memphis, TN-MS-AR	4731	Cigna	52	Aetna	45
Nashville-Davidson--Murfreesboro, TN	5462	Aetna	70	UnitedHlthcare	20
Texas	2032	Aetna	36	Scott & White Hlth	18
Amarillo, TX	9743	Covenant (FirstCare)	99	HCSC (BCBS)	1
Austin-Round Rock, TX	4174	Scott & White Hlth	53	Aetna	36
Beaumont-Port Arthur, TX	5749	Aetna	70	HCSC (BCBS)	28
College Station-Bryan, TX	5714	Scott & White Hlth	70	Covenant (FirstCare)	29
Dallas-Plano-Irving, TX	3084	Aetna	47	WellPoint	24
El Paso, TX	8544	Aetna	92	HCSC (BCBS)	8
Fort Worth-Arlington, TX	5828	Aetna	75	WellPoint	13
Houston-Sugar Land-Baytown, TX	3012	Aetna	46	HCSC (BCBS)	25
Killeen-Temple-Fort Hood, TX	6667	Scott & White Hlth	79	Covenant (FirstCare)	20
San Antonio, TX	2872	Aetna	43	Univ H. System	26
Waco, TX	7200	Scott & White Hlth	83	Covenant (FirstCare)	16
Utah	7274	Intermountain Hlth	84	Coventry	13
Logan, UT-ID	8891	Intermountain Hlth	94	Coventry	6
Ogden-Clearfield, UT	5697	Intermountain Hlth	70	Coventry	27
Provo-Orem, UT	7959	Intermountain Hlth	89	Coventry	7
Salt Lake City, UT	7612	Intermountain Hlth	87	Coventry	10
St. George, UT	9303	Intermountain Hlth	96	Coventry	3
Vermont	5406	BCBS VT	65	MVP Hlth Care	35
Burlington-South Burlington, VT	5428	BCBS VT	65	MVP Hlth Care	35
Virginia	1891	WellPoint	30	Kaiser	19
Blacksburg-Christiansburg-Radford, VA	8517	WellPoint	92	Coventry	4
Charlottesville, VA	4525	WellPoint	63	Coventry	15
Harrisonburg, VA	4564	WellPoint	63	Coventry	23
Lynchburg, VA	9154	WellPoint	96	Coventry	2
Richmond, VA	2467	WellPoint	39	Coventry	22
Roanoke, VA	7721	WellPoint	87	UnitedHlthcare	8

Table 2. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
HMO product markets

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Virginia Beach-Norfolk-Newport News, VA-NC	5309	Optima Hlth (Sentara)	66	WellPoint	31
Winchester, VA-WV	4806	WellPoint	67	UnitedHlthcare	15
Washington	5592	Group Hlth Cooperative	71	Kaiser	22
Bellingham, WA	9877	Group Hlth Cooperative	99	Kaiser	0
Bremerton-Silverdale, WA	9892	Group Hlth Cooperative	99	Providence Hlth	0
Kennewick-Richland-Pasco, WA	9681	Group Hlth Cooperative	98	Providence Hlth	1
Longview-Kelso, WA	9379	Kaiser	97	Providence Hlth	3
Mount Vernon-Anacortes, WA	9645	Group Hlth Cooperative	98	Providence Hlth	1
Olympia, WA	8400	Group Hlth Cooperative	91	Providence Hlth	7
Seattle-Bellevue-Everett, WA	8634	Group Hlth Cooperative	93	Providence Hlth	4
Spokane, WA	9898	Group Hlth Cooperative	99	Providence Hlth	0
Tacoma, WA	9144	Group Hlth Cooperative	96	Providence Hlth	2
Yakima, WA	9776	Group Hlth Cooperative	99	Kaiser	1
West Virginia	3946	Hlth Plan Upper Ohio	55	Coventry	29
Charleston, WV	8912	Coventry	94	UnitedHlthcare	6
Wheeling, WV-OH	8078	Hlth Plan Upper Ohio	90	Coventry	7
Wisconsin	1268	Dean Hlth Plan	26	Security HP of WI	12
Appleton, WI	3938	Affinity Hlth System	57	Humana	23
Eau Claire, WI	4218	Security HP of WI	51	GHC of Eau Claire	39
Fond du Lac, WI	2895	Unity Hlth Plans Ins Corp	42	Affinity Hlth System	30
Green Bay, WI	3319	Affinity Hlth System	49	Humana	25
Janesville, WI	2726	Dean Hlth Plan	37	Unity Hlth Plans Ins Corp	32
La Crosse, WI-MN	4625	Hlth Tradition HP	57	Gundersen HP	38
Madison, WI	2814	Dean Hlth Plan	37	Phys Plus Ins Corp	30
Milwaukee-Waukesha-West Allis, WI	3054	Humana	39	Dean Hlth Plan	35
Oshkosh-Neenah, WI	3406	Affinity Hlth System	51	Humana	21
Racine, WI	4212	Dean Hlth Plan	59	Humana	22
Sheboygan, WI	4011	Affinity Hlth System	58	Humana	24
Wausau, WI	9396	Security HP of WI	97	WellPoint	3
Wyoming	7504	Winhealth	86	Dakotacare	13
Cheyenne, WY	9972	Winhealth	100	UnitedHlthcare	0

Notes:

1. Data source: Managed Market Surveyor, © 2010 HealthLeaders-InterStudy. All rights reserved. Managed Market Surveyor data may not be reproduced, distributed, displayed or modified, in whole or in part, by any means, without the prior written consent of HLI.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the HMO product market are reported.
3. These data are based on enrollments in both fully and self-insured health plans.
4. We do not present data for geographic areas with fewer than 5,000 reported HMO enrollees.
5. The HHIs and market shares are rounded. As a result, in a few markets where the second largest insurer has very few covered lives, the market share appears as zero. The actual, unrounded shares are just above 0 percent.

Table 3. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010 PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	9096	BCBS AL	95	Aetna	2
Anniston-Oxford, AL	9197	BCBS AL	96	Aetna	2
Auburn-Opelika, AL	9386	BCBS AL	97	Aetna	2
Birmingham-Hoover, AL	9120	BCBS AL	95	Aetna	3
Decatur, AL	9429	BCBS AL	97	Aetna	2
Dothan, AL	9424	BCBS AL	97	Aetna	1
Florence, AL	9062	BCBS AL	95	Cigna	3
Gadsden, AL	9499	BCBS AL	97	Aetna	1
Huntsville, AL	9044	BCBS AL	95	Aetna	3
Mobile, AL	8846	BCBS AL	94	Aetna	3
Montgomery, AL	9378	BCBS AL	97	Aetna	2
Tuscaloosa, AL	9420	BCBS AL	97	Aetna	2
Alaska	4701	Premera	65	Aetna	22
Anchorage, AK	4313	Premera	59	Aetna	27
Fairbanks, AK	6126	Premera	77	Aetna	11
Arizona	3957	BCBS AZ	56	Aetna	27
Flagstaff, AZ	4314	BCBS AZ	58	Aetna	31
Phoenix-Mesa-Scottsdale, AZ	4072	BCBS AZ	55	Aetna	31
Prescott, AZ	5414	BCBS AZ	71	Aetna	17
Tucson, AZ	3087	BCBS AZ	48	Aetna	25
Yuma, AZ	6972	BCBS AZ	83	Aetna	5
Arkansas	4010	BCBS AR	60	Aetna	17
Fayetteville-Springdale-Rogers, AR-MO	2750	BCBS AR	43	WellPoint	20
Fort Smith, AR-OK	2501	BCBS AR	36	HCSC (BCBS)	29
Hot Springs, AR	3759	BCBS AR	57	Aetna	18
Jonesboro, AR	5861	BCBS AR	75	Aetna	12
Little Rock-North Little Rock, AR	3554	BCBS AR	54	Aetna	20
Pine Bluff, AR	5425	BCBS AR	72	Aetna	13
California	3956	WellPoint	58	BS of CA	20
Bakersfield, CA	5629	WellPoint	73	BS of CA	17
Chico, CA	4519	WellPoint	57	BS of CA	36
El Centro, CA	5643	WellPoint	71	BS of CA	25
Fresno, CA	3646	WellPoint	47	BS of CA	36
Hanford-Corcoran, CA	6119	WellPoint	76	BS of CA	19
Los Angeles-Long Beach-Glendale, CA	4482	WellPoint	63	BS of CA	17
Madera, CA	5157	WellPoint	67	BS of CA	24
Merced, CA	5501	WellPoint	71	BS of CA	22
Modesto, CA	4227	WellPoint	55	BS of CA	33
Napa, CA	6074	WellPoint	77	BS of CA	13
Oakland-Fremont-Hayward, CA	3686	WellPoint	54	BS of CA	22
Oxnard-Thousand Oaks-Ventura, CA	3942	WellPoint	58	Aetna	18
Redding, CA	4771	WellPoint	61	BS of CA	33
Riverside-San Bernardino-Ontario, CA	4460	WellPoint	63	Aetna	15
Sacramento-Arden-Arcade-Roseville, CA	4059	WellPoint	58	BS of CA	23

Table 3. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Salinas, CA	3831	WellPoint	54	BS of CA	28
San Diego-Carlsbad-San Marcos, CA	3229	WellPoint	48	Aetna	25
San Francisco-San Mateo-Redwood City, CA	3217	WellPoint	47	BS of CA	25
San Jose-Sunnyvale-Santa Clara, CA	3426	WellPoint	50	BS of CA	22
San Luis Obispo-Paso Robles, CA	5927	WellPoint	75	BS of CA	18
Santa Ana-Anaheim-Irvine, CA	4125	WellPoint	60	Aetna	17
Santa Barbara-Santa Maria, CA	4632	WellPoint	64	BS of CA	21
Santa Cruz-Watsonville, CA	5326	WellPoint	71	BS of CA	16
Santa Rosa-Petaluma, CA	3728	WellPoint	50	BS of CA	34
Stockton, CA	4200	WellPoint	60	BS of CA	21
Vallejo-Fairfield, CA	4968	WellPoint	68	Aetna	14
Visalia-Porterville, CA	5444	WellPoint	71	BS of CA	20
Yuba City-Marysville, CA	7009	WellPoint	83	BS of CA	11
Colorado	3100	WellPoint	46	Aetna	26
Boulder, CO	3462	WellPoint	49	Aetna	30
Colorado Springs, CO	2961	WellPoint	45	Aetna	25
Denver-Aurora, CO	3097	WellPoint	42	Aetna	34
Fort Collins-Loveland, CO	3729	WellPoint	56	Cigna	17
Grand Junction, CO	2961	WellPoint	48	Aetna	18
Greeley, CO	3354	WellPoint	50	Cigna	21
Pueblo, CO	3551	WellPoint	54	Cigna	21
Connecticut	4623	WellPoint	62	Aetna	28
Bridgeport-Stamford-Norwalk, CT	4035	WellPoint	54	Aetna	31
Danbury, CT	4001	WellPoint	54	Aetna	31
Hartford-West Hartford-East Hartford, CT	4849	WellPoint	62	Aetna	32
New Haven-Milford, CT	5415	WellPoint	70	Aetna	23
Waterbury, CT	5443	WellPoint	70	Aetna	22
Delaware	6379	BCBS DE	77	Aetna	20
Dover, DE	7837	BCBS DE	88	Aetna	9
Wilmington, DE-MD-NJ	5034	BCBS DE	66	Aetna	26
District of Columbia	6317	CareFirst	79	Aetna	11
Washington-Arlington-Alexandria, DC-VA-MD-WV	2669	WellPoint	31	CareFirst	31
Florida	4242	BCBS FL	61	Aetna	22
Cape Coral-Fort Myers, FL	3992	BCBS FL	57	Aetna	26
Deltona-Daytona Beach-Ormond Beach, FL	4150	BCBS FL	60	Aetna	20
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	3544	BCBS FL	48	Aetna	35
Fort Walton Beach-Crestview-Destin, FL	5080	BCBS FL	69	Aetna	14
Gainesville, FL	7365	BCBS FL	85	Aetna	7
Jacksonville, FL	4124	BCBS FL	56	Aetna	32
Lakeland-Winter Haven, FL	3770	BCBS FL	51	Aetna	32
Miami-Miami Beach-Kendall, FL	3475	BCBS FL	43	Aetna	39
Naples-Marco Island, FL	4571	BCBS FL	65	Aetna	17
Ocala, FL	6412	BCBS FL	79	Aetna	7
Orlando-Kissimmee, FL	3733	BCBS FL	49	Aetna	36

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Palm Bay-Melbourne-Titusville, FL	2674	BCBS FL	37	Cigna	30
Panama City-Lynn Haven, FL	6391	BCBS FL	79	Aetna	8
Pensacola-Ferry Pass-Brent, FL	5726	BCBS FL	74	Aetna	16
Port St. Lucie-Fort Pierce, FL	5578	BCBS FL	73	Aetna	11
Punta Gorda, FL	3489	BCBS FL	54	Aetna	19
Sarasota-Bradenton-Venice, FL	3961	BCBS FL	57	Aetna	25
Tallahassee, FL	7074	BCBS FL	83	Aetna	10
Tampa-St. Petersburg-Clearwater, FL	3001	BCBS FL	41	Aetna	33
Vero Beach, FL	6733	BCBS FL	82	UnitedHlthcare	5
West Palm Beach-Boca Raton-Boynton Beach, FL	4006	BCBS FL	57	Aetna	26
Georgia	4486	WellPoint	62	Aetna	26
Albany, GA	5085	WellPoint	69	Aetna	15
Athens-Clarke County, GA	7083	WellPoint	84	Aetna	8
Atlanta-Sandy Springs-Marietta, GA	4529	WellPoint	58	Aetna	33
Augusta-Richmond County, GA-SC	2911	WellPoint	38	BCBS SC	34
Brunswick, GA	5377	WellPoint	72	Aetna	11
Columbus, GA-AL	4147	WellPoint	60	BCBS AL	21
Dalton, GA	7753	WellPoint	88	Aetna	5
Gainesville, GA	3773	WellPoint	57	Medical Mutual	15
Hinesville-Fort Stewart, GA	5441	WellPoint	73	Aetna	10
Macon, GA	4906	WellPoint	66	Aetna	22
Rome, GA	4673	WellPoint	62	Aetna	27
Savannah, GA	3868	WellPoint	56	Aetna	25
Valdosta, GA	6074	WellPoint	77	Cigna	10
Warner Robins, GA	5669	WellPoint	74	Aetna	12
Hawaii	7202	HMSA (BCBS HI)	84	HI Med. Assurance Assn	6
Honolulu, HI	7304	HMSA (BCBS HI)	85	HI Med. Assurance Assn	6
Idaho	4187	BC of ID	60	Regence	22
Boise City-Nampa, ID	4301	BC of ID	61	Regence	22
Coeur d'Alene, ID	3480	BC of ID	54	Regence	20
Idaho Falls, ID	3442	BC of ID	49	Aetna	27
Lewiston, ID-WA	3041	BC of ID	38	Regence	35
Pocatello, ID	4428	BC of ID	62	Regence	22
Illinois	4716	HCSC (BCBS)	67	Aetna	12
Bloomington-Normal, IL	4245	HCSC (BCBS)	61	Aetna	21
Champaign-Urbana, IL	2505	Hlth Alliance Med Plans	37	HCSC (BCBS)	28
Chicago-Naperville-Joliet, IL	5453	HCSC (BCBS)	72	Aetna	13
Danville, IL	2882	HCSC (BCBS)	46	Hlth Alliance Med Plans	18
Davenport-Moline-Rock Island, IA-IL	2419	HCSC (BCBS)	41	Wellmark	20
Decatur, IL	4832	HCSC (BCBS)	68	UnitedHlthcare	12
Kankakee-Bradley, IL	4971	HCSC (BCBS)	69	WellPoint	9
Lake County-Kenosha County, IL-WI	4230	HCSC (BCBS)	61	Aetna	18
Peoria, IL	3404	UnitedHlthcare	41	HCSC (BCBS)	40

Table 3. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Rockford, IL	5215	HCSC (BCBS)	71	WellPoint	12
Springfield, IL	3954	HCSC (BCBS)	59	Hlth Alliance Med Plans	18
Indiana	6017	WellPoint	77	Aetna	11
Anderson, IN	7193	WellPoint	84	Aetna	5
Bloomington, IN	5567	WellPoint	72	Aetna	21
Columbus, IN	7232	WellPoint	85	Aetna	6
Elkhart-Goshen, IN	5702	WellPoint	74	Aetna	8
Evansville, IN-KY	4966	WellPoint	68	Humana	18
Fort Wayne, IN	5064	WellPoint	68	Aetna	20
Gary, IN	5356	WellPoint	71	Aetna	16
Indianapolis, IN	6822	WellPoint	82	Aetna	10
Kokomo, IN	7702	WellPoint	88	Humana	5
Lafayette, IN	4787	WellPoint	67	UnitedHlthcare	10
Michigan City-La Porte, IN	6664	WellPoint	81	Aetna	10
Muncie, IN	7375	WellPoint	86	Humana	6
South Bend-Mishawaka, IN-MI	3486	WellPoint	53	BCBS MI	21
Terre Haute, IN	7067	WellPoint	84	Cigna	5
Iowa	5978	Wellmark	76	Aetna	11
Ames, IA	4667	Wellmark	59	Aetna	35
Cedar Rapids, IA	6958	Wellmark	83	Aetna	12
Davenport-Moline-Rock Island, IA-IL	2419	HCSC (BCBS)	41	Wellmark	20
Des Moines, IA	6212	Wellmark	78	Aetna	11
Dubuque, IA	7801	Wellmark	88	Aetna	6
Iowa City, IA	7909	Wellmark	89	Aetna	7
Sioux City, IA-NE-SD	3892	Wellmark	59	Aetna	15
Waterloo-Cedar Falls, IA	7426	Wellmark	86	Aetna	5
Kansas	3888	BCBS KS	60	BCBS KS City	10
Lawrence, KS	6549	BCBS KS	80	Coventry	7
Topeka, KS	7014	BCBS KS	83	Humana	3
Wichita, KS	4654	BCBS KS	66	Preferred Hlth Systems	11
Kentucky	3935	WellPoint	50	Humana	37
Bowling Green, KY	6309	WellPoint	79	Aetna	9
Elizabethtown, KY	4246	WellPoint	52	Humana	39
Lexington-Fayette, KY	3464	WellPoint	44	Humana	38
Louisville, KY-IN	4126	WellPoint	56	Humana	29
Owensboro, KY	7450	WellPoint	86	Humana	7
Louisiana	4796	LA Hlth Serv & Ind (BCBS)	66	Humana	16
Alexandria, LA	4132	LA Hlth Serv & Ind (BCBS)	56	Humana	31
Baton Rouge, LA	3059	LA Hlth Serv & Ind (BCBS)	38	Humana	31
Houma-Bayou Cane-Thibodaux, LA	5391	LA Hlth Serv & Ind (BCBS)	71	Humana	18
Lafayette, LA	5573	LA Hlth Serv & Ind (BCBS)	73	Humana	13
Lake Charles, LA	3162	LA Hlth Serv & Ind (BCBS)	48	Humana	21
Monroe, LA	3348	Humana	41	LA Hlth Serv & Ind (BCBS)	39

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
New Orleans-Metairie-Kenner, LA	2848	LA Hlth Serv & Ind (BCBS)	35	Humana	31
Shreveport-Bossier City, LA	3543	LA Hlth Serv & Ind (BCBS)	52	Humana	25
Maine	3588	WellPoint	48	Aetna	31
Bangor, ME	4133	WellPoint	53	Aetna	36
Lewiston-Auburn, ME	4145	WellPoint	50	Aetna	40
Portland-South Portland, ME	3719	WellPoint	51	Aetna	29
Maryland	4738	CareFirst	64	Aetna	25
Baltimore-Towson, MD	5992	CareFirst	75	Aetna	20
Bethesda-Gaithersburg-Frederick, MD	3424	Aetna	46	CareFirst	34
Cumberland, MD-WV	2782	CareFirst	43	Highmark	21
Hagerstown-Martinsburg, MD-WV	2564	Highmark	31	Aetna	30
Salisbury, MD	5100	CareFirst	69	Aetna	17
Massachusetts	3465	BCBS MA	52	Tufts	19
Barnstable Town, MA	3372	BCBS MA	50	Harvard Pilgrim	23
Boston-Cambridge-Quincy, MA	2848	BCBS MA	46	Harvard Pilgrim	17
Brockton-Bridgewater-Easton, MA	3382	BCBS MA	49	Harvard Pilgrim	26
Framingham, MA	3565	BCBS MA	53	Tufts	19
Haverhill-North Andover-Amesbury, MA-NH	2262	BCBS MA	35	WellPoint	22
Lawrence-Methuen-Salem, MA-NH	2638	BCBS MA	43	WellPoint	16
Leominster-Fitchburg-Gardner, MA	3616	BCBS MA	54	Tufts	20
Lowell-Billerica-Chelmsford, MA-NH	2860	BCBS MA	46	Tufts	17
Lynn-Peabody-Salem, MA	3883	BCBS MA	57	Tufts	21
New Bedford, MA	3438	BCBS MA	48	Harvard Pilgrim	28
Pittsfield, MA	4958	BCBS MA	66	Tufts	24
Springfield, MA	2827	BCBS MA	47	Tufts	17
Taunton-Norton-Raynham, MA	3435	BCBS MA	48	Harvard Pilgrim	28
Worcester, MA-CT	2726	BCBS MA	45	Tufts	16
Michigan	7227	BCBS MI	85	Aetna	7
Ann Arbor, MI	7248	BCBS MI	85	Aetna	9
Battle Creek, MI	7920	BCBS MI	89	Aetna	4
Bay City, MI	7806	BCBS MI	88	Aetna	5
Detroit-Livonia-Dearborn, MI	5450	BCBS MI	73	Aetna	11
Flint, MI	7437	BCBS MI	86	Aetna	4
Grand Rapids-Wyoming, MI	5969	BCBS MI	76	Aetna	10
Holland-Grand Haven, MI	5198	BCBS MI	69	Aetna	18
Jackson, MI	6876	BCBS MI	82	Priority Hlth	8
Kalamazoo-Portage, MI	7174	BCBS MI	84	Aetna	8
Lansing-East Lansing, MI	7253	BCBS MI	85	Aetna	10
Monroe, MI	7055	BCBS MI	83	Aetna	9
Muskegon-Norton Shores, MI	6923	BCBS MI	82	Aetna	11
Niles-Benton Harbor, MI	7422	BCBS MI	86	Aetna	10
Saginaw-Saginaw Township North, MI	7978	BCBS MI	89	Aetna	4
Warren-Farmington Hills-Troy, MI	7182	BCBS MI	84	Aetna	7

Table 3. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2009**
PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Minnesota	3630	BCBS MN	49	Medica	31
Duluth, MN-WI	3264	BCBS MN	46	Medica	29
Minneapolis-St. Paul-Bloomington, MN-WI	3349	BCBS MN	46	Medica	30
St. Cloud, MN	3788	BCBS MN	50	Medica	32
Mississippi	5077	BCBS MS	69	Aetna	16
Gulfport-Biloxi, MS	4169	BCBS MS	60	Humana	17
Hattiesburg, MS	5886	BCBS MS	74	Aetna	18
Jackson, MS	4873	BCBS MS	67	Aetna	16
Pascagoula, MS	5868	BCBS MS	75	Aetna	17
Missouri	2128	WellPoint	35	BCBS KS City	23
Columbia, MO	3724	Coventry	56	Aetna	20
Jefferson City, MO	2611	WellPoint	41	Coventry	26
Joplin, MO	1926	WellPoint	35	CoxHealth	18
Kansas City, MO-KS	2566	BCBS KS City	43	Aetna	22
Springfield, MO	1638	CoxHealth	29	WellPoint	16
St. Joseph, MO-KS	5371	BCBS KS City	72	WellPoint	12
St. Louis, MO-IL	3170	WellPoint	51	Aetna	18
Montana	3988	Cigna	56	BCBS MT	28
Billings, MT	3292	Cigna	42	BCBS MT	34
Missoula, MT	4791	Cigna	65	BCBS MT	21
Nebraska	5944	BCBS NE	76	Aetna	9
Lincoln, NE	6837	BCBS NE	82	Aetna	7
Omaha-Council Bluffs, NE-IA	4318	BCBS NE	63	Aetna	15
Nevada	1989	WellPoint	32	Renown Health	19
Carson City, NV	2972	WellPoint	44	Renown Health	28
Las Vegas-Paradise, NV	1919	WellPoint	28	Aetna	20
Reno-Sparks, NV	2768	WellPoint	43	Renown Health	22
New Hampshire	3744	WellPoint	54	Harvard Pilgrim	23
Manchester, NH	3889	WellPoint	55	Harvard Pilgrim	24
Nashua, NH-MA	3253	WellPoint	48	Harvard Pilgrim	26
Portsmouth, NH-ME	3593	WellPoint	50	Harvard Pilgrim	28
Rochester-Dover, NH	3725	WellPoint	54	Harvard Pilgrim	20
New Jersey	3388	Horizon BCBS	41	Aetna	40
Atlantic City, NJ	7549	Horizon BCBS	86	Aetna	10
Camden, NJ	4282	Aetna	51	Horizon BCBS	41
Edison, NJ	3677	Aetna	46	Horizon BCBS	38
Newark-Union, NJ-PA	3532	Aetna	42	Horizon BCBS	41
Ocean City, NJ	5587	Horizon BCBS	72	Aetna	19
Trenton-Ewing, NJ	3762	Aetna	52	Horizon BCBS	30
Vineland-Millville-Bridgeton, NJ	5857	Horizon BCBS	73	Aetna	22
New Mexico	3962	HCSC (BCBS)	59	Presbyterian HC Services	18
Albuquerque, NM	2646	HCSC (BCBS)	40	Presbyterian HC Services	27
Farmington, NM	2400	Presbyterian HC Services	37	Aetna	23

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Las Cruces, NM	6808	HCSC (BCBS)	82	Aetna	8
Santa Fe, NM	5497	HCSC (BCBS)	72	Presbyterian HC Services	17
New York	2397	WellPoint	39	EmblemHealth	22
Albany-Schenectady-Troy, NY	2078	WellPoint	28	UnitedHlthcare	22
Binghamton, NY	2708	Lifetime Hlthcare	40	UnitedHlthcare	29
Buffalo-Cheektowaga-Tonawanda, NY	3377	HealthNow NY (BCBS)	48	EmblemHealth	30
Elmira, NY	3135	Lifetime Hlthcare	45	UnitedHlthcare	27
Glens Falls, NY	2955	WellPoint	47	UnitedHlthcare	19
Ithaca, NY	3037	Aetna	46	UnitedHlthcare	22
Kingston, NY	2581	WellPoint	40	UnitedHlthcare	25
New York-White Plains-Wayne, NY-NJ	2679	WellPoint	41	EmblemHealth	25
Poughkeepsie-Newburgh-Middletown, NY	2558	WellPoint	39	UnitedHlthcare	23
Rochester, NY	2681	Lifetime Hlthcare	39	MVP Hlth Care	27
Suffolk County-Nassau County, NY	3328	WellPoint	49	UnitedHlthcare	25
Syracuse, NY	2839	Lifetime Hlthcare	45	UnitedHlthcare	20
Utica-Rome, NY	2393	UnitedHlthcare	31	EmblemHealth	27
North Carolina	5949	BCBS NC	76	Aetna	14
Asheville, NC	6584	BCBS NC	81	Coventry	5
Burlington, NC	6250	BCBS NC	78	Aetna	13
Charlotte-Gastonia-Concord, NC-SC	3797	BCBS NC	54	Aetna	28
Durham, NC	6723	BCBS NC	81	Aetna	11
Goldsboro, NC	8427	BCBS NC	92	Aetna	5
Greensboro-High Point, NC	6178	BCBS NC	77	Aetna	15
Greenville, NC	8198	BCBS NC	90	Aetna	6
Hickory-Morganton-Lenoir, NC	7897	BCBS NC	89	Coventry	4
Raleigh-Cary, NC	6693	BCBS NC	81	Aetna	13
Rocky Mount, NC	8308	BCBS NC	91	Aetna	4
Wilmington, NC	6580	BCBS NC	80	Aetna	9
Winston-Salem, NC	5429	BCBS NC	70	Aetna	23
North Dakota	4438	BCBS ND	54	Aetna	39
Bismarck, ND	6478	Aetna	78	BCBS ND	19
Fargo, ND-MN	2617	BCBS MN	37	Medica	24
Grand Forks, ND-MN	2699	BCBS MN	38	Medica	25
Ohio	2876	WellPoint	39	Medical Mutual	33
Akron, OH	2714	Medical Mutual	37	WellPoint	31
Canton-Massillon, OH	2746	Medical Mutual	37	WellPoint	33
Cincinnati-Middletown, OH-KY-IN	4339	WellPoint	63	Humana	16
Cleveland-Elyria-Mentor, OH	3683	Medical Mutual	52	WellPoint	26
Columbus, OH	3239	Medical Mutual	43	WellPoint	28
Dayton, OH	4201	WellPoint	62	Aetna	17
Lima, OH	2593	WellPoint	35	Medical Mutual	30
Mansfield, OH	3679	WellPoint	47	Medical Mutual	37
Sandusky, OH	3653	Medical Mutual	45	WellPoint	39

Table 3. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Springfield, OH	2628	Aetna	36	WellPoint	33
Toledo, OH	3171	Medical Mutual	45	WellPoint	27
Weirton-Steubenville, WV-OH	2210	WellPoint	36	Coventry	20
Youngstown-Warren-Boardman, OH-PA	2535	WellPoint	39	Medical Mutual	24
Oklahoma	4728	HCSC (BCBS)	64	Aetna	23
Oklahoma City, OK	5103	HCSC (BCBS)	67	Aetna	24
Tulsa, OK	4701	HCSC (BCBS)	62	Aetna	28
Oregon	1868	Regence	33	PacificSource	15
Bend, OR	1936	Regence	28	PacificSource	25
Corvallis, OR	2459	Regence	41	ODS Health Plans	21
Eugene-Springfield, OR	3445	PacificSource	53	Regence	22
Medford, OR	1817	Regence	29	Aetna	19
Portland-Vancouver-Beaverton, OR-WA	2151	Regence	37	Aetna	20
Salem, OR	2284	Regence	39	ODS Health Plans	19
Pennsylvania	2195	Highmark	38	Independence BC	20
Allentown-Bethlehem-Easton, PA-NJ	2697	Highmark	42	Capital BC	25
Altoona, PA	6339	Highmark	79	Geisinger	6
Erie, PA	5535	Highmark	72	Coventry	20
Harrisburg-Carlisle, PA	3325	Highmark	48	Capital BC	28
Johnstown, PA	6933	Highmark	83	UPMC Hlth System	7
Lancaster, PA	3102	Highmark	45	Capital BC	27
Lebanon, PA	3357	Highmark	47	Capital BC	28
Philadelphia, PA	5591	Independence BC	70	Aetna	26
Pittsburgh, PA	5377	Highmark	72	Coventry	10
Reading, PA	3415	Highmark	49	Capital BC	29
Scranton--Wilkes-Barre, PA	5097	BC of N.E. PA	69	Geisinger	12
State College, PA	3690	Highmark	51	Capital BC	30
Williamsport, PA	4121	BC of N.E. PA	60	Coventry	21
York-Hanover, PA	3323	Highmark	48	Capital BC	29
Rhode Island	5628	BCBS RI	73	UnitedHlthcare	13
Norwich-New London, CT-RI	4825	WellPoint	67	Aetna	14
Providence-Fall River-Warwick, RI-MA	4099	BCBS RI	62	UnitedHlthcare	11
South Carolina	6892	BCBS SC	82	Aetna	9
Anderson, SC	7776	BCBS SC	88	Aetna	6
Charleston-North Charleston, SC	6887	BCBS SC	82	Aetna	7
Columbia, SC	7374	BCBS SC	85	Aetna	9
Florence, SC	7464	BCBS SC	86	Aetna	9
Greenville, SC	7287	BCBS SC	85	Aetna	9
Myrtle Beach-Conway-North Myrtle Beach, SC	6758	BCBS SC	82	Aetna	7
Spartanburg, SC	7502	BCBS SC	86	Aetna	9
Sumter, SC	7954	BCBS SC	89	Aetna	5

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
South Dakota	5104	Wellmark	69	Avera Hlth	18
Rapid City, SD	5129	Wellmark	69	Avera Hlth	18
Sioux Falls, SD	5329	Wellmark	70	Avera Hlth	18
Tennessee	5620	BCBS TN	74	Aetna	10
Chattanooga, TN-GA	4971	BCBS TN	68	WellPoint	15
Clarksville, TN-KY	2954	BCBS TN	43	WellPoint	28
Cleveland, TN	6267	BCBS TN	78	Humana	9
Jackson, TN	6507	BCBS TN	80	Humana	11
Johnson City, TN	5291	BCBS TN	71	Humana	13
Kingsport-Bristol, TN-VA	3736	BCBS TN	55	WellPoint	23
Knoxville, TN	5362	BCBS TN	71	Aetna	11
Memphis, TN-MS-AR	2954	BCBS TN	48	Aetna	22
Morristown, TN	6355	BCBS TN	79	Humana	8
Nashville-Davidson--Murfreesboro, TN	5750	BCBS TN	74	Aetna	13
Texas	3613	HCSC (BCBS)	50	Aetna	32
Abilene, TX	4228	HCSC (BCBS)	57	Humana	31
Amarillo, TX	2982	HCSC (BCBS)	36	Humana	31
Austin-Round Rock, TX	4609	HCSC (BCBS)	58	Aetna	35
Beaumont-Port Arthur, TX	4961	HCSC (BCBS)	65	Aetna	26
Brownsville-Harlingen, TX	4688	HCSC (BCBS)	64	Aetna	21
College Station-Bryan, TX	7176	HCSC (BCBS)	84	Aetna	9
Corpus Christi, TX	4908	HCSC (BCBS)	63	Aetna	31
Dallas-Plano-Irving, TX	3638	HCSC (BCBS)	45	Aetna	38
El Paso, TX	3102	Aetna	37	HCSC (BCBS)	30
Fort Worth-Arlington, TX	2864	HCSC (BCBS)	36	Aetna	35
Houston-Sugar Land-Baytown, TX	3469	Aetna	41	HCSC (BCBS)	41
Killeen-Temple-Fort Hood, TX	4441	HCSC (BCBS)	61	Aetna	25
Laredo, TX	6666	HCSC (BCBS)	81	Aetna	8
Longview, TX	6134	HCSC (BCBS)	76	Aetna	20
Lubbock, TX	4246	HCSC (BCBS)	59	Humana	25
McAllen-Edinburg-Mission, TX	5247	HCSC (BCBS)	69	Aetna	20
Midland, TX	6400	HCSC (BCBS)	79	Aetna	14
Odessa, TX	6707	HCSC (BCBS)	81	Aetna	11
San Angelo, TX	6645	HCSC (BCBS)	80	Aetna	16
San Antonio, TX	4205	HCSC (BCBS)	53	Aetna	37
Sherman-Denison, TX	5479	HCSC (BCBS)	70	Aetna	22
Texarkana, TX-AR	3444	HCSC (BCBS)	55	Aetna	15
Tyler, TX	6269	HCSC (BCBS)	77	Aetna	19
Victoria, TX	5031	HCSC (BCBS)	64	Aetna	30
Waco, TX	5306	HCSC (BCBS)	69	Aetna	22
Wichita Falls, TX	6583	HCSC (BCBS)	79	Aetna	17

Table 3. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Utah	3356	Regence	52	Aetna	23
Logan, UT-ID	3124	Regence	49	BC of ID	18
Ogden-Clearfield, UT	2663	Regence	39	Aetna	29
Provo-Orem, UT	2760	Aetna	37	Regence	28
Salt Lake City, UT	3466	Regence	51	Aetna	27
St. George, UT	2992	Regence	47	Aetna	22
Vermont	2920	BCBS VT	47	Cigna	18
Burlington-South Burlington, VT	2873	BCBS VT	45	Aetna	23
Virginia	4578	WellPoint	65	Aetna	17
Blacksburg-Christiansburg-Radford, VA	7617	WellPoint	87	Aetna	10
Charlottesville, VA	4815	WellPoint	68	Aetna	12
Danville, VA	8278	WellPoint	91	Piedmont (Centra)	3
Harrisonburg, VA	7560	WellPoint	87	Optima Hlth (Sentara)	5
Lynchburg, VA	5721	WellPoint	74	Piedmont (Centra)	13
Richmond, VA	6124	WellPoint	76	Aetna	18
Roanoke, VA	6646	WellPoint	80	Aetna	13
Virginia Beach-Norfolk-Newport News, VA-NC	5495	WellPoint	73	Aetna	12
Winchester, VA-WV	4930	WellPoint	68	Optima Hlth (Sentara)	15
Washington	3158	Premera	40	Regence	37
Bellingham, WA	3742	Regence	52	Premera	30
Bremerton-Silverdale, WA	2563	Premera	36	Group Hlth Cooperative	26
Kennewick-Richland-Pasco, WA	3722	Premera	56	Aetna	17
Longview-Kelso, WA	3705	Premera	55	Regence	22
Mount Vernon-Anacortes, WA	3745	Regence	50	Premera	33
Olympia, WA	2965	Premera	39	Regence	32
Seattle-Bellevue-Everett, WA	3204	Premera	40	Regence	33
Spokane, WA	4138	Premera	58	Regence	25
Tacoma, WA	3257	Regence	41	Premera	36
Wenatchee, WA	5378	Premera	71	Regence	17
Yakima, WA	3956	Premera	52	Regence	34
West Virginia	3947	Highmark	59	Aetna	19
Charleston, WV	3776	Highmark	53	Aetna	27
Huntington-Ashland, WV-KY-OH	2185	WellPoint	34	Highmark	20
Morgantown, WV	5481	Highmark	73	Cigna	9
Parkersburg-Marietta-Vienna, WV-OH	2462	WellPoint	38	Highmark	26
Wheeling, WV-OH	2364	WellPoint	33	Highmark	25
Wisconsin	2255	WellPoint	35	Humana	25
Appleton, WI	2592	Humana	39	WellPoint	25
Eau Claire, WI	2925	Humana	46	WellPoint	23
Fond du Lac, WI	2745	Humana	47	WellPoint	18
Green Bay, WI	2609	Humana	41	WellPoint	26
Janesville, WI	2277	Humana	32	WellPoint	32
La Crosse, WI-MN	1672	BCBS MN	23	Humana	22
Madison, WI	1997	WellPoint	35	Humana	18

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Milwaukee-Waukesha-West Allis, WI	2654	WellPoint	37	Aetna	27
Oshkosh-Neenah, WI	2863	Humana	37	WellPoint	36
Racine, WI	2699	WellPoint	41	Humana	24
Sheboygan, WI	3253	WellPoint	43	Humana	36
Wausau, WI	3839	WellPoint	58	Aetna	15
Wyoming	4865	Cigna	66	UnitedHlthcare	22
Casper, WY	5693	Cigna	72	UnitedHlthcare	21
Cheyenne, WY	5946	Cigna	76	UnitedHlthcare	12

Notes:

1. Data source: Managed Market Surveyor, © 2010 HealthLeaders-InterStudy (HLIS). All rights reserved. Managed Market Surveyor data may not be reproduced, distributed, displayed or modified, in whole or in part, by any means, without the prior written consent of HLIS.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the PPO product market are reported.
3. These data are based on enrollments in both fully and self-insured health plans.
4. Due to a recategorization of product types by HLIS and UnitedHealthcare (United), there was a very large shift in United's reported enrollment from PPO to POS between Jan. 1, 2009 (used for 2011 edition) and Jan. 1, 2010 (used for this edition). In 2009, United had about 70 percent of its reported commercial enrollment in PPO, but in 2010, about 70 percent was in POS. Consequently, whereas previously United was among the largest PPO insurers in many geographic areas, in this study, it is among the largest insurers in many POS markets. We found it necessary to validate United's enrollment reported to HLIS, and had it verified by both HLIS and United staff.

Table 4. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010 POS product markets

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	5900	UnitedHlthcare	71	Cigna	29
Birmingham-Hoover, AL	6403	UnitedHlthcare	76	Cigna	24
Huntsville, AL	5173	UnitedHlthcare	59	Cigna	41
Mobile, AL	5888	UnitedHlthcare	71	Cigna	29
Montgomery, AL	6157	UnitedHlthcare	74	Cigna	26
Alaska	5003	UnitedHlthcare	56	Cigna	43
Arizona	5050	UnitedHlthcare	61	Cigna	36
Flagstaff, AZ	5591	UnitedHlthcare	67	Cigna	33
Phoenix-Mesa-Scottsdale, AZ	4932	UnitedHlthcare	58	Cigna	40
Prescott, AZ	5426	UnitedHlthcare	69	Cigna	26
Tucson, AZ	6241	UnitedHlthcare	76	Cigna	20
Yuma, AZ	3775	Cigna	43	UnitedHlthcare	41
Arkansas	2960	UnitedHlthcare	41	Cigna	29
Fayetteville-Springdale-Rogers, AR-MO	3021	Cigna	41	UnitedHlthcare	33
Fort Smith, AR-OK	3479	UnitedHlthcare	51	Cigna	22
Hot Springs, AR	3078	UnitedHlthcare	45	BCBS AR	22
Jonesboro, AR	2780	UnitedHlthcare	39	Cigna	22
Little Rock-North Little Rock, AR	3891	UnitedHlthcare	57	Cigna	16
Pine Bluff, AR	2787	Cigna	35	UnitedHlthcare	32
California	3493	UnitedHlthcare	46	Cigna	34
Bakersfield, CA	3937	UnitedHlthcare	58	Cigna	21
Chico, CA	5216	UnitedHlthcare	69	Cigna	20
Fresno, CA	3284	UnitedHlthcare	46	Cigna	30
Los Angeles-Long Beach-Glendale, CA	2999	UnitedHlthcare	40	Cigna	33
Merced, CA	4004	UnitedHlthcare	56	Cigna	28
Modesto, CA	4036	UnitedHlthcare	51	Cigna	36
Oakland-Fremont-Hayward, CA	4304	UnitedHlthcare	53	Cigna	38
Oxnard-Thousand Oaks-Ventura, CA	3619	UnitedHlthcare	52	Cigna	28
Riverside-San Bernardino-Ontario, CA	3001	UnitedHlthcare	40	Cigna	28
Sacramento-Arden-Arcade-Roseville, CA	4384	UnitedHlthcare	53	Cigna	40
Salinas, CA	4369	UnitedHlthcare	56	Cigna	34
San Diego-Carlsbad-San Marcos, CA	3814	UnitedHlthcare	46	Cigna	40
San Francisco-San Mateo-Redwood City, CA	4279	UnitedHlthcare	54	Cigna	37
San Jose-Sunnyvale-Santa Clara, CA	4174	UnitedHlthcare	51	Cigna	39
San Luis Obispo-Paso Robles, CA	4777	UnitedHlthcare	64	Cigna	23
Santa Ana-Anaheim-Irvine, CA	3520	UnitedHlthcare	46	Cigna	35
Santa Barbara-Santa Maria, CA	3250	UnitedHlthcare	43	Cigna	33
Santa Cruz-Watsonville, CA	3762	UnitedHlthcare	46	Cigna	39
Santa Rosa-Petaluma, CA	4798	UnitedHlthcare	65	Cigna	21
Stockton, CA	4157	UnitedHlthcare	54	Cigna	34
Vallejo-Fairfield, CA	3741	UnitedHlthcare	50	Cigna	32
Visalia-Porterville, CA	3245	WellPoint	41	Cigna	28
Yuba City-Marysville, CA	3822	WellPoint	44	UnitedHlthcare	41

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Colorado	4790	UnitedHlthcare	55	Cigna	42
Boulder, CO	5000	UnitedHlthcare	59	Cigna	39
Colorado Springs, CO	4680	UnitedHlthcare	55	Cigna	41
Denver-Aurora, CO	4870	UnitedHlthcare	56	Cigna	42
Fort Collins-Loveland, CO	4824	UnitedHlthcare	57	Cigna	39
Grand Junction, CO	4297	Cigna	46	UnitedHlthcare	46
Greeley, CO	4583	Cigna	49	UnitedHlthcare	47
Pueblo, CO	4861	UnitedHlthcare	62	Cigna	32
Connecticut	3337	UnitedHlthcare	40	Cigna	39
Bridgeport-Stamford-Norwalk, CT	3679	Cigna	43	UnitedHlthcare	41
Danbury, CT	3584	Cigna	42	UnitedHlthcare	41
Hartford-West Hartford-East Hartford, CT	3203	Cigna	46	UnitedHlthcare	27
New Haven-Milford, CT	3140	Cigna	44	UnitedHlthcare	30
Waterbury, CT	3085	Cigna	43	UnitedHlthcare	30
Delaware	3264	UnitedHlthcare	46	Cigna	30
Dover, DE	3069	UnitedHlthcare	45	Cigna	26
Wilmington, DE-MD-NJ	2761	UnitedHlthcare	43	Cigna	25
District of Columbia	6210	CareFirst	77	UnitedHlthcare	13
Washington-Arlington-Alexandria, DC-VA-MD-WV	3420	CareFirst	44	UnitedHlthcare	28
Florida	4960	UnitedHlthcare	61	Cigna	36
Cape Coral-Fort Myers, FL	5804	UnitedHlthcare	70	Cigna	30
Deltona-Daytona Beach-Ormond Beach, FL	4042	UnitedHlthcare	56	Cigna	26
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	4643	UnitedHlthcare	58	Cigna	35
Fort Walton Beach-Crestview-Destin, FL	6435	UnitedHlthcare	77	Cigna	23
Gainesville, FL	5937	UnitedHlthcare	75	Cigna	17
Jacksonville, FL	5267	UnitedHlthcare	65	Cigna	31
Lakeland-Winter Haven, FL	4949	UnitedHlthcare	57	Cigna	41
Miami-Miami Beach-Kendall, FL	4886	UnitedHlthcare	63	Cigna	29
Naples-Marco Island, FL	5350	UnitedHlthcare	63	Cigna	37
Ocala, FL	5652	UnitedHlthcare	71	Cigna	26
Orlando-Kissimmee, FL	4910	UnitedHlthcare	52	Cigna	46
Palm Bay-Melbourne-Titusville, FL	5166	UnitedHlthcare	59	Cigna	41
Panama City-Lynn Haven, FL	5328	UnitedHlthcare	63	Cigna	37
Pensacola-Ferry Pass-Brent, FL	7295	UnitedHlthcare	84	Cigna	12
Port St. Lucie-Fort Pierce, FL	4968	Cigna	57	UnitedHlthcare	41
Punta Gorda, FL	5010	UnitedHlthcare	53	Cigna	47
Sarasota-Bradenton-Venice, FL	5221	UnitedHlthcare	65	Cigna	32
Tallahassee, FL	5565	UnitedHlthcare	71	Cigna	20
Tampa-St. Petersburg-Clearwater, FL	5641	UnitedHlthcare	70	Cigna	28
Vero Beach, FL	5037	UnitedHlthcare	64	Cigna	31
West Palm Beach-Boca Raton-Boynton Beach, FL	4691	UnitedHlthcare	52	Cigna	44
Georgia	4323	UnitedHlthcare	61	Cigna	23
Albany, GA	5805	UnitedHlthcare	74	Cigna	16
Athens-Clarke County, GA	5416	UnitedHlthcare	71	Cigna	13

Table 4. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
POS product markets

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Atlanta-Sandy Springs-Marietta, GA	4089	UnitedHlthcare	59	Cigna	24
Augusta-Richmond County, GA-SC	5123	UnitedHlthcare	68	Cigna	20
Brunswick, GA	6150	UnitedHlthcare	77	Cigna	14
Columbus, GA-AL	4605	UnitedHlthcare	62	Cigna	26
Dalton, GA	7675	Cigna	87	UnitedHlthcare	8
Gainesville, GA	4221	UnitedHlthcare	60	Cigna	23
Hinesville-Fort Stewart, GA	4493	UnitedHlthcare	62	Cigna	17
Macon, GA	4138	UnitedHlthcare	61	Cigna	14
Rome, GA	4292	UnitedHlthcare	61	Cigna	22
Savannah, GA	3929	UnitedHlthcare	55	Cigna	28
Valdosta, GA	6075	UnitedHlthcare	76	Cigna	13
Warner Robins, GA	5122	UnitedHlthcare	69	Cigna	14
Idaho	3421	Group Hlth Cooperative	51	UnitedHlthcare	25
Boise City-Nampa, ID	4114	UnitedHlthcare	58	Cigna	22
Coeur d'Alene, ID	7450	Group Hlth Cooperative	86	UnitedHlthcare	8
Idaho Falls, ID	3728	UnitedHlthcare	54	Cigna	22
Illinois	4773	UnitedHlthcare	57	Cigna	39
Bloomington-Normal, IL	4991	Cigna	67	UnitedHlthcare	20
Champaign-Urbana, IL	5045	Cigna	66	UnitedHlthcare	26
Chicago-Naperville-Joliet, IL	5050	UnitedHlthcare	59	Cigna	39
Davenport-Moline-Rock Island, IA-IL	6275	UnitedHlthcare	78	Cigna	14
Kankakee-Bradley, IL	5055	Cigna	61	UnitedHlthcare	36
Lake County-Kenosha County, IL-WI	5550	UnitedHlthcare	70	Cigna	26
Peoria, IL	4517	Cigna	57	UnitedHlthcare	34
Rockford, IL	4725	UnitedHlthcare	57	Cigna	39
Springfield, IL	5148	Cigna	69	UnitedHlthcare	15
Indiana	3715	UnitedHlthcare	51	Cigna	31
Anderson, IN	4812	UnitedHlthcare	61	Cigna	32
Bloomington, IN	4835	SE IN Hlth Org	66	UnitedHlthcare	20
Columbus, IN	4294	SE IN Hlth Org	59	UnitedHlthcare	25
Evansville, IN-KY	3340	UnitedHlthcare	47	Welborn Hlth Plans	26
Fort Wayne, IN	4928	UnitedHlthcare	62	Cigna	34
Gary, IN	5358	UnitedHlthcare	67	Cigna	30
Indianapolis, IN	4137	UnitedHlthcare	51	Cigna	38
Kokomo, IN	5007	Cigna	62	UnitedHlthcare	35
Lafayette, IN	5268	UnitedHlthcare	64	Cigna	34
Michigan City-La Porte, IN	4685	UnitedHlthcare	56	Cigna	39
South Bend-Mishawaka, IN-MI	4804	UnitedHlthcare	62	Cigna	31
Terre Haute, IN	4572	Cigna	50	UnitedHlthcare	46
Iowa	4789	UnitedHlthcare	66	Cigna	17
Ames, IA	5101	UnitedHlthcare	69	Wellmark	11
Cedar Rapids, IA	3520	UnitedHlthcare	45	Cigna	37
Davenport-Moline-Rock Island, IA-IL	6275	UnitedHlthcare	78	Cigna	14

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Des Moines, IA	5789	UnitedHlthcare	75	Cigna	11
Dubuque, IA	6280	UnitedHlthcare	78	Cigna	14
Iowa City, IA	3563	UnitedHlthcare	51	Wellmark	23
Sioux City, IA-NE-SD	5992	UnitedHlthcare	76	Cigna	12
Waterloo-Cedar Falls, IA	5943	UnitedHlthcare	75	Cigna	14
Kansas	3454	UnitedHlthcare	49	Cigna	29
Lawrence, KS	3502	Cigna	41	UnitedHlthcare	36
Topeka, KS	4614	UnitedHlthcare	53	Cigna	42
Wichita, KS	3818	Preferred Hlth Systems	52	UnitedHlthcare	31
Kentucky	4145	UnitedHlthcare	58	Cigna	22
Bowling Green, KY	3679	UnitedHlthcare	52	Cigna	24
Elizabethtown, KY	3349	UnitedHlthcare	44	Cigna	33
Lexington-Fayette, KY	3825	UnitedHlthcare	54	Cigna	21
Louisville, KY-IN	3767	UnitedHlthcare	55	Cigna	22
Owensboro, KY	4603	UnitedHlthcare	64	Cigna	16
Louisiana	4956	UnitedHlthcare	66	Cigna	23
Alexandria, LA	5799	UnitedHlthcare	73	Cigna	21
Baton Rouge, LA	4801	UnitedHlthcare	63	Cigna	29
Houma-Bayou Cane-Thibodaux, LA	5999	UnitedHlthcare	74	Cigna	21
Lafayette, LA	5548	UnitedHlthcare	69	Cigna	27
Lake Charles, LA	5624	UnitedHlthcare	70	Cigna	27
Monroe, LA	6829	UnitedHlthcare	81	Cigna	14
New Orleans-Metairie-Kenner, LA	4787	UnitedHlthcare	65	Cigna	18
Shreveport-Bossier City, LA	3602	UnitedHlthcare	45	Cigna	36
Maine	4503	WellPoint	56	Cigna	37
Bangor, ME	4541	WellPoint	50	Cigna	44
Lewiston-Auburn, ME	4659	WellPoint	59	Cigna	33
Portland-South Portland, ME	4933	WellPoint	64	Cigna	28
Maryland	3599	CareFirst	44	UnitedHlthcare	36
Baltimore-Towson, MD	3532	CareFirst	42	UnitedHlthcare	38
Bethesda-Gaithersburg-Frederick, MD	3663	UnitedHlthcare	41	CareFirst	40
Cumberland, MD-WV	4999	UnitedHlthcare	67	CareFirst	16
Hagerstown-Martinsburg, MD-WV	3872	UnitedHlthcare	53	Cigna	29
Salisbury, MD	3996	UnitedHlthcare	54	CareFirst	31
Massachusetts	3381	BCBS MA	39	Cigna	35
Barnstable Town, MA	3591	BCBS MA	46	Cigna	30
Boston-Cambridge-Quincy, MA	3282	BCBS MA	40	Cigna	33
Brockton-Bridgewater-Easton, MA	3420	BCBS MA	40	Cigna	32
Framingham, MA	3412	BCBS MA	38	Cigna	37
Haverhill-North Andover-Amesbury, MA-NH	2992	Cigna	44	UnitedHlthcare	22
Lawrence-Methuen-Salem, MA-NH	2909	Cigna	40	BCBS MA	24
Leominster-Fitchburg-Gardner, MA	3486	Cigna	44	BCBS MA	31
Lowell-Billerica-Chelmsford, MA-NH	3146	BCBS MA	36	Cigna	35

Table 4. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
POS product markets

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lynn-Peabody-Salem, MA	3388	BCBS MA	37	Cigna	35
New Bedford, MA	3388	BCBS MA	38	UnitedHlthcare	35
Springfield, MA	3079	Cigna	44	BCBS MA	25
Taunton-Norton-Raynham, MA	3386	BCBS MA	38	UnitedHlthcare	35
Worcester, MA-CT	3246	Cigna	43	BCBS MA	29
Michigan	2401	UnitedHlthcare	37	Cigna	24
Ann Arbor, MI	3981	Cigna	51	UnitedHlthcare	36
Battle Creek, MI	5103	UnitedHlthcare	68	Priority Hlth	18
Detroit-Livonia-Dearborn, MI	3275	UnitedHlthcare	40	Cigna	39
Flint, MI	2352	UnitedHlthcare	31	HealthPlus MI	29
Grand Rapids-Wyoming, MI	3613	Priority Hlth	41	UnitedHlthcare	41
Holland-Grand Haven, MI	4652	Priority Hlth	62	UnitedHlthcare	28
Jackson, MI	3883	Priority Hlth	55	UnitedHlthcare	22
Kalamazoo-Portage, MI	5400	UnitedHlthcare	69	Priority Hlth	24
Lansing-East Lansing, MI	6816	Sparrow Hlth Sys	82	UnitedHlthcare	7
Monroe, MI	3004	UnitedHlthcare	36	Cigna	34
Muskegon-Norton Shores, MI	4645	Priority Hlth	64	UnitedHlthcare	18
Saginaw-Saginaw Township North, MI	3373	HealthPlus MI	51	UnitedHlthcare	22
Warren-Farmington Hills-Troy, MI	3517	UnitedHlthcare	43	Cigna	40
Minnesota	3540	Cigna	43	UnitedHlthcare	38
Duluth, MN-WI	3326	UnitedHlthcare	52	Cigna	18
Minneapolis-St. Paul-Bloomington, MN-WI	3246	Cigna	40	UnitedHlthcare	37
St. Cloud, MN	3346	Cigna	46	UnitedHlthcare	27
Mississippi	5137	UnitedHlthcare	58	Cigna	42
Gulfport-Biloxi, MS	5001	Cigna	51	UnitedHlthcare	49
Hattiesburg, MS	8023	UnitedHlthcare	89	Cigna	11
Jackson, MS	5206	UnitedHlthcare	60	Cigna	40
Pascagoula, MS	5557	UnitedHlthcare	67	Cigna	33
Missouri	3470	UnitedHlthcare	52	Cigna	19
Columbia, MO	4057	UnitedHlthcare	55	WellPoint	29
Jefferson City, MO	4457	UnitedHlthcare	60	WellPoint	27
Joplin, MO	4167	UnitedHlthcare	57	WellPoint	27
Kansas City, MO-KS	4034	UnitedHlthcare	54	Cigna	33
Springfield, MO	3330	UnitedHlthcare	49	Sisters of Mercy	21
St. Joseph, MO-KS	3620	UnitedHlthcare	48	WellPoint	27
St. Louis, MO-IL	3829	UnitedHlthcare	58	Cigna	14
Montana	2535	New West	29	UnitedHlthcare	27
Billings, MT	3172	UnitedHlthcare	47	Cigna	22
Nebraska	5001	UnitedHlthcare	66	Coventry	22
Lincoln, NE	4435	UnitedHlthcare	58	Coventry	30
Omaha-Council Bluffs, NE-IA	5439	UnitedHlthcare	71	Coventry	17
Nevada	4840	UnitedHlthcare	57	Cigna	40
Las Vegas-Paradise, NV	5024	UnitedHlthcare	58	Cigna	40
Reno-Sparks, NV	4233	UnitedHlthcare	57	Cigna	30

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
New Hampshire	4375	Cigna	58	WellPoint	29
Manchester, NH	4256	Cigna	57	WellPoint	27
Nashua, NH-MA	3955	Cigna	54	WellPoint	27
Portsmouth, NH-ME	3836	Cigna	48	WellPoint	35
Rochester-Dover, NH	4395	Cigna	53	WellPoint	39
New Jersey	3681	UnitedHlthcare	47	Cigna	35
Atlantic City, NJ	3637	Cigna	53	Horizon BCBS	24
Camden, NJ	2652	UnitedHlthcare	30	Cigna	30
Edison, NJ	3739	UnitedHlthcare	46	Cigna	37
Newark-Union, NJ-PA	3963	UnitedHlthcare	46	Cigna	41
Ocean City, NJ	3052	Horizon BCBS	43	Independence BC	27
Trenton-Ewing, NJ	3506	UnitedHlthcare	45	Cigna	36
Vineland-Millville-Bridgeton, NJ	2834	Horizon BCBS	41	Cigna	22
New Mexico	5329	UnitedHlthcare	64	Cigna	36
Albuquerque, NM	5065	UnitedHlthcare	58	Cigna	41
Farmington, NM	5344	Cigna	63	UnitedHlthcare	37
Las Cruces, NM	5498	UnitedHlthcare	66	Cigna	34
Santa Fe, NM	7272	UnitedHlthcare	84	Cigna	16
New York	4292	UnitedHlthcare	62	Cigna	17
Albany-Schenectady-Troy, NY	3701	UnitedHlthcare	49	WellPoint	29
Buffalo-Cheektowaga-Tonawanda, NY	3627	Independent Hlth	53	HealthNow NY (BCBS)	26
Glens Falls, NY	3463	UnitedHlthcare	41	Cigna	33
Kingston, NY	4251	UnitedHlthcare	58	Cigna	23
New York-White Plains-Wayne, NY-NJ	4886	UnitedHlthcare	65	Cigna	24
Poughkeepsie-Newburgh-Middletown, NY	4682	UnitedHlthcare	63	Cigna	20
Rochester, NY	6195	Lifetime Hlthcare	77	UnitedHlthcare	16
Suffolk County-Nassau County, NY	5395	UnitedHlthcare	70	Cigna	21
Syracuse, NY	5788	UnitedHlthcare	70	Cigna	29
Utica-Rome, NY	6918	UnitedHlthcare	81	Cigna	19
North Carolina	4465	UnitedHlthcare	49	Cigna	45
Asheville, NC	4654	Cigna	49	UnitedHlthcare	47
Burlington, NC	5004	UnitedHlthcare	66	Cigna	21
Charlotte-Gastonia-Concord, NC-SC	4155	UnitedHlthcare	47	Cigna	44
Durham, NC	4271	Cigna	47	UnitedHlthcare	44
Goldsboro, NC	4841	Cigna	57	UnitedHlthcare	40
Greensboro-High Point, NC	6104	UnitedHlthcare	74	Cigna	23
Greenville, NC	5928	Cigna	73	UnitedHlthcare	24
Hickory-Morganton-Lenoir, NC	4340	Cigna	49	UnitedHlthcare	43
Raleigh-Cary, NC	4434	Cigna	48	UnitedHlthcare	46
Rocky Mount, NC	6350	Cigna	77	UnitedHlthcare	22
Wilmington, NC	5667	UnitedHlthcare	68	Cigna	32
Winston-Salem, NC	4761	UnitedHlthcare	50	Cigna	47

Table 4. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
POS product markets

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
North Dakota	6776	BCBS ND	81	UnitedHlthcare	12
Bismarck, ND	6219	BCBS ND	77	UnitedHlthcare	18
Fargo, ND-MN	4614	BCBS ND	63	UnitedHlthcare	22
Grand Forks, ND-MN	6127	BCBS ND	77	UnitedHlthcare	12
Ohio	5078	UnitedHlthcare	69	Cigna	16
Akron, OH	3160	UnitedHlthcare	47	Cigna	21
Canton-Massillon, OH	5567	UnitedHlthcare	71	Cigna	21
Cincinnati-Middletown, OH-KY-IN	4981	UnitedHlthcare	67	Humana	17
Cleveland-Elyria-Mentor, OH	4480	UnitedHlthcare	62	Cigna	22
Columbus, OH	7034	UnitedHlthcare	82	Cigna	16
Dayton, OH	5878	UnitedHlthcare	75	Humana	12
Mansfield, OH	4564	UnitedHlthcare	58	Cigna	35
Springfield, OH	5380	UnitedHlthcare	70	Humana	21
Toledo, OH	3269	Medical Mutual	40	UnitedHlthcare	35
Youngstown-Warren-Boardman, OH-PA	4574	UnitedHlthcare	62	Cigna	25
Oklahoma	6233	UnitedHlthcare	75	Cigna	25
Oklahoma City, OK	6347	UnitedHlthcare	76	Cigna	24
Tulsa, OK	6444	UnitedHlthcare	77	Cigna	23
Oregon	4942	UnitedHlthcare	58	Cigna	39
Corvallis, OR	8054	UnitedHlthcare	89	Cigna	10
Eugene-Springfield, OR	5841	UnitedHlthcare	72	Cigna	27
Portland-Vancouver-Beaverton, OR-WA	4903	UnitedHlthcare	57	Cigna	41
Salem, OR	5425	UnitedHlthcare	67	Cigna	30
Pennsylvania	2876	UnitedHlthcare	36	Independence BC	30
Allentown-Bethlehem-Easton, PA-NJ	3051	UnitedHlthcare	40	Independence BC	29
Erie, PA	3755	UnitedHlthcare	52	Coventry	26
Harrisburg-Carlisle, PA	3907	Cigna	45	UnitedHlthcare	42
Lancaster, PA	2790	Independence BC	36	Coventry	31
Philadelphia, PA	3637	Independence BC	47	UnitedHlthcare	29
Pittsburgh, PA	3872	UnitedHlthcare	47	Cigna	40
Reading, PA	3825	Independence BC	53	UnitedHlthcare	26
Scranton--Wilkes-Barre, PA	2927	UnitedHlthcare	33	Cigna	33
York-Hanover, PA	4514	UnitedHlthcare	56	Cigna	37
Rhode Island	6583	UnitedHlthcare	78	Cigna	22
Norwich-New London, CT-RI	4153	UnitedHlthcare	60	Cigna	18
Providence-Fall River-Warwick, RI-MA	5668	UnitedHlthcare	71	Cigna	23
South Carolina	3405	Cigna	41	UnitedHlthcare	40
Anderson, SC	3987	Cigna	50	UnitedHlthcare	38
Charleston-North Charleston, SC	3098	Cigna	40	UnitedHlthcare	36
Columbia, SC	2782	Cigna	35	UnitedHlthcare	33
Florence, SC	2927	UnitedHlthcare	38	Cigna	31
Greenville, SC	4192	Cigna	47	UnitedHlthcare	44
Myrtle Beach-Conway-North Myrtle Beach, SC	3334	UnitedHlthcare	46	Cigna	31

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Spartanburg, SC	3682	Cigna	43	UnitedHlthcare	41
Sumter, SC	2749	UnitedHlthcare	33	Cigna	33
South Dakota	5050	Cigna	56	UnitedHlthcare	44
Sioux Falls, SD	5599	Cigna	67	UnitedHlthcare	33
Tennessee	5465	Cigna	65	UnitedHlthcare	34
Chattanooga, TN-GA	4588	UnitedHlthcare	51	Cigna	44
Clarksville, TN-KY	4362	Cigna	56	UnitedHlthcare	35
Cleveland, TN	5226	Cigna	61	UnitedHlthcare	39
Jackson, TN	7005	Cigna	82	UnitedHlthcare	18
Johnson City, TN	5093	Cigna	58	UnitedHlthcare	41
Kingsport-Bristol, TN-VA	6936	Cigna	82	UnitedHlthcare	17
Knoxville, TN	5178	Cigna	60	UnitedHlthcare	40
Memphis, TN-MS-AR	5497	Cigna	66	UnitedHlthcare	33
Morristown, TN	5543	Cigna	67	UnitedHlthcare	33
Nashville-Davidson--Murfreesboro, TN	5297	Cigna	62	UnitedHlthcare	38
Texas	4138	UnitedHlthcare	58	Cigna	24
Abilene, TX	4469	HCSC (BCBS)	59	UnitedHlthcare	28
Amarillo, TX	4719	UnitedHlthcare	62	HCSC (BCBS)	28
Austin-Round Rock, TX	3601	UnitedHlthcare	52	HCSC (BCBS)	24
Beaumont-Port Arthur, TX	3618	UnitedHlthcare	40	Cigna	40
Brownsville-Harlingen, TX	4015	UnitedHlthcare	53	HCSC (BCBS)	30
College Station-Bryan, TX	3768	UnitedHlthcare	45	Cigna	38
Corpus Christi, TX	5398	UnitedHlthcare	70	HCSC (BCBS)	18
Dallas-Plano-Irving, TX	5146	UnitedHlthcare	66	Cigna	29
El Paso, TX	3584	Cigna	43	UnitedHlthcare	37
Fort Worth-Arlington, TX	5287	UnitedHlthcare	67	Cigna	27
Houston-Sugar Land-Baytown, TX	4247	UnitedHlthcare	58	Cigna	28
Killeen-Temple-Fort Hood, TX	4976	UnitedHlthcare	66	Cigna	19
Laredo, TX	3379	UnitedHlthcare	46	HCSC (BCBS)	28
Longview, TX	4677	UnitedHlthcare	62	Cigna	28
Lubbock, TX	4544	HCSC (BCBS)	60	UnitedHlthcare	29
McAllen-Edinburg-Mission, TX	4470	UnitedHlthcare	60	HCSC (BCBS)	27
Midland, TX	4187	UnitedHlthcare	57	Cigna	27
Odessa, TX	3663	UnitedHlthcare	48	Cigna	28
San Angelo, TX	4165	HCSC (BCBS)	52	UnitedHlthcare	36
San Antonio, TX	4381	UnitedHlthcare	62	Humana	18
Sherman-Denison, TX	4541	UnitedHlthcare	59	Cigna	31
Texarkana, TX-AR	2592	UnitedHlthcare	40	HCSC (BCBS)	23
Tyler, TX	4068	UnitedHlthcare	55	HCSC (BCBS)	26
Victoria, TX	3568	UnitedHlthcare	45	Cigna	32
Waco, TX	4247	UnitedHlthcare	57	Cigna	26
Wichita Falls, TX	4495	HCSC (BCBS)	59	UnitedHlthcare	31

Table 4. (continued) **Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2010**
POS product markets

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Utah	4144	UnitedHlthcare	56	Coventry	26
Logan, UT-ID	6077	UnitedHlthcare	76	Coventry	17
Ogden-Clearfield, UT	3966	UnitedHlthcare	53	Coventry	29
Provo-Orem, UT	4642	UnitedHlthcare	63	Coventry	20
Salt Lake City, UT	4231	UnitedHlthcare	58	Coventry	22
St. George, UT	5049	Coventry	65	UnitedHlthcare	29
Vermont	5213	Cigna	65	BCBS VT	31
Burlington-South Burlington, VT	4995	Cigna	62	BCBS VT	34
Virginia	2709	Cigna	39	UnitedHlthcare	30
Blacksburg-Christiansburg-Radford, VA	3752	UnitedHlthcare	44	Cigna	41
Charlottesville, VA	5273	Coventry	71	Cigna	12
Harrisonburg, VA	3906	Coventry	55	Cigna	21
Lynchburg, VA	2772	Cigna	33	Piedmont (Centra)	33
Richmond, VA	4070	Cigna	55	UnitedHlthcare	30
Roanoke, VA	4131	UnitedHlthcare	50	Cigna	40
Virginia Beach-Norfolk-Newport News, VA-NC	3165	Cigna	41	UnitedHlthcare	28
Winchester, VA-WV	4770	Cigna	61	UnitedHlthcare	32
Washington	2729	UnitedHlthcare	38	Group Hlth Cooperative	23
Bellingham, WA	2767	Group Hlth Cooperative	35	UnitedHlthcare	30
Bremerton-Silverdale, WA	3183	UnitedHlthcare	44	Group Hlth Cooperative	29
Kennewick-Richland-Pasco, WA	3553	Group Hlth Cooperative	42	UnitedHlthcare	36
Mount Vernon-Anacortes, WA	2724	Group Hlth Cooperative	33	Regence	27
Olympia, WA	2905	Group Hlth Cooperative	37	UnitedHlthcare	32
Seattle-Bellevue-Everett, WA	2697	UnitedHlthcare	37	Regence	24
Spokane, WA	3981	UnitedHlthcare	53	Group Hlth Cooperative	28
Tacoma, WA	2600	UnitedHlthcare	30	Group Hlth Cooperative	29
Yakima, WA	3014	Group Hlth Cooperative	44	UnitedHlthcare	23
West Virginia	3868	Cigna	46	UnitedHlthcare	39
Charleston, WV	4039	Cigna	52	UnitedHlthcare	35
Huntington-Ashland, WV-KY-OH	4711	UnitedHlthcare	65	Cigna	19
Parkersburg-Marietta-Vienna, WV-OH	5681	Cigna	73	UnitedHlthcare	19
Wisconsin	5648	UnitedHlthcare	74	Cigna	9
Appleton, WI	5957	UnitedHlthcare	76	WPS Hlth Ins	7
Eau Claire, WI	2901	UnitedHlthcare	40	WellPoint	29
Fond du Lac, WI	4000	UnitedHlthcare	61	WPS Hlth Ins	9
Green Bay, WI	6055	UnitedHlthcare	77	Cigna	6
Janesville, WI	2497	Cigna	36	UnitedHlthcare	28
La Crosse, WI-MN	2608	UnitedHlthcare	40	Hlth Tradition HP	18
Madison, WI	2351	Cigna	29	Phys Plus Ins Corp	27
Milwaukee-Waukesha-West Allis, WI	7225	UnitedHlthcare	84	WellPoint	7
Oshkosh-Neenah, WI	5511	UnitedHlthcare	73	WPS Hlth Ins	10

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Racine, WI	8352	UnitedHlthcare	91	Cigna	5
Sheboygan, WI	6424	UnitedHlthcare	80	WPS Hlth Ins	6
Wausau, WI	5479	UnitedHlthcare	71	Cigna	15
Wyoming	3623	Cigna	46	UnitedHlthcare	32

Notes:

1. Data source: Managed Market Surveyor, © 2010 HealthLeaders-InterStudy (HLIS). All rights reserved. Managed Market Surveyor data may not be reproduced, distributed, displayed or modified, in whole or in part, by any means, without the prior written consent of HLIS.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the POS product market are reported.
3. These data are based on enrollments in both fully and self-insured health plans.
4. We do not present data for geographic areas with fewer than 5,000 reported POS enrollees.
5. Due to a recategorization of product types by HLIS and UnitedHealthcare (United), there was a very large shift in United's reported enrollment from PPO to POS between Jan. 1, 2009 (used for 2011 edition) and Jan. 1, 2010 (used for this edition). In 2009, United had about 70 percent of its reported commercial enrollment in PPO, but in 2010, about 70 percent was in POS. Consequently, whereas previously United was among the largest PPO insurers in many geographic areas, in this study, it is among the largest insurers in many POS markets. We found it necessary to validate United's enrollment reported to HLIS, and had it verified by both HLIS and United staff.

Table 5. State and MSA HHI by product type, as of Jan. 1, 2010

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Alabama	7712	9270	9096	5900
Anniston-Oxford, AL	8085	-------	9197	-------
Auburn-Opelika, AL	7991	-------	9386	-------
Birmingham-Hoover, AL	7292	9373	9120	6403
Decatur, AL	8561	-------	9429	-------
Dothan, AL	8326	-------	9424	-------
Florence, AL	8279	-------	9062	-------
Gadsden, AL	8848	-------	9499	-------
Huntsville, AL	7819	-------	9044	5173
Mobile, AL	7070	9623	8846	5888
Montgomery, AL	8029	9901	9378	6157
Tuscaloosa, AL	8333	-------	9420	-------
Alaska	4413	-------	4701	5003
Anchorage, AK	3997	-------	4313	-------
Fairbanks, AK	5965	-------	6126	-------
Arizona	2224	2552	3957	5050
Flagstaff, AZ	3203	-------	4314	5591
Phoenix-Mesa-Scottsdale, AZ	2270	3136	4072	4932
Prescott, AZ	3345	-------	5414	5426
Tucson, AZ	2564	2383	3087	6241
Yuma, AZ	4797	-------	6972	3775
Arkansas	2428	7507	4010	2960
Fayetteville-Springdale-Rogers, AR-MO	1836	-------	2750	3021
Fort Smith, AR-OK	1943	-------	2501	3479
Hot Springs, AR	2553	-------	3759	3078
Jonesboro, AR	3499	-------	5861	2780
Little Rock-North Little Rock, AR	2474	6948	3554	3891
Pine Bluff, AR	3026	-------	5425	2787
California	2051	3498	3956	3493
Bakersfield, CA	2905	3650	5629	3937
Chico, CA	3919	4980	4519	5216
El Centro, CA	4449	3587	5643	-------
Fresno, CA	2686	3154	3646	3284
Hanford-Corcoran, CA	4446	3348	6119	-------
Los Angeles-Long Beach-Glendale, CA	2142	3499	4482	2999
Madera, CA	3211	3276	5157	-------
Merced, CA	3960	2753	5501	4004
Modesto, CA	2406	4492	4227	4036
Napa, CA	3458	7068	6074	-------
Oakland-Fremont-Hayward, CA	2738	5616	3686	4304
Oxnard-Thousand Oaks-Ventura, CA	2311	2557	3942	3619
Redding, CA	4426	8161	4771	-------
Riverside-San Bernardino-Ontario, CA	2079	3480	4460	3001
Sacramento-Arden-Arcade-Roseville, CA	2346	3993	4059	4384
Salinas, CA	4964	9170	3831	4369

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
San Diego-Carlsbad-San Marcos, CA	1649	2587	3229	3814
San Francisco-San Mateo-Redwood City, CA	2021	4163	3217	4279
San Jose-Sunnyvale-Santa Clara, CA	2061	5149	3426	4174
San Luis Obispo-Paso Robles, CA	4534	4499	5927	4777
Santa Ana-Anaheim-Irvine, CA	1936	2455	4125	3520
Santa Barbara-Santa Maria, CA	2838	2186	4632	3250
Santa Cruz-Watsonville, CA	2857	2147	5326	3762
Santa Rosa-Petaluma, CA	3306	6352	3728	4798
Stockton, CA	2515	4651	4200	4157
Vallejo-Fairfield, CA	3402	5282	4968	3741
Visalia-Porterville, CA	3993	2907	5444	3245
Yuba City-Marysville, CA	5321	3909	7009	3822
Colorado	1809	5012	3100	4790
Boulder, CO	1961	5323	3462	5000
Colorado Springs, CO	1750	4874	2961	4680
Denver-Aurora, CO	1882	5508	3097	4870
Fort Collins-Loveland, CO	2323	2629	3729	4824
Grand Junction, CO	2017	-------	2961	4297
Greeley, CO	2116	4159	3354	4583
Pueblo, CO	2134	4255	3551	4861
Connecticut	2560	2490	4623	3337
Bridgeport-Stamford-Norwalk, CT	2531	2539	4035	3679
Danbury, CT	2479	2499	4001	3584
Hartford-West Hartford-East Hartford, CT	2514	3075	4849	3203
New Haven-Milford, CT	3139	2969	5415	3140
Waterbury, CT	3169	2951	5443	3085
Delaware	4818	3793	6379	3264
Dover, DE	5836	3964	7837	3069
Wilmington, DE-MD-NJ	3642	3345	5034	2761
District of Columbia	5305	4046	6317	6210
Washington-Arlington-Alexandria, DC-VA-MD-WV	1966	2472	2669	3420
Florida	2054	1867	4242	4960
Cape Coral-Fort Myers, FL	2557	4605	3992	5804
Deltona-Daytona Beach-Ormond Beach, FL	2763	3470	4150	4042
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1604	2001	3544	4643
Fort Walton Beach-Crestview-Destin, FL	3881	-------	5080	6435
Gainesville, FL	4205	3974	7365	5937
Jacksonville, FL	2303	3700	4124	5267
Lakeland-Winter Haven, FL	2186	3208	3770	4949
Miami-Miami Beach-Kendall, FL	1629	2069	3475	4886
Naples-Marco Island, FL	2968	-------	4571	5350
Ocala, FL	3553	2461	6412	5652
Orlando-Kissimmee, FL	2387	3604	3733	4910
Palm Bay-Melbourne-Titusville, FL	2030	3287	2674	5166
Panama City-Lynn Haven, FL	5020	-------	6391	5328

Table 5. State and MSA HHI by product type, as of Jan. 1, 2010
(continued)

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Pensacola-Ferry Pass-Brent, FL	3400	3761	5726	7295
Port St. Lucie-Fort Pierce, FL	3094	3165	5578	4968
Punta Gorda, FL	2365	5909	3489	5010
Sarasota-Bradenton-Venice, FL	2429	4270	3961	5221
Tallahassee, FL	6956	8301	7074	5565
Tampa-St. Petersburg-Clearwater, FL	2199	3294	3001	5641
Vero Beach, FL	4087	-------	6733	5037
West Palm Beach-Boca Raton-Boynton Beach, FL	2046	2586	4006	4691
Georgia	2200	2277	4486	4323
Albany, GA	3447	-------	5085	5805
Athens-Clarke County, GA	2920	3535	7083	5416
Atlanta-Sandy Springs-Marietta, GA	2011	2486	4529	4089
Augusta-Richmond County, GA-SC	2239	5885	2911	5123
Brunswick, GA	3526	-------	5377	6150
Columbus, GA-AL	2892	6118	4147	4605
Dalton, GA	3787	5251	7753	7675
Gainesville, GA	2168	2603	3773	4221
Hinesville-Fort Stewart, GA	3864	-------	5441	4493
Macon, GA	2546	2612	4906	4138
Rome, GA	2410	3090	4673	4292
Savannah, GA	2439	4017	3868	3929
Valdosta, GA	3809	-------	6074	6075
Warner Robins, GA	3874	5681	5669	5122
Hawaii	5298	5001	7202	-------
Honolulu, HI	5491	5027	7304	-------
Idaho	2763	6539	4187	3421
Boise City-Nampa, ID	3402	-------	4301	4114
Coeur d'Alene, ID	3633	9946	3480	7450
Idaho Falls, ID	2843	-------	3442	3728
Lewiston, ID-WA	2905	-------	3041	-------
Pocatello, ID	3713	-------	4428	-------
Illinois	3385	4338	4716	4773
Bloomington-Normal, IL	2973	8883	4245	4991
Champaign-Urbana, IL	3212	6831	2505	5045
Chicago-Naperville-Joliet, IL	4218	6512	5453	5050
Danville, IL	2343	6779	2882	-------
Davenport-Moline-Rock Island, IA-IL	2735	6566	2419	6275
Decatur, IL	3597	-------	4832	-------
Kankakee-Bradley, IL	2734	2357	4971	5055
Lake County-Kenosha County, IL-WI	2770	4433	4230	5550
Peoria, IL	2823	2896	3404	4517
Rockford, IL	3723	4404	5215	4725
Springfield, IL	2471	3992	3954	5148

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Indiana	3438	2685	6017	3715
Anderson, IN	4840	-------	7193	4812
Bloomington, IN	3898	-------	5567	4835
Columbus, IN	4158	-------	7232	4294
Elkhart-Goshen, IN	4142	5482	5702	-------
Evansville, IN-KY	2636	6140	4966	3340
Fort Wayne, IN	3262	5974	5064	4928
Gary, IN	2997	2894	5356	5358
Indianapolis, IN	3776	5130	6822	4137
Kokomo, IN	3630	5406	7702	5007
Lafayette, IN	2570	4050	4787	5268
Michigan City-La Porte, IN	4003	-------	6664	4685
Muncie, IN	4414	4012	7375	-------
South Bend-Mishawaka, IN-MI	2436	2749	3486	4804
Terre Haute, IN	5580	-------	7067	4572
Iowa	3302	3125	5978	4789
Ames, IA	3359	4606	4667	5101
Cedar Rapids, IA	3671	3382	6958	3520
Davenport-Moline-Rock Island, IA-IL	2735	6566	2419	6275
Des Moines, IA	3083	3358	6212	5789
Dubuque, IA	4305	5479	7801	6280
Iowa City, IA	5862	5614	7909	3563
Sioux City, IA-NE-SD	2839	4375	3892	5992
Waterloo-Cedar Falls, IA	4205	6502	7426	5943
Kansas	2362	3137	3888	3454
Lawrence, KS	4034	-------	6549	3502
Topeka, KS	5047	-------	7014	4614
Wichita, KS	3033	8402	4654	3818
Kentucky	3139	5132	3935	4145
Bowling Green, KY	3823	-------	6309	3679
Elizabethtown, KY	3562	-------	4246	3349
Lexington-Fayette, KY	2899	3879	3464	3825
Louisville, KY-IN	2766	3916	4126	3767
Owensboro, KY	4911	-------	7450	4603
Louisiana	2954	4482	4796	4956
Alexandria, LA	2640	-------	4132	5799
Baton Rouge, LA	2043	5777	3059	4801
Houma-Bayou Cane-Thibodaux, LA	3250	-------	5391	5999
Lafayette, LA	3474	-------	5573	5548
Lake Charles, LA	2194	-------	3162	5624
Monroe, LA	2449	-------	3348	6829
New Orleans-Metairie-Kenner, LA	2115	6425	2848	4787
Shreveport-Bossier City, LA	2042	3609	3543	3602

Table 5. State and MSA HHI by product type, as of Jan. 1, 2010
(continued)

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Maine	3462	4335	3588	4503
Bangor, ME	3827	6057	4133	4541
Lewiston-Auburn, ME	3793	4536	4145	4659
Portland-South Portland, ME	3578	3508	3719	4933
Maryland	3087	2552	4738	3599
Baltimore-Towson, MD	3798	2562	5992	3532
Bethesda-Gaithersburg-Frederick, MD	2529	2820	3424	3663
Cumberland, MD-WV	2796	-------	2782	4999
Hagerstown-Martinsburg, MD-WV	1975	3062	2564	3872
Salisbury, MD	3075	3134	5100	3996
Massachusetts	2930	2999	3465	3381
Barnstable Town, MA	3240	3647	3372	3591
Boston-Cambridge-Quincy, MA	2872	3501	2848	3282
Brockton-Bridgewater-Easton, MA	3199	3609	3382	3420
Framingham, MA	3081	3360	3565	3412
Haverhill-North Andover-Amesbury, MA-NH	2060	2679	2262	2992
Lawrence-Methuen-Salem, MA-NH	2463	3090	2638	2909
Leominster-Fitchburg-Gardner, MA	2775	2898	3616	3486
Lowell-Billerica-Chelmsford, MA-NH	2761	3406	2860	3146
Lynn-Peabody-Salem, MA	3474	3824	3883	3388
New Bedford, MA	3292	3835	3438	3388
Pittsfield, MA	4683	5698	4958	-------
Springfield, MA	2447	2966	2827	3079
Taunton-Norton-Raynham, MA	3288	3821	3435	3386
Worcester, MA-CT	2339	2752	2726	3246
Michigan	4900	3108	7227	2401
Ann Arbor, MI	5481	3902	7248	3981
Battle Creek, MI	6153	8663	7920	5103
Bay City, MI	6057	4908	7806	-------
Detroit-Livonia-Dearborn, MI	3656	4235	5450	3275
Flint, MI	5275	4160	7437	2352
Grand Rapids-Wyoming, MI	3794	6962	5969	3613
Holland-Grand Haven, MI	3758	7538	5198	4652
Jackson, MI	5473	4963	6876	3883
Kalamazoo-Portage, MI	4969	7468	7174	5400
Lansing-East Lansing, MI	4651	4726	7253	6816
Monroe, MI	4943	3625	7055	3004
Muskegon-Norton Shores, MI	4256	5481	6923	4645
Niles-Benton Harbor, MI	6725	-------	7422	-------
Saginaw-Saginaw Township North, MI	5903	4726	7978	3373
Warren-Farmington Hills-Troy, MI	5201	4071	7182	3517

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Minnesota	3241	2793	3630	3540
Duluth, MN-WI	2739	2389	3264	3326
Minneapolis-St. Paul-Bloomington, MN-WI	2883	2724	3349	3246
St. Cloud, MN	3513	3499	3788	3346
Mississippi	3025	-------	5077	5137
Gulfport-Biloxi, MS	2727	-------	4169	5001
Hattiesburg, MS	3543	-------	5886	8023
Jackson, MS	3053	-------	4873	5206
Pascagoula, MS	3422	-------	5868	5557
Missouri	1649	2383	2128	3470
Columbia, MO	2399	-------	3724	4057
Jefferson City, MO	2312	-------	2611	4457
Joplin, MO	1887	-------	1926	4167
Kansas City, MO-KS	1854	5035	2566	4034
Springfield, MO	1842	7112	1638	3330
St. Joseph, MO-KS	4188	7087	5371	3620
St. Louis, MO-IL	2095	3313	3170	3829
Montana	3042	5262	3988	2535
Billings, MT	2596	-------	3292	3172
Missoula, MT	3401	6864	4791	-------
Nebraska	3634	6950	5944	5001
Lincoln, NE	4037	-------	6837	4435
Omaha-Council Bluffs, NE-IA	2529	5477	4318	5439
Nevada	2613	6465	1989	4840
Carson City, NV	2290	-------	2972	-------
Las Vegas-Paradise, NV	3412	8757	1919	5024
Reno-Sparks, NV	1861	2968	2768	4233
New Hampshire	3352	5396	3744	4375
Manchester, NH	3027	4871	3889	4256
Nashua, NH-MA	2666	4035	3253	3955
Portsmouth, NH-ME	3299	5254	3593	3836
Rochester-Dover, NH	3870	6122	3725	4395
New Jersey	2440	3629	3388	3681
Atlantic City, NJ	4387	3231	7549	3637
Camden, NJ	3221	5142	4282	2652
Edison, NJ	2599	3556	3677	3739
Newark-Union, NJ-PA	2526	3896	3532	3963
Ocean City, NJ	4039	4032	5587	3052
Trenton-Ewing, NJ	2960	5503	3762	3506
Vineland-Millville-Bridgeton, NJ	3447	4591	5857	2834
New Mexico	2392	4639	3962	5329
Albuquerque, NM	2212	4598	2646	5065
Farmington, NM	2043	4835	2400	5344

Table 5. State and MSA HHI by product type, as of Jan. 1, 2010
(continued)

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Las Cruces, NM	3635	4292	6808	5498
Santa Fe, NM	2949	5602	5497	7272
New York	1886	1342	2397	4292
Albany-Schenectady-Troy, NY	2028	4928	2078	3701
Binghamton, NY	2819	5231	2708	-------
Buffalo-Cheektowaga-Tonawanda, NY	3036	6264	3377	3627
Elmira, NY	3558	9816	3135	-------
Glens Falls, NY	2200	4624	2955	3463
Ithaca, NY	2672	-------	3037	-------
Kingston, NY	2148	5416	2581	4251
New York-White Plains-Wayne, NY-NJ	2151	2500	2679	4886
Poughkeepsie-Newburgh-Middletown, NY	2177	3005	2558	4682
Rochester, NY	3304	5556	2681	6195
Suffolk County-Nassau County, NY	2882	3336	3328	5395
Syracuse, NY	2725	5376	2839	5788
Utica-Rome, NY	2118	4864	2393	6918
North Carolina	3054	2105	5949	4465
Asheville, NC	3284	-------	6584	4654
Burlington, NC	3151	-------	6250	5004
Charlotte-Gastonia-Concord, NC-SC	2158	3333	3797	4155
Durham, NC	2941	7129	6723	4271
Goldsboro, NC	5816	-------	8427	4841
Greensboro-High Point, NC	3245	2931	6178	6104
Greenville, NC	5906	-------	8198	5928
Hickory-Morganton-Lenoir, NC	4530	7028	7897	4340
Raleigh-Cary, NC	3309	2446	6693	4434
Rocky Mount, NC	4907	-------	8308	6350
Wilmington, NC	3349	-------	6580	5667
Winston-Salem, NC	2925	5039	5429	4761
North Dakota	4271	6211	4438	6776
Bismarck, ND	5058	-------	6478	6219
Fargo, ND-MN	2355	-------	2617	4614
Grand Forks, ND-MN	2557	-------	2699	6127
Ohio	1812	1699	2876	5078
Akron, OH	1911	3232	2714	3160
Canton-Massillon, OH	1662	5407	2746	5567
Cincinnati-Middletown, OH-KY-IN	2584	5249	4339	4981
Cleveland-Elyria-Mentor, OH	2316	4060	3683	4480
Columbus, OH	2221	6383	3239	7034
Dayton, OH	2437	5588	4201	5878
Lima, OH	1802	-------	2593	-------
Mansfield, OH	2514	-------	3679	4564
Sandusky, OH	2546	-------	3653	-------

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Springfield, OH	2012	6389	2628	5380
Toledo, OH	2457	3351	3171	3269
Weirton-Steubenville, WV-OH	1640	5199	2210	-------
Youngstown-Warren-Boardman, OH-PA	1848	2294	2535	4574
Oklahoma	2803	3703	4728	6233
Oklahoma City, OK	3215	3163	5103	6347
Tulsa, OK	2419	5876	4701	6444
Oregon	1201	5182	1868	4942
Bend, OR	1478	8632	1936	-------
Corvallis, OR	1712	-------	2459	8054
Eugene-Springfield, OR	2541	8864	3445	5841
Medford, OR	1508	-------	1817	-------
Portland-Vancouver-Beaverton, OR-WA	1517	5686	2151	4903
Salem, OR	1590	6424	2284	5425
Pennsylvania	1709	2264	2195	2876
Allentown-Bethlehem-Easton, PA-NJ	1629	3348	2697	3051
Altoona, PA	5407	5368	6339	-------
Erie, PA	4794	5377	5535	3755
Harrisburg-Carlisle, PA	2673	3163	3325	3907
Johnstown, PA	5943	5129	6933	-------
Lancaster, PA	2008	4196	3102	2790
Lebanon, PA	2834	3385	3357	-------
Philadelphia, PA	4538	4941	5591	3637
Pittsburgh, PA	3545	3970	5377	3872
Reading, PA	2138	3964	3415	3825
Scranton–Wilkes-Barre, PA	4097	4274	5097	2927
State College, PA	3272	3212	3690	-------
Williamsport, PA	3907	4678	4121	-------
York-Hanover, PA	2586	3119	3323	4514
Rhode Island	3998	9849	5628	6583
Norwich-New London, CT-RI	3270	3850	4825	4153
Providence-Fall River-Warwick, RI-MA	2547	2654	4099	5668
South Carolina	4031	3889	6892	3405
Anderson, SC	4292	-------	7776	3987
Charleston-North Charleston, SC	4234	-------	6887	3098
Columbia, SC	4087	4542	7374	2782
Florence, SC	4313	-------	7464	2927
Greenville, SC	3622	-------	7287	4192
Myrtle Beach-Conway-North Myrtle Beach, SC	4536	-------	6758	3334
Spartanburg, SC	4451	-------	7502	3682
Sumter, SC	5471	-------	7954	2749
South Dakota	2438	5125	5104	5050
Rapid City, SD	2645	5847	5129	-------
Sioux Falls, SD	2309	3904	5329	5599

Table 5. State and MSA HHI by product type, as of Jan. 1, 2010
(continued)

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Tennessee	2988	3742	5620	5465
Chattanooga, TN-GA	2807	2867	4971	4588
Clarksville, TN-KY	2063	6832	2954	4362
Cleveland, TN	3248	-------	6267	5226
Jackson, TN	3744	-------	6507	7005
Johnson City, TN	2800	8062	5291	5093
Kingsport-Bristol, TN-VA	2249	7261	3736	6936
Knoxville, TN	2702	6890	5362	5178
Memphis, TN-MS-AR	2492	4731	2954	5497
Morristown, TN	3300	-------	6355	5543
Nashville-Davidson--Murfreesboro, TN	3282	5462	5750	5297
Texas	2262	2032	3613	4138
Abilene, TX	3592	-------	4228	4469
Amarillo, TX	2168	9743	2982	4719
Austin-Round Rock, TX	2751	4174	4609	3601
Beaumont-Port Arthur, TX	3237	5749	4961	3618
Brownsville-Harlingen, TX	3435	-------	4688	4015
College Station-Bryan, TX	3581	5714	7176	3768
Corpus Christi, TX	3222	-------	4908	5398
Dallas-Plano-Irving, TX	2300	3084	3638	5146
El Paso, TX	2302	8544	3102	3584
Fort Worth-Arlington, TX	2040	5828	2864	5287
Houston-Sugar Land-Baytown, TX	2157	3012	3469	4247
Killeen-Temple-Fort Hood, TX	2694	6667	4441	4976
Laredo, TX	4936	-------	6666	3379
Longview, TX	3693	-------	6134	4677
Lubbock, TX	3709	-------	4246	4544
McAllen-Edinburg-Mission, TX	3784	-------	5247	4470
Midland, TX	4034	-------	6400	4187
Odessa, TX	4537	-------	6707	3663
San Angelo, TX	5446	-------	6645	4165
San Antonio, TX	2358	2872	4205	4381
Sherman-Denison, TX	3140	-------	5479	4541
Texarkana, TX-AR	2455	-------	3444	2592
Tyler, TX	4419	-------	6269	4068
Victoria, TX	3563	-------	5031	3568
Waco, TX	2558	7200	5306	4247
Wichita Falls, TX	5700	-------	6583	4495
Utah	2330	7274	3356	4144
Logan, UT-ID	2768	8891	3124	6077
Ogden-Clearfield, UT	2365	5697	2663	3966
Provo-Orem, UT	2981	7959	2760	4642
Salt Lake City, UT	2226	7612	3466	4231
St. George, UT	2548	9303	2992	5049

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Vermont	3482	5406	2920	5213
Burlington-South Burlington, VT	3432	5428	2873	4995
Virginia	2431	1891	4578	2709
Blacksburg-Christiansburg-Radford, VA	6289	8517	7617	3752
Charlottesville, VA	2934	4525	4815	5273
Danville, VA	7302	-------	8278	-------
Harrisonburg, VA	4564	4564	7560	3906
Lynchburg, VA	4368	9154	5721	2772
Richmond, VA	3292	2467	6124	4070
Roanoke, VA	5070	7721	6646	4131
Virginia Beach-Norfolk-Newport News, VA-NC	3467	5309	5495	3165
Winchester, VA-WV	3590	4806	4930	4770
Washington	1942	5592	3158	2729
Bellingham, WA	2487	9877	3742	2767
Bremerton-Silverdale, WA	2854	9892	2563	3183
Kennewick-Richland-Pasco, WA	2329	9681	3722	3553
Longview-Kelso, WA	3345	9379	3705	-------
Mount Vernon-Anacortes, WA	2523	9645	3745	2724
Olympia, WA	2506	8400	2965	2905
Seattle-Bellevue-Everett, WA	2050	8634	3204	2697
Spokane, WA	2381	9898	4138	3981
Tacoma, WA	2177	9144	3257	2600
Wenatchee, WA	4623	-------	5378	-------
Yakima, WA	2504	9776	3956	3014
West Virginia	2362	3946	3947	3868
Charleston, WV	2505	8912	3776	4039
Huntington-Ashland, WV-KY-OH	1756	-------	2185	4711
Morgantown, WV	3206	-------	5481	-------
Parkersburg-Marietta-Vienna, WV-OH	1774	-------	2462	5681
Wheeling, WV-OH	2162	8078	2364	-------
Wisconsin	1362	1268	2255	5648
Appleton, WI	2189	3938	2592	5957
Eau Claire, WI	1811	4218	2925	2901
Fond du Lac, WI	1534	2895	2745	4000
Green Bay, WI	2616	3319	2609	6055
Janesville, WI	1410	2726	2277	2497
La Crosse, WI-MN	1176	4625	1672	2608
Madison, WI	1898	2814	1997	2351
Milwaukee-Waukesha-West Allis, WI	3042	3054	2654	7225
Oshkosh-Neenah, WI	1992	3406	2863	5511
Racine, WI	3738	4212	2699	8352
Sheboygan, WI	2452	4011	3253	6424
Wausau, WI	2485	9396	3839	5479

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI
Wyoming	3656	7504	4865	3623
Casper, WY	5513	-------	5693	-------
Cheyenne, WY	3605	9972	5946	-------

Notes:

1. Data source: Managed Market Surveyor, © 2010 HealthLeaders-InterStudy. All rights reserved. Managed Market Surveyor data may not be reproduced, distributed, displayed or modified, in whole or in part, by any means, without the prior written consent of HLI.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) are reported. The "Total HHI" pertains to the combined HMO+PPO+POS product market.
3. These data are based on enrollments in both fully and self-insured health plans.
4. We do not present data for geographic areas with fewer than 5,000 reported enrollees in a given product. This restriction only affected HMO and POS product markets.

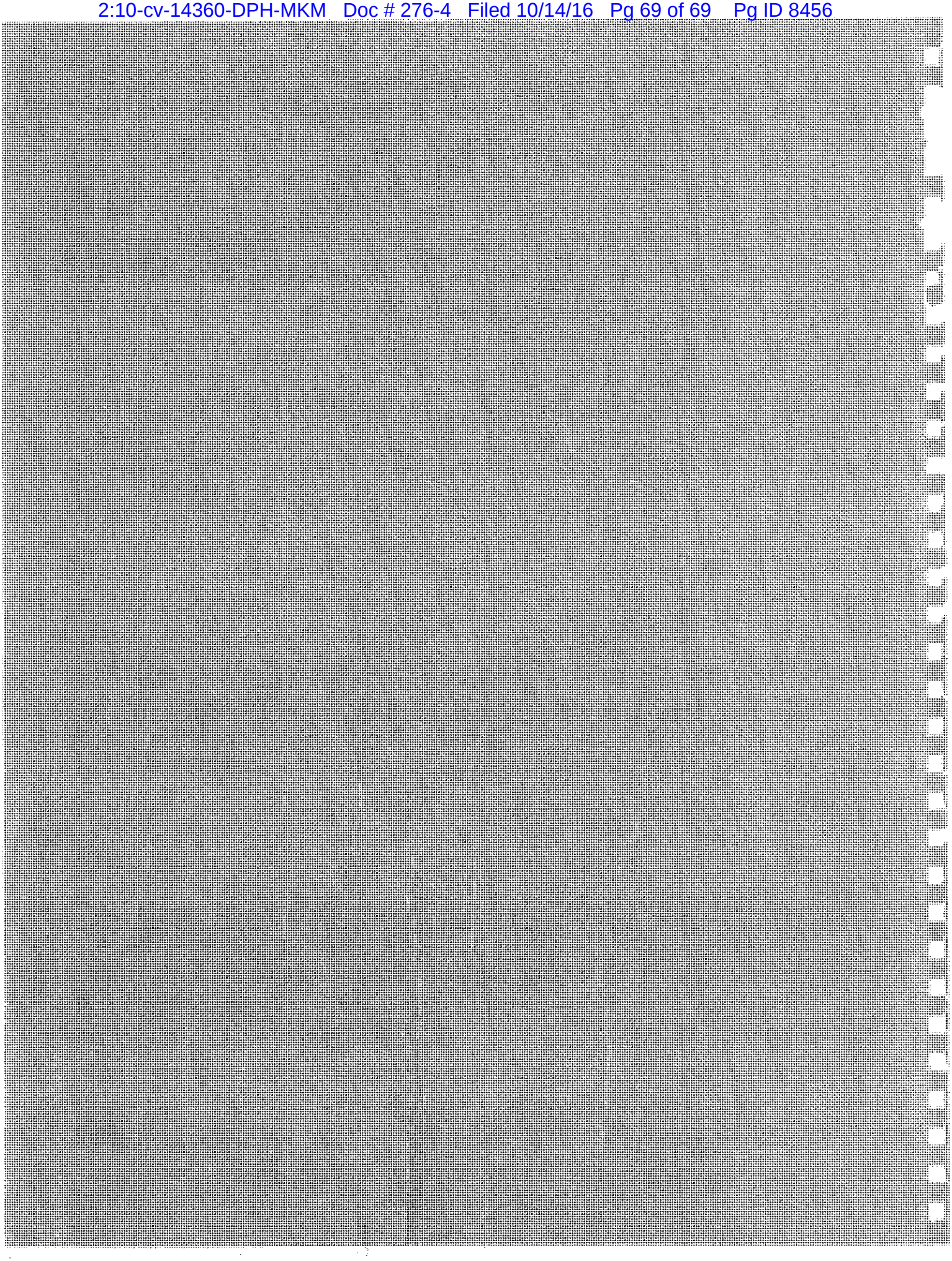

Exhibit E

From: Brown, David O. <DBrown2@bcbsm.com>
Sent: Monday, August 10, 2009 7:34 PM
To: Connolly, Jeffrey <JConnolly@bcbsm.com>
Subject: Re: Priority Health Deal with Bronson

Jeff,

Completely agree with your comments. Helen has assured me that our deal is better. Trying to get specific details regarding PH's deal. Will share once I have a better handle. I can't believe how jumpy BCBSM folks are...we are the dominant carrier and just need to keep blocking and tackling and keep our eye on the ball.

From: Connolly, Jeffrey
To: Brown, David O.
Sent: Mon Aug 10 18:31:05 2009
Subject: Fw: Priority Health Deal with Bronson
Fyi

From: Connolly, Jeffrey
To: Dunn, John; Farah, Christine; Monterusso, Kelley J.; Dallafior, Ken; Milewski, Robert
Cc: Sorget, Kim
Sent: Mon Aug 10 18:24:47 2009
Subject: Re: Priority Health Deal with Bronson
Been many emails. My take is the following.

1. This was inevitable. Other carriers have been through same scenario over the years.
2. Similar to ann arbor. Having BOTH systems causes a reduction in value in Borgess contract, just like uofm.
3. Just because they have a deal, does not mean they have a good deal. My experience is only us (BCBSM) have been able to sustain strength in all systems in markets like this.
4. That being said, we have even more reason to collaborate and create more trust and value with the community. It is a differentiator we have that others do not. Can't lose sight of this or take it for granted.
5. Another reason to put emphasis on BCN as well. The HMO is Priority's sweet spot. As such, we need to make sure we allow BCN the opportunity to compete on a level playing field.

Thanks

Jeff

From: Dunn, John
To: Farah, Christine; Connolly, Jeffrey
Cc: Sorget, Kim
Sent: Mon Aug 10 16:52:11 2009
Subject: RE: Priority Health Deal with Bronson
Jeff / Kim - will this adversely impact Priority's relation or discount with borgess?

From: Farah, Christine
Sent: Monday, August 10, 2009 4:49 PM
To: Dunn, John
Subject: Re: Priority Health Deal with Bronson

Heard back. Connolly is for staying the course and feels it will be worthwhile.

Christine M. Farah
Mobile: (248) 763-6678
-This message was sent via BackBerry device-

From: Dunn, John
To: Farah, Christine

Brown
EXHIBIT NO. 25
10-2-12 MEF

Sent: Mon Aug 10 16:38:53 2009
Subject: RE: Priority Health Deal with Bronson
ok

From: Farah, Christine
Sent: Monday, August 10, 2009 4:21 PM
To: Dunn, John
Subject: Re: Priority Health Deal with Bronson

We made the investment based on Priority's lack of network. I would agree this action should help but feel we should validate the move to ensure it is money well spent given this change. I'll ask Kelley.

Christine M. Farah
Mobile: (248) 763-6678
-This message was sent via BackBerry device-

From: Dunn, John
To: Farah, Christine
Sent: Mon Aug 10 15:46:38 2009
Subject: RE: Priority Health Deal with Bronson
We are lowering the kalamazoo rates, what else did you have in mind?

From: Farah, Christine
Sent: Monday, August 10, 2009 3:43 PM
To: Dunn, John
Subject: Fw: Priority Health Deal with Bronson

This hurts. The Kalamazoo regional play we suggested on the Parent side should be discussed with this news.

Christine M. Farah
Mobile: (248) 763-6678
-This message was sent via BackBerry device-

From: Stojic, Helen
To: Connolly, Jeffrey; Withrow, Melissa; Rossi, Lynda; Dallafior, Ken; Hubbell, Patricia; Aubuchon, Linda; Hetzel, Andy; Milewski, Robert; Sorget, Kim; Simmer, Thomas M.D.; Seitz, Kevin; Gavin, Gary; Levine, Kathryn G.; Farah, Christine
Cc: Quinn, Sophia
Sent: Mon Aug 10 15:25:29 2009
Subject: Priority Health Deal with Bronson
This story just popped up online.

Priority Health deal with Bronson fills Kalamazoo market gap

by Mark Sanchez | Business Review West Michigan
Monday August 10, 2009, 3:00 PM

Jeff Hoerle

Three years after entering the market, Priority Health has signed a participating agreement with Bronson Healthcare Group that should significantly expand its ability to draw business.

The agreement announced today, effective Sept. 1 and for Priority Health's HMO and PPO health plans, covers all of Bronson's primary care practices and specialty clinics, as well as Bronson Methodist Hospital, Bronson Vicksburg Hospital and Bronson LakeView Hospital in Paw Paw.

The deal fills a significant gap in the Grand Rapids-based Priority Health's care network in southwest Michigan. The health plan first entered the market in July 2006 when it signed a then-exclusive participating agreement with Borgess Health in Kalamazoo.

"This partnership strengthens our commitment to Southwestern Michigan," said Jeff Hoerle, executive director of the southwest Michigan market for Priority Health. "This network expansion makes Priority Health a competitive health benefits option for employers in this region."

Without a participating agreement, people in Kalamazoo covered by Priority Health wanted care at Bronson had to pay out-of-network fees that may have steered them elsewhere.

"Now, Priority Health members will be able to choose Bronson without hesitation," said Helen Hughes, director of managed care and business relations at Bronson Healthcare.

The lack of a deal with Bronson has clearly limited Priority Health's ability to pick up market share in southwest, said Roger Edgren of the Grand Rapids office of benefits consultant McGraw Wentworth.

The participating agreement with Bronson makes Priority Health a much more viable option for employers -- particularly small businesses -- in the marketplace that has been largely held by Blue Cross Blue Shield of Michigan.

Priority Health has about 14,000 members in southwest Michigan and more than 500,000 statewide. Edgren expects Priority Health to market aggressively in southwest Michigan and pursue market share, "which should create some price competitiveness and competition for Blue Cross."

Helen Stojic
Corporate Affairs Director/Spokesperson
Blue Cross Blue Shield of Michigan/Blue Care Network
313 225-8113 (office)
hstojic@bcbsm.com
cell 313 969 0698

Exhibit H

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

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

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

Detroit, Michigan

Wednesday, November 14, 2012

Confidential Video Deposition of:

DOUGLAS DARLAND,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan 48226, before Quentina R. Snowden, CSR-5519, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 10:00 a.m., when were present on behalf of the respective parties:

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Q Okay. And this arose in the context of where Mr. Loepp had met with the president of Beaumont or the CEO of Beaumont and he had told Mr. Loepp about a visit that he, the CEO of Beaumont, had had with United Healthcare; is that correct?
MR. GILMAN: Objection, form.
THE WITNESS: That's what it appears to state, yes.
BY MR. KRAMER:
Q And when you were referencing in your e-mail at the top of Exhibit 6 in the first sentence, "Clearly the only market share worth attacking by a new competitor is ours", would the new competitor be, in the context of Exhibit 6, United?
A I'm not sure. Certainly that would be one of them.
Q And when the reference is to "market share is ours", the "ours" would be Blue Cross's?
A Yes.
Q And why was it your view that, as you wrote in the first sentence in the e-mail at the top of Exhibit 6 that, "Clearly the only market share worth attacking by a new competitor" was Blue Cross's?
A Well, it was just personal opinion and speculation. We're the biggest -- you know, we had

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the biggest market share in the State.
Q And you go on to note that Beaumont had offered to consider a strategic alliance concerning some type of exclusive arrangement to shut out competing plans; do you have a recollection of that?
A I don't have a recollection of that.
Q Do you have any reason to believe that what is stated there is in any way inaccurate today?
MR. GILMAN: Objection, form, foundation.
THE WITNESS: I would say it's -- it's inaccurate in terms of the extreme that it indicates, to shut out competing plans. Yeah, I would say that that was a little bit of hyperbole.
BY MR. KRAMER:
Q And would it be more to keep competing plans at a competitive disadvantage as opposed to shut them out?
MR. GILMAN: Objection, form, foundation.
THE WITNESS: Well, I think what we're talking about here is market share.
BY MR. KRAMER:
Q What do you mean by that, please?
A By whatever means if we were able to maintain

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our market share, I mean that's a big driving force behind getting the biggest discount, the volume discount that you're aware of in any other industry.
Q And why is that?
A Why?
MR. GILMAN: Objection, form.
BY MR. KRAMER:
Q Is market share a big driving force in getting the biggest discount?
A Well, I'm not sure I can explain the economic theory very well. I --
Q Let me just interrupt you there, and I apologize. I'm not asking for any economic theory, but from your experience as head of Hospital Contracting at Blue Cross, what the practical reason would be.
A The practical reason is, the bigger you are, the more leverage you have.
Q Anything else?
A I think that's -- that's the essence. The bigger you are, the more leverage you have, the better that can translate into a better cost to be able to offer to your customers.
Q And when you say the more leverage you have, in what way does that play into it?

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MR. GILMAN: Objection, form.
THE WITNESS: It plays into it in that hospitals, for all intents and purposes, couldn't survive at this juncture without Blue Cross, and so, you know, that -- and so being 50 percent of their commercial book of business, gave us leverage to say, you need us. And we're willing to work with you, but, you know, there's -- there's no getting around the fact that you need us. And so, that very need translates into them, not literally perhaps, but in many cases close to literally, having to take what we offer. So we have tremendous clout.
BY MR. KRAMER:
Q And you qualify your last answer saying "at this juncture", I take it referring to the time of Exhibit 6, although we were talking about -- in your view, has that changed since the time of Exhibit 6?
A I'm not sure, to tell you the truth. Generally speaking it hasn't changed. I mean, clearly Blue Cross is still the largest player in the State of Michigan. The degree, I'm not sure if it's shifted one way or the other a little bit.
Q Okay. Let's go back to Exhibit 6, where you wrote -- and this is in reference to Beaumont expressing a willingness to, as you put it in

Exhibit I

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

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

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

Detroit, Michigan

Wednesday, November 14, 2012

Confidential Video Deposition of:

DOUGLAS DARLAND,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan 48226, before Quentina R. Snowden, CSR-5519, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 10:00 a.m., when were present on behalf of the respective parties:

hospitals to raise their rates to other payors?
A Yes, except the option that I mentioned earlier nobody took advantage of, was also the ability for them to further reduce our rates down to that same level.
(Darland Exhibit No. 12 was marked for identification.)
BY MR. KRAMER:
Q I'm going to hand you a document marked as Exhibit 12, sir.
A (Reviewing.)
Q And my questions here will focus on the first page right at the top, a couple of sentences. So just familiarize yourself generally and then focus there, please.
The document is Blue Cross MI-99-01059573 through 9575. And the top of the first page appears to be an e-mail from Mr. Darland dated December 13, 2006, to Mr. Sorget. I take it you're familiar with Exhibit 12?
A Yes.
Q And essentially what is the issue you were addressing in Exhibit 12, please?
A You know what, I don't know. I say yes prematurely.

Q Okay.
A Yes, because -- because it's from me, but -- okay. Generally speaking, I mean unless you want me to review this --
Q Generally for now.
A -- with some deliberation -- the general idea, what I'm saying here is that, you know, we put them out on the table, they come back with suggestions and revisions. I don't find any of them acceptable, and here's how I suggest we move forward on those suggestions.
Q And -- and in the second sentence of your message or right at the top of Exhibit 12 you state, "Rather than accept any of them, it would be more beneficial for BCBSM to individually contract with the hospitals that we feel are most out of line."
A Yes.
Q What did you mean by that, please?
A Well, this is the thing we were trying to avoid that I mentioned a few minutes ago. This was coming in as the 800-pound gorilla saying we're paying you too much. We tried to come up with a model, now you're going to take what we say or you're not going to take what we say, but that's going to be the end of it.

So it was going to be that very heavy-handed, that we were trying to avoid. But, that if they were going to come -- continue to come to us with these suggestions that we found were just not in the realm of acceptability, we'd have to consider doing that.
Q And when you say "consider doing that", what did you mean by, "that"?
A Considering the heavy-handed approach. Individually approaching hospitals, with or without a model in hand, and saying, we're paying you too much, here's how much we offer.
Q Why did you view it to be more beneficial for Blue Cross to individually contract with hospitals that you thought were most out of line?
MR. GILMAN: Objection, form, foundation, mischaracterizes the document.
THE WITNESS: Because based on the suggestions that they were making, we weren't going to get out of this what we felt we needed to get out of it. And we would get more closely out of it what we felt we needed, and therefore more beneficial to simply approach them individually.
BY MR. KRAMER:
Q How did it work out ultimately, where you did

have the PG5 PHA; did you still end up with some hospitals getting more than you likely would have been able to get individually with them if you took that approach?
A If we had taken that approach, I don't know what would have happened. We were, by far, for these hospitals, especially even more so the largest commercial payor. And so, we had a lot of leverage that we could have imposed. So, I think your question was did we get as good a deal by the final model as we could have if we had just gone individually? I think the answer is probably not. But we were trying to have a fair and consistent approach through a reimbursement model.
Q Would the model likely have overpaid some hospitals that were subject to it?
MR. GILMAN: Objection, form.
THE WITNESS: What do you mean by overpaid?
BY MR. KRAMER:
Q Relative to what you thought would be a fair deal given the circumstances of particular hospitals?
A Probably. But most of them took a pretty good cut on this. And so, it's -- it's -- it's hard for me to remember specifics, I think.

Exhibit J

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.	:	
BLUE CROSS BLUE SHIELD OF MICHIGAN,	:	2:11-cv-15346-DPH-MKM
Defendant.	:	

Detroit, Michigan

Thursday, October 11, 2012

Confidential Video Deposition of:

ROBERT MILEWSKI,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Dickinson Wright, 500 Woodward Avenue, Suite 4000, Detroit, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:10 a.m., when were present on behalf of the respective parties:

A Not the Participating Hospital Agreement. I sat on the Reimbursement Committee, which negotiated the annual update factor, which was like an inflationary increase.
Q It might be helpful if you just explained what the Michigan Hospital Association is.
A Michigan Hospital Association is a trade association, which all the hospitals in the state -- I think all the hospitals in the state of Michigan are a member of it. It has a board, which is mostly hospital CEOs or high level executives on their board. And it's basically a trade association, but it does a variety of -- it does lobbying on behalf of hospitals.
And in the state of Michigan it was somewhat unique, I believe -- I learned that later after coming to the Blues -- that they also had this Participating Hospital Agreement in which, years earlier, they had drafted a model contract, basically. The hospitals still have to negotiate with the Blues individually their contract, but there was a model contract that they could choose to accept or not accept.
Q When you served on the Reimbursement Committee, you were responsible for negotiating the annual update?
A The committee was, yes.

Q And what is an annual update?
A It's a -- within the -- and, again, I may be on my tether here, but I believe within the PHA contract there was a provision for evaluating inflationary impact on hospitals and increases. And part of that, I believe the Reimbursement Committee was mandated by the PHA -- eventually it went away, that committee, but for a period of time there that committee was part of the PHA, and that committee had representatives from Blue Cross, Blue Cross board, the hospitals -- hospital community, MHA, as well as some community members, I believe, as well. And so it was trying to come up with a fair increase rate on the payment rate.
Q In your experience, is it unusual to have health insurers and hospitals working together to make the determination of the annual update rate?
A I don't know the answer to that question.
Q During the course of your tenure at the MHA, did any other hospital CEOs suggest strategies to increase competition for Blue Cross in Michigan?
A During my --
MR. GILMAN: Objection, form.
THE WITNESS: Repeat the question, please.
BY MR. GRINGER:

Q During your time participating at the Michigan Hospital Association, did any other hospital CEOs suggest strategies to increase competition for Blue Cross --
MR. GILMAN: Objection.
THE WITNESS: Yes.
BY MR. GRINGER:
Q -- in Michigan?
A Yes.
MR. GILMAN: Same objection.
BY MR. GRINGER:
Q Who did so?
A I remember it being discussed at board meetings.
Q You remember what being discussed at board meetings?
A Competition for Blue Cross. And I specifically -- the only specific person I remember doing that was Rick Breon, the CEO of Spectrum, who also owned Priority.
Q And why was -- what -- strike that.
When discussion was raised about more competition for Blue Cross, was anything ever -- was it ever discussed why that competition should be added for Blue Cross?

MR. GILMAN: Objection, form.
BY MR. GRINGER:
Q Let me try and ask a better question.
When there was discussion about competition for Blue Cross, were there any discussions about why that competition should be brought to Michigan?
MR. GILMAN: Objection, form.
THE WITNESS: Do you want me to answer?
MR. GILMAN: Yeah.
THE WITNESS: Just because Blue Cross was big.
BY MR. GRINGER:
Q And why was there a concern that Blue Cross was big?
MR. GILMAN: Objection, form.
THE WITNESS: It's because of their size, their leverage.
BY MR. GRINGER:
Q When you say "leverage," what are you referring to?
A Well, same thing I see on this side; volume has leverage. The more volume you can bring to an organization, the more leverage you have.
Q Why were -- why were --

Exhibit L

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

Birmingham, Michigan

Tuesday, August 14, 2012

Highly Confidential Video Deposition of:

PATRICK McGUIRE,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Brooks Wilkins Sharkey & Turco, PLC, 401 South Old Woodward Avenue, Birmingham, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:12 a.m., when were present on behalf of the respective parties:

reimbursement rate was in the fiscal year 2010?
MR. STENERSON: Object to the form.
THE WITNESS: Generally, these look very reasonable to me.
BY MR. KOENIG:
Q Okay. Over the past five years, have those numbers, the low 40s numbers that you just pointed out, have they -- have they always been at that level or have they changed somehow?
MR. DEMITRACK: "That level" being what to what?
MR. KOENIG: The 40 percent.
MR. DEMITRACK: Well, none of them are 40 percent.
MR. KOENIG: Okay.
BY MR. KOENIG:
Q We're talking orders of magnitude here, on in -- these numbers, the reimbursement rates for Blue Cross, the two columns in Exhibit 1, you would agree are roughly in the low 40s; correct?
MR. STENERSON: Object to, quote, "orders of magnitude," close quote.
THE WITNESS: Correct.
BY MR. KOENIG:
Q Okay. Over the past five years, how, if at

all, have those numbers changed?
A I have not seen an analysis that would tell me how they have changed.
Q Okay. Do you have a general understanding of how they've changed?
A I know that over that period of time we have not changed our charges very much, and I know that each year we have gotten some very modest increase in Blue Cross reimbursement. So my -- my guess is that they have stayed relatively in this range over that period.
Q Relative to what?
MR. STENERSON: Object to the form.
THE WITNESS: Orders of magnitude when -- you said have they stayed relatively --
BY MR. KOENIG:
Q Okay.
A -- near these numbers, my guess would be that they have -- they have not dramatically changed over the five years.
Q Okay.
MR. DEMITRACK: And just to be clear, in response to Todd's question during the break, I believe the earlier iteration of this for a period -- previous periods of time in fact shows those numbers, so if you have --

MR. KOENIG: Well --
MR. DEMITRACK: -- that with you --
MR. KOENIG: -- yes, although it's several inches thick, so it's just not....
MR. DEMITRACK: I understand, but the numbers are what the numbers are.
MR. KOENIG: I understand.
MR. DEMITRACK: It's a little unfair to ask him to remember something that's --
MR. KOENIG: All I'm asking is for his general recollection.
MR. STENERSON: I object to the Government's position that the facts are not to be accurate because the exhibit is too thick.
BY MR. KOENIG:
Q Okay. Over the past five years, have Blue Cross's reimbursement rates at St. John Providence Health increased or decreased, or stayed the same?
MR. STENERSON: Object to the form.
THE WITNESS: Reimbursement rates?
BY MR. KOENIG:
Q Yes, as shown on Exhibit 1.
MR. STENERSON: Object to the form, misstates the record.
MR. DEMITRACK: You mean average

reimbursement rate?
MR. KOENIG: Sure.
THE WITNESS: Do you mean as a percentage of charges?
BY MR. KOENIG:
Q Yes.
MR. STENERSON: Same objections.
THE WITNESS: Again, not having reviewed the history, my -- knowing the inputs, I would assume that they've stayed about the same.
BY MR. KOENIG:
Q Okay. Thanks.
MR. DEMITRACK: Just to be clear, though, you don't remember one way -- you don't have a memory today of what those numbers are for earlier periods of time?
THE WITNESS: That's correct.
MR. KOENIG: All right. I'm going to mark Plaintiff's Exhibit McGuire 2.
(Plaintiff's Exhibit McGuire 2 was marked.)
BY MR. KOENIG:
Q And if you could just take a quick look through this, because I know it's a rather thick document, but I have very limited questions with respect

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to it.
A (Reviewing Plaintiff's Exhibit McGuire 2.) I'm generally familiar with the document.
Q Okay. Okay. Thank you. And what is Plaintiff's Exhibit McGuire 2?
A It is part -- it is part of our ISOFP documentation. ISOFP stands for Integrated Strategic Operational and Financial Plan, our five-year planning forecast. And the document has various components to it, of which this is Appendix 4.
Q Okay. And if you could for the record, on the very first page of Plaintiff's McGuire Exhibit 2, the very first page, could you just read the number in the bottom right corner into the record.
A The number is 0110512.
Q Okay. And the first part of it, the letters, as well?
A ASHLT.
Q Okay. Thank you. If you could turn for me to --
MR. DEMITRACK: I'll just ask the witness. You described this as the part of the ISOFP that's Appendix 4.
THE WITNESS: Correct.
MR. DEMITRACK: If you could look at page

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528. Is that still Appendix 4?
THE WITNESS: No. That begins Appendix 5.
BY MR. KOENIG:
Q Okay. And what is Appendix 5 of Exhibit 2?
A It is just another appendix within the ISOFP.
Q Okay. Great. Thank you. If you could then turn -- within Appendix 5 of Exhibit 2, if you could turn to the page that has the number at the bottom right corner ASHLT-0110539.
A (Reviewing Plaintiff's McGuire Exhibit 2.)
Q Have you reviewed that page?
A I have.
Q Okay. Thank you. First, let me back up. Do you prepare -- did you prepare this document, Exhibit 2?
A It is prepared by my staff.
Q Okay.
A Partially prepared by my staff, partially prepared by the Planning staff, which does not report to me.
Q Okay. And this particular page of Exhibit 2, ASHLT-0110539, is that prepared by your staff?
A It's -- it's really hard to say. It could have been prepared by the Planning staff also.
Q Okay. Have you seen this page of Exhibit 2

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before?
A Yes.
Q Okay. And when did you see it?
A At the time that it was submitted.
Q Which was...?
A Which would have been -- this is our '12, our fiscal '12 plan, and so this would have been submitted in April of 2011.
Q Okay. If I could direct your attention to the row that says "Payer Concentration." Do you see that?
A Yes.
Q Okay. And could you please just in the second column, if you go to the last half of the last sentence, the sentence that starts, "With the economic climate...." Do you see that?
A Yes.
Q Okay. And do you see where the word "Blue Cross" is? The words "Blue Cross" are?
A Yes.
Q Okay. Could you please read that into the record.
A "...but it is Blue Cross who has ultimate leverage in our community."
Q And then the following sentence, as well, please.

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A "The 'must haves' within St. John Providence Health System's service area are: Henry Ford Health, St. John Providence Health, Beaumont Hospitals, Oakwood Health, and DMC...."
Q DMC...?
A "(Children's)."
Q Children's. Okay. Could you please explain what your understanding of those -- well, first, what is your understanding of what the "...Blue Cross who has ultimate leverage in our community" means?
MR. STENERSON: Object to the form.
THE WITNESS: I believe the term "ultimate leverage" refers to the fact that Blue Cross has a significant percentage of the market and has significant market power when dealing with the hospital community.
BY MR. KOENIG:
Q Okay. And the next sentence -- and do you agree with that characterization?
A I do.
Q Okay. And then the next sentence, the one that starts with "The 'must haves'..." in Exhibit 2, what is your understanding of that sentence, please?
MR. STENERSON: Object to the form.
THE WITNESS: I'm not sure exactly what

Exhibit M

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

UNITED STATES OF AMERICA and the STATE OF MICHIGAN,	
Plaintiffs,	Civil Action no.: 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. 2:11-cv-15346-DPH-MKM
v.	
BLUE CROSS BLUE SHIELD OF MICHIGAN,	
Defendant.	

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:

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you are estimating -- if you're giving me, you know, your best estimate, just let me know.
A Okay.
Q I'm happy with that.
So you contracted with Priority. Had you had a contract with Priority before this contract that you're referencing?
A No.
Q Okay. So this was a new -- a new contract?
A That's correct.
Q All right. And at the time, did Priority have any significant volume at Borgess?
A They did not.
Q Okay. And so -- and so in light of their lack of volume at the time, why were you willing to extend to Priority a contract?
A It was twofold. One, we were looking as an employer to try an opportunity for our own employees to see if we could get a better plan and better rates.
Priority was a regional player. They were known in the area, but they hadn't really developed locally. Their focus was on small business, which was a focus that we had at that time, to see if we could get a lot of small businesses. They could not compete in the nationwide business because they didn't have nationwide

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coverage, so they couldn't go there. So it was a compound.
We eventually put in about half of our employees into coverage, the employer health insurance coverage, with Priority, and still have some coverage as of today.
So it was a twofold; they're a regional player, we were thinking about them, they had a good program for our own employees, so it fit.
Q Okay. I think you mentioned for the Borgess employees, I think you said you were looking for a better plan or better rates?
A Better rates, better coverage. They had -- they had what appeared to be at the time some very good approaches to controlling medical costs. We had to control our medical costs as well, so it was a good fit for us at the time.
Q Okay. And prior to this, who were the Borgess employees covered through?
A We were self-insured through -- I don't know. At this moment, I don't remember what we -- what we were covered.
Q Okay.
A Sorry.
Q That's fine. And when you -- when you entered

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into a contract with Priority, did you extend to them a discount?
A Yes, I did.
Q Okay. What kind of discount did you give them at the time, if you recall?
A I don't recall precisely, but it was slightly better than I would have given them just walking in the door. As I indicated earlier, we gave them the benefit of the doubt to try to take some business away.
Q Okay. And so did you think that contracting with Priority and extending a discount to them would benefit Borgess?
A Yes.
Q Did you think it would benefit the community?
A Yes.
Q Did you think it would benefit local employers?
A Yes.
Q How so?
A If you have some competition, and the employers would be able to have choice and maybe someone that could manage their plans better from a community standpoint, again, access, a different way to have access to us.
From our standpoint, we could maybe move

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some business from Blue Cross to Priority; therefore, getting paid more for the same business that Blue Cross was managing. So it was a win/win/win for everyone.
Q Okay. And so prior to 2006, was there, in your perception, a lack of choice?
MR. STENERSON: Object to the form, leading.
THE WITNESS: Blue Cross is a dominant player, so, yes, it would be less choice than I would like. And the reason why I like choice is because that maybe allows me to get a better rate from the other players.
BY MR. JOYCE:
Q What do you mean when you describe Blue Cross as a "dominant player"?
MR. STENERSON: Object to the form.
THE WITNESS: It's my understanding that Blue Cross controls 80 percent of the managed care market in the state. With that kind of buying power, they have a significant amount of power on rates and how they apply their rules and regulations.
BY MR. JOYCE:
Q Okay. Do you consider them to be dominant in the Kalamazoo area?
MR. STENERSON: Object to the form.

Exhibit N

4675 Hill Street
Cass City, MI 48726

Hills & Dales General Hospital

(989) 872-2121
www.hillsanddales.com

December 16, 2008

Ms. Laura Spencer
PPOM/Cofinity
P.O. Box 2720
Farmington Hills, MI 48333

Dear Ms. Spencer:

Enclosed please find two originals of an amendment to our agreement dated October 1, 1992. This amendment is driven by the fact that Hills and Dales now has, in place, an agreement with its largest commercial payer that includes a Most Favored Nations clause that we need to honor. As such, Hills and Dales needs to adjust the compensation format of its commercial agreements to be consistent with that Most Favored Nations clause.

Since that payer is reimbursing us on a percentage of charge basis, it will be far easier for Hills and Dales to comply if all of its commercial contracts are on a percentage of charge basis. And, since that payer pays us the same rate for hospital charges whether they are inpatient or outpatient you will note that the amendment has the same rates across the board except for physician charges (which are exempt from the Most Favored Nations clause).

Hills and Dales has enjoyed its relationship with PPOM/Cofinity and hopes to continue that relationship into the future. However, since the payer in question represents upwards of thirty percent of our business whereas PPOM/Cofinity represents considerably less, and the penalties for non-compliance are extensive to the point where we can not afford to be out of compliance, Hills and Dales must insist on this amendment to our payment schedule with PPOM/Cofinity. We have made an effort to comply with the Most Favored Nations clause only to the extent necessary and not to be in any way excessive in the difference in our payment from PPOM/Cofinity versus the payment we receive from that payer.

After you have had an opportunity to review the amendment with whomever you may need to within the organization, please have the appropriate person sign and date both originals returning one to me and keeping one for your records.

If you have any questions please do not hesitate to contact me. I look forward to an ongoing productive and mutually beneficial relationship.

Sincerely,

Michael J. Falatko, FACHE
President & CEO

Enclosures

"Then, Now & Always"

AMENDMENT TO HOSPITAL AGREEMENT

This Amendment is attached to a certain Hospital Agreement dated October 1, 1992 (the "Agreement"), by and between PPOM L.L.C., a Delaware limited liability company or its predecessor in interest ("PPOM") and Hills and Dales General Hospital, a duly licensed hospital in the State of Michigan ("Hospital") and incorporated by reference therein as if same or more fully set forth therein.

The parties hereby agree that effective February 1, 2009 the Agreement is hereby amended as follows:

1. Section 11(A) paragraph 1, 11(A)(1) and 11(A)(2) of the Agreement are hereby deleted in their entirety and restated as follows:

"A. Hospital shall submit to PPOM all claims for Hospital Services within a reasonable time after the provision of such Hospital Services. Hospital shall submit same on its customary billing form and shall set forth therein its usual and customary charges for the Hospital Services rendered based on its then current charge master. However, except as set forth in subparagraph C herein below, Hospital agrees to accept as payment in full for all hospital services rendered:

1. For all Hospital Inpatient Services the payment shall be eighty-nine percent (89%) of billed charges.

2. For Outpatient services (including but not limited to ambulatory surgery, urgent care, and emergency care) the payment shall be eighty-nine percent (89%) of billed charges."

2. Section 11(E) line 1 and 2 of the Agreement are hereby deleted and restated as follows:

"E. It is hereby acknowledged and agreed that the Inpatient rates and Outpatient rates set forth herein are the product of arms-length negotiation by and between PPOM and Hospital only."

3. Except as stated herein to the contrary, the Agreement is not amended or modified in any manner whatsoever.

IN WITNESS WHEREOF, the parties have executed this Amendment to Hospital Agreement the ____ day of _____, 2009.

"PPOM"

By: _____

Its: _____

"HOSPITAL"

By: Richard J. Shutts

Its: President & CEO

Federal Tax Identification Number (TIN): 38-1619577

Exhibit O

From: Noxon, Gerald
Sent: Thursday, July 22, 2010 5:49 PM
To: Darland, Doug; Sorget, Kim
Subject: RE: Hospital Strategy

I would add Charity Care (not Bad Debt) to item 5 of Doug's. GME and Charity Care are social expenditures and their current burden is not being spread evenly throughout our customer base. Most important is that if individuals chose hospitals based on price, teaching hospitals and community hospitals providing a significant amount of charity care look to be more expensive and will suffer from adverse selection if we go forward and ignore this disproportionate distribution.

I would also like to get something on the table to discuss our reliance on hospital discount. The easiest way to describe my concern in a brief e-mail is to ask the question – Why wouldn't BCBSM be able to compete in the market if we had to pay what our competitors pay for hospital services? Something is out of balance in our company and it needs to be addressed. It may be that we can keep our discount differential, but the likelihood is that it will erode and if we don't address the underlying reason for our non-competitiveness, working on the discount under the clause of hospital strategy, isn't going to keep us in business.

By the way, what ever happened to workshop 2?

From: Darland, Doug
Sent: Wednesday, July 21, 2010 4:59 PM
To: Sorget, Kim; Noxon, Gerald
Subject: RE: Hospital Strategy

That's the idea. Not to replace your list. I think you hit the core elements we need to consider. - Doug

From: Sorget, Kim
Sent: Wednesday, July 21, 2010 4:51 PM
To: Darland, Doug; Noxon, Gerald
Subject: Re: Hospital Strategy

These would be additive to my list?

From: Darland, Doug
To: Sorget, Kim; Noxon, Gerald
Sent: Wed Jul 21 16:48:11 2010
Subject: RE: Hospital Strategy

Here are a few things to consider:

1. Achieve goals of narrow network through benefit design
2. Remain sensitive to reform related issues that hospitals face
3. Partner with Pharmacy to address hospital/drug issues/opportunities ("free" name brands provided at discharge)
4. Partner with Case management to address/negotiate on high cost claims
5. Consider alternative funding methodologies for GME (to spread cost across non-teaching and smaller teaching hospitals)

From: Sorget, Kim
Sent: Wednesday, July 21, 2010 6:55 AM
To: Noxon, Gerald; Darland, Doug
Subject: Fw: Hospital Strategy

I am not sure of the motivation for this discussion. I suspect it maybe coming from McKinsey. If any one thinks we can deeper discounts that is very tall order and not likely.

That being said I would suggest that our strategy falls in the following primary areas:

1) A targeted revision in reimbursement for peer group 4 hospitals.

2) Move towards value based incentive arrangements.

3) Make available incentive funds to hospital to invest in operational improvements to reduce cost structures.

4) More alignment between PGIP and hospital incentive programs.

If you have other strategies we have not talked about please forward.

From: Barkell, Susan
To: Simmer, Thomas M.D.; Milewski, Robert; Sorget, Kim
Sent: Mon Jul 19 11:02:12 2010
Subject: Hospital Strategy

I am going to ask Lisa to schedule some time with the four of us to talk about Hospital strategy. We can also try to get some time during the summer meeting.

A few of topics include:

1) What should be in the hospital contract and what shouldn't?

2) Narrow networks

3) Spectrum

4) Overall hospital strategy - need someone worried about this every day.

I am sure there are others....

Thanks,

Sue

*Susan Barkell * Sr. Vice President * Health Care Value*

248-448-5608 * Cell 313-969-0570

sbarkell@bcbsm.com

Exhibit P

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

Detroit, Michigan

Thursday, October 4, 2012

Confidential Video Deposition of:

GERALD NOXON,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:08 a.m., when were present on behalf of the respective parties:

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Q Do you recall who they were?
A I do not.
Q Does the name Tom Pellathy ring a bell?
A Yes, I do know Tom.
Q Was he at any of these strategy sessions?
A I don't recall.
Q What about Shubham Singhal? Does that name ring a bell?
A I know Shubham.
Q Do you know if he participated in the strategy sessions?
A I don't recall.
Q Did these strategy sessions come up with any steps to take to retain or improve Blue Cross's discount advantage?
A I don't remember any --
Q Are you aware of any steps since you've been working at Blue Cross that the company has taken to retain or improve your discount advantage?
A None that I can articulate off the top of my head, no.
Q Let me ask you about a specific one. Seeking most favored nation clauses in your hospital contracts, was that a strategy to retain or improve Blue Cross's discount advantage?

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A It was not one of my strategies, no.
Q I didn't ask if it was one of your strategies. Was that -- was seeking most favored nation clauses in hospital contracts one of Blue Cross's strategies to retain or improve its discount advantage?
MR. GILMAN: Objection, form and foundation, asked and answered.
THE WITNESS: I don't recall it being presented to me that way, no.
BY MR. GRINGER:
Q And do I understand your testimony to be that you don't believe seeking MFN clauses in hospital contracts does retain or improve your discount advantage?
A That's correct.
Q Why not?
A That's my belief.
Q What's your -- what's the basis for your belief?
A Well, I guess the most, you know, prevalent belief is that -- or basis of that belief is that our discount advantage has been reducing over years, and even though we have an MFN, it's still -- it's still reducing. So the anecdotal evidence is it's not changing anything.

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Q When you were negotiating most favored discount clauses, did you believe that they were retaining or improving your discount advantage?
A I believe I told you what I believed while I was negotiating.
Q So that's a no to my last question?
A I don't recall the question.
Q The question is when you were negotiating most favored discount clauses, did you believe that they were retaining or improving your discount advantage?
A No.
Q You mentioned your discount advantage eroding over time. Is that your hospital discount advantage or your overall discount advantage?
A I believe I would have been speaking of hospital advantage.
Q And your hospital discount advantage has eroded over time?
A That's my understanding, yes.
Q When did that start?
A I don't know.
Q When do you have information -- what's the endpoint that you have information on it eroding?
A Endpoint as current or past?
Q I don't know. I'm asking where --

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A You're asking for an endpoint. Is the endpoint the most current?
Q No, I'm asking --
A I think the most current point we're up to is 2010 --
Q Okay.
A -- 2011.
Q And Blue Cross doesn't have most favored nation clauses with all hospitals; right?
A That's correct.
Q So it's possible that the discount erosion occurred at hospitals without an MFN; correct?
A Anything is possible.
Q You don't know that that isn't what happened?
A No.
MR. GILMAN: David --
THE WITNESS: So would that be a good breaking point?
MR. GRINGER: Yes. Excellent breaking point.
VIDEOGRAPHER: Going off the record at 10:18 a.m.
(Recess - 10:18 a.m. to 10:36 a.m.)
VIDEOGRAPHER: We're back on the record at 10:36 a.m.

Exhibit Q

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

Detroit, Michigan

Thursday, October 4, 2012

Confidential Video Deposition of:

GERALD NOXON,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:08 a.m., when were present on behalf of the respective parties:

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Q And we discussed earlier Blue Cross's discount erosion in hospitals. One of the reasons that your discount advantage was eroding was because competitors were seeking better discounts in Michigan hospitals?
A I'm not sure I said that, but that's fine. That's true. I mean --
Q That's true?
A Yeah.
Q And when you report to your superiors, Mr. Milewski and Mr. Sorget, that your hospital discounts are under pressure for a host of reasons, you're doing so because you want them to address the problem; right?
A I don't know that that's what I was doing here. I obviously clearly labeled this as an "Editorial," so I'm speaking on behalf of myself.
Q Right, right. But when a newspaper runs an editorial, it usually runs the editorial because it wants people to listen to it; right?
A Well, certainly I would want somebody to listen to me, but I think that what I wanted listened to was in defense of what was said prior to this in the e-mail.
Q Okay. And what specifically?
A I don't know without reading the whole thing,

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but, I mean, I'm -- clearly, there's four or five conversations before we get to that point. And, you know, you can see that there's discussion with me, between me and Bob, and so this is kind of the end result of that conversation.
Q And you're -- you're urging Mr. Milewski and Mr. Sorget, are you not -- I shouldn't say urging. Let me strike that.
It's your view that you were urging -- strike that again.
You are identifying an issue in your editorial to your two superiors; right?
A That I'm concerned about, yes.
Q And that concern is that there is a host of pressures on your hospital discount advantage?
A That is a concern I'm expressing here, yes.
Q And when you expressed the concern to them, was it with the hope that they would address your concern somehow or you just wanted to mark it as a concern?
A I'm not sure.
Q So how long, in your view, would it take to get your administrative costs in line?
A I don't know.
Q Did you have -- when you wrote Noxon 13, your

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editorial, did you have a time frame in mind in which you would need to hold on to your hospital discount advantage?
A I didn't, that I can recall, no.
Q Your final sentence of your editorial in Noxon 13 is that it was "...not reasonable to assume that" Blue Cross "can hold on to a competitive" discount advantage -- "competitive advantage forever." Do you see that?
A Yes.
Q Why not? Why is it not reasonable to assume that Blue Cross can hold on to a competitive advantage forever?
A Nothing lasts forever. I -- sorry, but that's my opinion. It's just nothing lasts forever.
Q Would one way to at least prolong the discount advantage you had was to use MFN and MFN plus clauses in your hospital contracts?
A I don't know if that would work or not. It doesn't appear to be.
Q But would it be worth a try?
A Many things are worth trying.
Q And is that one of them?
A It's one that is being tried.
Q So part of the reason, then, for preserving

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the discount advantage -- part of the reason for seeking MFN clauses, I should say, was to protect and preserve Blue Cross's discount advantage?
MR. GILMAN: Objection, form and foundation.
THE WITNESS: Please repeat.
BY MR. GRINGER:
Q Part of the reason Blue Cross is seeking most favored nation clauses is to protect and preserve Blue Cross's competitive discount advantage?
MR. GILMAN: Same objection.
THE WITNESS: Again, I'm not sure why everyone in the company who was involved with this was seeking it, but for myself, I don't see how it was keeping our competitive advantage.
BY MR. GRINGER:
Q Do you have an understanding of whether Mr. Sorget believed that such clauses would help protect your hospital discount advantage?
A I don't.
Q Do you have an understanding of whether Mr. Milewski believed that such clauses would help protect your hospital discount advantage?
A I don't.
Q Do you believe that's what they thought?

Exhibit R

Cost-Based Payment Ratio Analysis
2004 - 2008

	#277 Providence	#48 SJ Macomb	#56 SJ River District	#116 SJH & MC	#269 SJ Oakland	#13 SJ Riverview	Total SJHS
2005 Impact	-77,592	-44,272	0	-72,657	-24,374	-6,070	-224,964
2006 Impact	-47,366	-36,683	0	-46,722	-21,032	-6,008	-157,812
2007 Impact	-54,156	-43,802	0	-50,755	-22,744	0	-171,457
2008 Impact *	-54,156	-43,802	0	-50,755	-22,744	0	-171,457
Total '05 - '07	**-233,270**	**-168,559**	**0**	**-220,890**	**-90,894**	**-12,078**	**-725,690**

* 2008 Impact assumed to be atleast 2007 impact. Full passthrough calculation not performed.

Cost-Based Payment Factor Analysis

	Original HFR #277 Providence	Revised HFR #277 Providence	Actual #277 Providence	
2003 Actual Payment Ratio	[redacted]	[redacted]	[redacted]	
2004 Update Factor	1.0335	1.0335	1.0335	2004 update factor
2004 Attested Price Increase	1.1633 **	1.1633 **	1.0900	2004 attested price increase
2004 Adjustment Factor	0.8884	0.8884	0.9482	2004 Adjustment Factor
2004 Payment Ratio	[redacted]	[redacted]	[redacted]	2004 Payment Ratio
PT/ST/OT Budget Neutral	(0.0018)	(0.0018)	(0.0018)	PT/ST/OT Budget Neutral
Revised 2004 Payment Ratio	[redacted]	[redacted]	[redacted]	Revised 2004 Rate 7/1/03 - 10/26/03
			1.1082	10/27/2003 Price Increase
			[redacted]	Revised 2004 Rate 10/27/03 - 6/30/04
2004 Settlement & Vouchering Rate	[redacted]	[redacted]	0.0000	Difference
2004 Actual Payment Ratio	[redacted]	[redacted]		
2005 Update Factor	1.0340	1.0340		
2005 Attested Price Increase	1.0606 **	1.0259		
2005 Adjustment Factor	0.9749	1.0079		
Revised 2005 Rate	[redacted]	[redacted]		
			48,495,236	Cost-Based Contract Charges
2005 Settlement & Vouchering Rate	[redacted]	[redacted]	-0.0016	Difference
			-77,592	**Impact of Difference**
2005 Actual Payment Ratio	[redacted]	[redacted]		
2006 Update Factor	1.0380	1.0380		
2006 Attested Price Increase	1.0661	1.0661		
2006 Adjustment Factor	0.9736	0.9736		
Revised 2006 Rate	[redacted]	[redacted]		
Additional Reimbursement per LOU	1.0370	1.0370		
Final Revised 2006 Rate	[redacted]	[redacted]		
			27,862,400	Cost-Based Contract Charges
2006 Settlement & Vouchering Rate	[redacted]	[redacted]	-0.0017	Difference
			-47,366	**Impact of Difference**

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

2004 - 2006 LCC.xls 11/3/2008

Cost-Based Payment Factor Analysis

	Original HFR #277 Providence	Revised HFR #277 Providence	Actual #277 Providence	
2006 Actual Payment Ratio	[redacted]	[redacted]	[redacted]	
2007 Update Factor	1.0440	1.0440	1.0440	2004 update factor
2007 Attested Price Increase	1.0521 (1)	1.0521 **	1.0640	2004 attested price increase
2007 Adjustment Factor	0.9923	0.9923	0.9812	2004 Adjustment Factor
Revised 2007 Rate	[redacted]	[redacted]	[redacted]	Revised 2007 Rate
Additional Reimbursement per LOU	1.0300	1.0300	1.0300	Additional Reimbursement per LOU
	[redacted]	[redacted]	[redacted]	Revised 2007 Rate 7/1/06 - 3/31/07
			1.0109	4/1/07 Price Decrease
			[redacted]	Revised 2007 Rate 4/1/07 - 6/30/07
			30,086,424	Cost-Based Covered Charges
2007 Settlement & Vouchering Rate	[redacted]	[redacted]	-0.0018	Difference
			-54,156	Impact of Difference
2007 Actual Payment Ratio	[redacted]	[redacted]		
2008 Update Factor	1.04125	1.04125		
2008 Attested Price Increase	1.0625	1.0625		
2008 Adjustment Factor	0.9800	0.9800		
			-179,114	Total Impact 2005 - 2007

(1) = Original attestation of 6.4% submitted. Mid-year (4/1/07) attestation of -1.09% submitted. The 5.21% was their blended attestation.

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Cost-Based Payment Factor Analysis

	Original HFR #48 SJ Macomb	Revised HFR #48 SJ Macomb	Actual #48 SJ Macomb	
2003 Actual Payment Ratio	[redacted]	[redacted]	[redacted]	
2004 Update Factor	1.0335	1.0335	1.0335	2004 update factor
2004 Attested Price Increase	1.1302 **	1.1302 **	1.0900	2004 attested price increase
2004 Adjustment Factor	0.9144	0.9144	0.9482	2004 Adjustment Factor
2004 Payment Ratio	[redacted]	[redacted]	[redacted]	2004 Payment Ratio
PT/OT/ST Budget Neutral	0.0393	0.0393	0.0393	PT/ST/OT Budget Neutral
Rounding	0.0000	0.0000	0.0000	Rounding
Revised 2004 Payment Ratio	[redacted]	[redacted]	[redacted]	Revised 2004 Rate 7/1/03 - 9/30/03
			1.0537	10/1/2003 Price Increase
			[redacted]	Revised 2004 Rate 10/1/03 - 6/30/04
2004 Settlement & Vouchering Rate	[redacted]	[redacted]	0.0000	Difference
2004 Actual Payment Ratio	[redacted]	[redacted]		
2005 Update Factor	1.0340	1.0340		
2005 Attested Price Increase	1.0685 **	1.0551		
2005 Adjustment Factor	0.9677	0.9800		
Revised 2005 Rate	[redacted]	[redacted]		
			16,396,882	Cost-Based Contract Charges
2005 Settlement & Vouchering Rate	[redacted]	[redacted]	-0.0027	Difference
			-44,272	**Impact of Difference**
2005 Actual Payment Ratio	[redacted]	[redacted]		
2006 Update Factor	1.0380	1.0380		
2006 Attested Price Increase	1.0296	1.0296		
2006 Adjustment Factor	1.0082	1.0082		
Revised 2006 Rate	[redacted]	[redacted]		
Additional Reimbursement per LOU	1.0370	1.0370		
Final Revised 2006 Rate	[redacted]	[redacted]		
			13,101,170	Cost-Based Contract Charges
2006 Settlement & Vouchering Rate	[redacted]	[redacted]	-0.0028	Difference
			-36,683	**Impact of Difference**

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Cost-Based Payment Factor Analysis

	Original HFR #48 SJ Macomb	Revised HFR #48 SJ Macomb	Actual #48 SJ Macomb
2006 Actual Payment Ratio	[redacted]	[redacted]	
2007 Update Factor	1.0440	1.0440	
2007 Attested Price Increase	1.0530	1.0530	
2007 Adjustment Factor	0.9915	0.9915	
Revised 2007 Rate	[redacted]	[redacted]	
Additional Reimbursement per LOU	1.0300	1.0300	
	[redacted]	[redacted]	
2007 Settlement & Vouchering Rate	[redacted]	[redacted]	15,104,126 Cost-Based Covered Charges
			-0.0029 Difference
			-43,802 Impact of Difference
2007 Actual Payment Ratio	[redacted]	[redacted]	
2008 Update Factor	1.04125	1.04125	
2008 Attested Price Increase	1.0000	1.0000	
2008 Adjustment Factor	1.04125	1.04125	
			-124,757 Total Impact 2005 - 2007

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Cost-Based Payment Factor Analysis

	Original HFR #56 SJ River District	Revised HFR #56 SJ River District	Actual #56 SJ River District
2003 Actual Payment Ratio	[redacted]	[redacted]	
2004 Update Factor	1.0335	1.0335	
2004 Attested Price Increase	1.0500	1.0500	
2004 Adjustment Factor	0.9843	0.9843	
2004 Payment Ratio	[redacted]	[redacted]	
PT/OT/ST Budget Neutral	0.0504	0.0504	
Rounding	0.0000	0.0000	
Revised 2004 Payment Ratio	[redacted]	[redacted]	
2004 Settlement & Vouchering Rate	[redacted]	[redacted]	0.0000 Difference
2004 Actual Payment Ratio	[redacted]	[redacted]	
2005 Update Factor	1.0340	1.0340	
2005 Attested Price Increase	1.0700	1.0700	
2005 Adjustment Factor	0.9664	0.9664	
Revised 2005 Rate	[redacted]	[redacted]	
2005 Settlement & Vouchering Rate	[redacted]	[redacted]	0 Cost-Based Contract Charges 0.0000 Difference **0 Impact of Difference**
2005 Actual Payment Ratio	[redacted]	[redacted]	
2006 Update Factor	1.0380	1.0380	
2006 Attested Price Increase	1.0491	1.0491	
2006 Adjustment Factor	0.9894	0.9894	
Revised 2006 Rate	[redacted]	[redacted]	
Additional Reimbursement Increase per L	1.0370	1.0370	
Final Revised 2006 Rate	[redacted]	[redacted]	
2006 Settlement & Vouchering Rate	[redacted]	[redacted]	0 Cost-Based Contract Charges 0.0000 Difference **0 Impact of Difference**

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Cost-Based Payment Factor Analysis

	Original HFR #56 SJ River District	Revised HFR #56 SJ River District	Actual #56 SJ River District
2006 Actual Payment Ratio	[redacted]	[redacted]	
2007 Update Factor	1.0440	1.0440	
2007 Attested Price Increase	1.0380	1.0380	
2007 Adjustment Factor	1.0058	1.0058	
Revised 2007 Rate	[redacted]	[redacted]	
Additional Reimbursement per LOU	1.0300	1.0300	
	[redacted]	[redacted]	
2007 Settlement & Vouchering Rate	[redacted] *	[redacted]	0 Cost-Based Covered Charges
			0.0000 Difference
			0 Impact of Difference
2007 Actual Payment Ratio	[redacted]	[redacted]	
2008 Update Factor	1.04125	1.04125	
2008 Attested Price Increase	1.0000	1.0000	
2008 Adjustment Factor	1.04125	1.04125	
			0 Total Impact 2005 - 2007

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Cost-Based Payment Factor Analysis

	Original HFR #116 SJH & MC	Revised HFR #116 SJH & MC	Actual #116 SJH & MC	
2003 Settlement Payment Ratio	[redacted]	[redacted]	[redacted]	
2003 Actual Payment Ratio				
2004 Update Factor	1.0335	1.0335	1.0335	2004 update factor
2004 Attested Price Increase	1.1305 **	1.1305 **	1.0900	2004 attested price increase
2004 Adjustment Factor	0.9142	0.9142	0.9482	2004 Adjustment Factor
2004 Payment Ratio	[redacted]	[redacted]	[redacted]	2004 Payment Ratio
PT/OT/ST Budget Neutral	0.0217	0.0217	0.0217	PT/ST/OT Budget Neutral
Revised 2004 Payment Ratio	[redacted]	[redacted]	[redacted]	Revised 2004 Rate 7/1/03 - 10/5/03
			1.0553	10/6/2003 Price Increase
			[redacted]	Revised 2004 Rate 10/6/03 - 6/30/04
2004 Settlement & Vouchering Rate	[redacted]	[redacted]		0.0000 Difference
2004 Actual Payment Ratio	[redacted]	[redacted]		
2005 Update Factor	1.0340	1.0340		
2005 Attested Price Increase	1.0559 **	1.0414		
2005 Adjustment Factor	0.9793	0.9929		
Revised 2005 Rate	[redacted]	[redacted]		
2005 Settlement & Vouchering Rate	[redacted]	[redacted]		33,025,944 Cost-Based Contract Charges
				-0.0022 Difference
				-72,657 Impact of Difference
2005 Actual Payment Ratio	[redacted]	[redacted]		
2006 Update Factor	1.0380	1.0380		
2006 Attested Price Increase	1.0433	1.0433		
2006 Adjustment Factor	0.9949	0.9949		
Revised 2006 Rate	[redacted]	[redacted]		
Additional Reimbursement per LOU	1.0370	1.0370		
Final Revised 2006 Rate	[redacted]	[redacted]		
2006 Settlement & Vouchering Rate	[redacted]	[redacted]		22,248,755 Cost-Based Contract Charges
				-0.0021 Difference
				-46,722 Impact of Difference

@ = Need to use the LOU number to arrive at 2004, 2005, 2006 and 2007 Cash Reconciliation payment ratio.
The ER adjustment appears to be the difference between .4265 on LOU and .4455 on 2003 Cash Reconciliation.

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Cost-Based Payment Factor Analysis

	Original HFR #116 SJH & MC	Revised HFR #116 SJH & MC	Actual #116 SJH & MC	
2006 Actual Payment Ratio	[redacted]	[redacted]		
2007 Update Factor	1.0440	1.0440		
2007 Attested Price Increase	1.0241	1.0241		
2007 Adjustment Factor	1.0194	1.0194		
Revised 2007 Rate	[redacted]	[redacted]		
Additional Reimbursement per LOU	1.0300	1.0300		
	[redacted]	[redacted]		
2007 Settlement & Vouchering Rate	[redacted]	* [redacted]	23,070,574	Cost-Based Covered Charges
			-0.0022	Difference
			-50,755	**Impact of Difference**
2007 Actual Payment Ratio	[redacted]	[redacted]		
2008 Update Factor	1.04125	1.04125		
2008 Attested Price Increase	1.0341	1.0341		
2008 Adjustment Factor	1.00691	1.00691		
			-170,135	Total Impact 2005 - 2007

@ = Need to use the LOU number to arrive at 2004, 2005, 2006 and 2007 Cash Reconciliation payment ratio.
The ER adjustment appears to be the difference between .4265 on LOU and .4455 on 2003.

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Cost-Based Payment Factor Analysis

	Original HFR #269 SJ Oakland	Revised HFR #269 SJ Oakland	Actual #269 SJ Oakland	
2003 Actual Payment Ratio	[redacted]	[redacted]	[redacted]	
2004 Update Factor	1.0335	1.0335	1.0335	2004 update factor
2004 Attested Price Increase	1.1950 **	1.1950 **	1.0900	2004 attested price increase
2004 Adjustment Factor	0.8649	0.8649	0.9482	2004 Adjustment Factor
2004 Payment Ratio	[redacted]	[redacted]	[redacted]	2004 Payment Ratio
PT/OT/ST Budget Neutral	0.0164	0.0164	0.0164	PT/ST/OT Budget Neutral
Revised 2004 Payment Ratio	[redacted]	[redacted]	[redacted]	Revised 2004 Rate 7/1/03 - 9/30/03
			1.1403	10/1/2003 Price Increase
			[redacted]	Revised 2004 Rate 10/1/03 - 6/30/04
2004 Settlement & Vouchering Rate	[redacted]	[redacted]		0.0000 Difference
2004 Actual Payment Ratio	[redacted]	[redacted]		
2005 Update Factor	1.0340	1.0340		
2005 Attested Price Increase	1.0805 **	1.0455		
2005 Adjustment Factor	0.9570	0.9890		
Revised 2005 Rate	[redacted]	[redacted]		
2005 Settlement & Vouchering Rate	[redacted] *	[redacted]		6,249,696 Cost-Based Contract Charges
				-0.0039 Difference
				-24,374 Impact of Difference
2005 Actual Payment Ratio	[redacted]	[redacted]		
2006 Update Factor	1.0380	1.0380		
2006 Attested Price Increase	1.0231	1.0231		
2006 Adjustment Factor	1.0146	1.0146		
Revised 2006 Rate	[redacted]	[redacted]		
Additional Reimbursement per LOU	1.0370	1.0370		
Final Revised 2006 Rate	[redacted]	[redacted]		
2006 Settlement & Vouchering Rate	[redacted]	[redacted]		5,129,820 Cost-Based Contract Charges
				-0.0041 Difference
				-21,032 Impact of Difference

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

2006 Actual Payment Ratio	[redacted]	[redacted]
2007 Update Factor	1.0440	1.0440
2007 Attested Price Increase	1.0169	1.0169
2007 Adjustment Factor	1.0266	1.0266
Revised 2007 Rate	[redacted]	[redacted]
Additional Reimbursement per LOU	1.0300	1.0300
	[redacted]	[redacted]
2007 Settlement & Vouchering Rate	[redacted]	[redacted]
2007 Actual Payment Ratio	[redacted]	[redacted]
2008 Update Factor	n/a	n/a
2008 Attested Price Increase	n/a	n/a
2008 Adjustment Factor	n/a	n/a

5,169,106 Cost-Based Covered Charges
-0.0044 Difference
-22,744 Impact of Difference

Combined with #48 Macomb in 2008

-68,150 Total Impact 2005 - 2007

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Cost-Based Payment Factor Analysis

	Original HFR #13 SJ Riverview	Revised HFR #13 SJ Riverview	Actual #13 SJ Riverview	
2003 Actual Payment Ratio	[redacted] *	[redacted]	[redacted]	
2004 Update Factor	1.0335	1.0335	1.0335	2004 update factor
2004 Attested Price Increase	1.1079 **	1.1079 **	1.0900	2004 attested price increase
2004 Adjustment Factor	0.9328	0.9328	0.9482	2004 Adjustment Factor
2004 Payment Ratio	[redacted]	[redacted]	[redacted]	2004 Payment Ratio
PT/OT/ST Budget Neutral	0.0465	0.0465	0.0465	PT/ST/OT Budget Neutral
Revised 2004 Payment Ratio	[redacted]	[redacted]	[redacted]	Revised 2004 Rate 7/1/03 - 1/31/04
			1.0434	2/1/2004 Price Increase
			[redacted]	Revised 2004 Rate 2/1/04 - 6/30/04
2004 Settlement & Vouchering Rate	[redacted] *	[redacted]		0.0000 Difference
2004 Actual Payment Ratio	[redacted]	[redacted]		
2005 Update Factor	1.0340	1.0340		
2005 Attested Price Increase	1.0650 **	1.0396		
2005 Adjustment Factor	0.9709	0.9946		
Revised 2005 Rate	[redacted]	[redacted]		
2005 Settlement & Vouchering Rate	[redacted]	[redacted]		3,371,965 Cost-Based Contract Charges
				-0.0018 Difference
				-6,070 **Impact of Difference**
2005 Actual Payment Ratio	[redacted]	[redacted]		
2006 Update Factor	1.0380	1.0380		
2006 Attested Price Increase	1.0500	1.0500		
2006 Adjustment Factor	0.9886	0.9886		
Revised 2006 Rate	[redacted]	[redacted]		
Additional Reimbursement Increase per LC	1.0370	1.0370		
Final Revised 2006 Rate	[redacted]	[redacted]		
2006 Settlement & Vouchering Rate	[redacted]	[redacted]		3,162,282 Cost-Based Contract Charges
				-0.0019 Difference
				-6,008 **Impact of Difference**

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Cost-Based Payment Factor Analysis

	Original HFR #13 SJ Riverview	Revised HFR #13 SJ Riverview	Actual #13 SJ Riverview
2006 Actual Payment Ratio	0.0000	0.0000	
2007 Update Factor	0.0000	0.0000	***Hospital ceased providing IP services & some OP billed under Macomb #48***
2007 Attested Price Increase	0.0000	0.0000	
2007 Adjustment Factor	0.0000	0.0000	
Revised 2007 Rate	0.0000	0.0000	
Additional Reimbursement per LOU	0.0000	0.0000	
	0.0000	0.0000	
2007 Settlement & Vouchering Rate	0.0000	0.0000	0 Cost-Based Covered Charges
			0.0000 Difference
			0 Impact of Difference
2007 Actual Payment Ratio	0.0000	0.0000	
2008 Update Factor	n/a	n/a	
2008 Attested Price Increase	n/a	n/a	
2008 Adjustment Factor	n/a	n/a	
			-12,078 Total Impact 2005 - 2007

* = Traced to latest version of Cash Reconciliation.
** = Blended Attestation.

Exhibit S

HOSPITAL COMPENSATION STRATEGY

BACKGROUND

MISSION

BCBSM's original mission and purpose was to provide prepaid hospital and physician services to the people of the state of Michigan at an affordable cost. This is still at the core of our mission, with other health care services added and quality now also an added aspect.

BCBSM's current enabling legislation, Public Act 350 of 1980, states that the purpose of a nonprofit health care organization (of which BCBSM is the only one in the state) is to:

- promote an appropriate distribution of health care services for all residents of this state
- promote the progress of the science and art of health care in this state
- assure reasonable access to, and reasonable cost and quality of, health care services

HOSPITALS

BCBSM has built a strong base in its hospital coverage to achieve and assist in attaining these objectives.

- Network – We have a broad network of hospitals that covers as many communities and as large a geographic area as possible because every acute care, general hospital participates in our network. This broad network is possible because:
  - Partnership – MHHA substantially and comprehensively participates in the development and administrative oversight of the multi-year (currently 3 years) model contract for all hospitals which provides an equal starting point for each hospitals contractual relationship with BCBSM.
  - Stable Platform – The multi-year nature of the contract provides stability and predictability so that hospitals and BCBSM can plan and accurately anticipate finances and mutual behavior.
  - Strength – The breadth of the network strengthens the network by allowing BCBSM to continue to provide access to members even if an individual hospital deparicipates.

- Change Opportunities – The periodic re-opening and renegotiation of the contract allows hospitals and BCBSM to incorporate changes and enhancements to adapt financial arrangements to changing marketplace conditions and to introduce new processes to enhance and improve health care and the process by which it is delivered.

- Compensation
  - Peer Groups
    - Recognize variations in size, geographic community, academic role and specialty services through
  - Inpatient
    - DRG-based reimbursement
      - Recognizes intensity of care
      - Simplifies administration
      - Outliers are recognized and handled differently
    - DRGs and peer groups allow tailoring of price
    - Significant discount
    - Recognizes uncompensated care (e.g., bad debt, charity care)
    - Community improvement factor
  - Outpatient
    - Community-based pricing: base prices for payments for outpatient services will not be greater than BCBSM's base prices for non-hospital facilities and providers.
      - Passthroughs for bad debt, GME and capital expenses are included for current community-based priced services

IMPERATIVE FOR CHANGE

- Discount advantage on inpatient has been eroded by other payors
- Hospital systems present a challenge to network viability
- Hospital markets vary greatly and our current mechanisms do not allow us to address the differences most effectively; need to hospitals and communities more specifically than envisioned in current mechanisms
- Health system capacity and potential oversupply still an issue
- Specific types of services within a hospital may need different approaches than other services (e.g., ER)
- Linking compensation with quality of care is a step that is seen as necessary to continue to improve our position and differentiate us from competitors
- Use of certain services is greater than necessary for high quality and represents a cost reduction opportunity

STRATEGIC PHILOSOPHY & FRAMEWORK

VISION

BCBSM is recognized for its progressive leadership in developing competitively priced products that provide value and quality to customers. This leadership will be characterized by:

- Network Management
  - Maintain broad access to facilities and services balanced with quality and incentive and use management activities
  - Enhance steerage capacity
- Partnering for Value
  - Incentive programs that reward high quality service
- Medical Management
  - Use management programs for selected services will incorporate national/regional benchmark data to ensure more efficient operation of the health care system
- Value-based response to new technology
  - Recognize and compensate new technology based on its value
  - Adjust compensation and use management as technology matures
- Flexibility and responsiveness to market
  - Tailor compensation arrangements to hospital↔community needs
  - Quickly develop and implement management programs and compensation changes

CONSTRAINTS

Known constraints affecting this vision include:

- Want to keep a broad hospital network
  - Different markets and hospital↔community relations vary our opportunities
  - Some services are more important that others (ER)
- Want to keep our discount strength and enhance it as possible
- Current hospital contract provisions
- Current health care system capacity

To continue the strength of current network and compensation structure, to maintain and strengthen our competitive ability and to expand the value profile of our hospital coverage BCBSM needs to:

- keep its current network and compensation structures
- strengthen selected features to maximize their effectiveness and develop
- introduce new elements that build upon and complement the strengths we have now.

GENERAL FRAMEWORK

In realizing this vision, BCBSM must strike a balance between maintain key policies which have been critical to BCBSM's success to date and applying new policies which will enable BCSM to create enhanced and unique value that will ensure our continued market success into the future. To do this, BCBSM conceives a hospital compensation strategy that is generally constructed as follows:

1. Network – A hospital network that is broad based is necessary. Broad-based means:
   A. All hospitals will be asked to participate under the conditions of the model agreement.
   B. For hospitals that require/request exceptions or variations from the model agreement, individual circumstances will be assessed to determine the desirability/trade-offs of participating under variations from the standard contract. While having all hospitals in the network, it may not be possible if the requested conditions that are so at variance with BCBSM's basic practices, goals, objectives, or legal requirements that we would not be able to accommodate the conditions without violating our trust with other providers or with customers and members or our obligations under law, regulation or other contractual covenants.
   C. Steerage to higher-performing or better-performing hospitals should be accomplished through the development of consumer-oriented mechanisms applied correspondingly and progressively need to be developed and applied to help patients selected "preferred" providers.
2. Compensation – Fair compensation for appropriate services and appropriately-performed services is necessary to enhance the functioning of health care system in servicing the people of the state.
   A. Compensation methodologies may vary depending on the necessity/emergency nature of the service or on whether the service is also available from non-hospital, non-acute-care providers.
3. Performance Trends – Mechanisms/structures which promote movement toward increasing the overall quality of service through paying for performance and through monitoring performance to benchmark are important and necessary to not only control cost and use while improving

quality but also to respond effectively to competitors' actions and customers' demands/expectations.

A. Paying appropriately and proportionately for desired performance should be built into all aspects of BCBSM's relationships with providers.

B. Additionally, performance standards or benchmarks based on national/regional/academic/clinical best practices should be incorporated into programs that encourage/require providers to improve their behavior and practice in ways more consistent with the standard.

4. Capacity – Excess capacity causes overpayment even when compensation and reimbursement policies pay on a fixed-price basis. Overpayment is caused through overutilization and inappropriate use of inappropriate resources. Activities and behaviors which limit overcapacity are needed to promote a more rational operation and development of an effective health care system in Michigan.

STRATEGIC AGENDA

GUIDELINES

1. Network – The model contract provides a useful basic document for most arrangement between BCBSM and hospital, though variations are necessary in certain instances. The process for this and the outcomes need increased standardization or monitoring as hospitals evolve and react to markets.

   A. Variations to the model contract – Variations to the model contract are necessary to react to the healthcare market and economic conditions, maintain the integrity of the network and provide adequate coverage to members. What kinds of changes are acceptable (type, number, size, etc.) requires closer management to ensure the hospital network is appropriately managed and to adequately monitor and track the effects of the variations.

   B. Steerage – Consumer-oriented mechanisms applied correspondingly and progressively need to be developed and applied to help patients selected "preferred" providers.

2. Compensation – Fair compensation for appropriate services and appropriately-performed services is necessary to enhance the functioning of health care system in servicing the people of the state.

   A. For services necessary to the community, BCBSM should pay a fair price but not more than a fair price. Market and hospital⇔community relations will play a role in this determination.

   B. Payment amounts and compensation structures should cover costs, encourage improvement and narrow the range of inefficiencies.

   C. Community pricing, using the same base fees as are used for other non-hospital providers of service in the community and without passthroughs,

should be applied and expanded to as many applicable services as possible.

D. For services that only hospitals typically offer, compensation should be structured on a fixed-price basis rather than a cost-basis or a percent-of-charge basis.

E. Inpatient compensation: BCBSM's average payment per admission for each individual hospital will be equal to or lower than all commercial insurers.

3. Performance Trends – Movement toward increasing the overall quality of service through paying for performance and through monitoring performance to benchmark

   A. Pay for Performance

      1. Enhance current incentive payment programs by incorporating national/regional benchmarks.

      2. Use the benchmarks as standards of comparison for price and for use

      3. Develop pay for performance applications for all peer groups

   B. Use Management

      1. Establish programs that provide appropriate service-specific use benchmarks for comparison and/or for use in pay for performance programs

4. Capacity – Excess capacity causes overpayment even when compensation and reimbursement policies use fixed prices through overutilization and inappropriate use of inappropriate resources.

   A. Hospital and other facility and facility service overcapacity should be especially focused on.

   B. Hospital acquisition/backing/development of physician or other practices also contributes to the problem.

ACTIONS

1. Network

   A. Variations/exceptions to model contract

      1. Establish parameters/guidelines/confidence intervals/rules of thumb for variations/exceptions to be made to standard model contract

         a. Dollar impact, percentage or total dollars, should be a primary area of guideline development

         b. Specific, special, unique or other services needed by the community might be reasons for exceptions

2. Establish a body/committee/designated group to provide guidance/direction/oversight/approval to proposed variations/exceptions

    a. Composition of group to be determined, partly in consideration of the issues addressed in the guidelines for exceptions

B. Steerage mechanisms should be explored and assessed for greatest impact

2. Compensation

A. Inpatient

1. Adopt and implement the most current version of refined DRG system currently used by Medicare.
2. Conduct a comparative analysis of the effectiveness of DRGs versus per diem reimbursement in controlling use rates for inpatient rehabilitation services.
3. Conduct a feasibility study on converting PG 5 hospitals from percent of charge to DRG reimbursement
4. Re-evaluate the appropriateness of the operating cost components and passthrough factors that comprise the DRG payment for PG 1-4 hospitals.
5. Consider incorporating catastrophic costs into DRG rates
6. Exclude from year end reconciliation, short stays (one day) reimbursed charges rather than a DRG.
7. Develop an appropriate compensation structure to recognize the high cost of new technology.

B. Outpatient

1. Establish pure community prices (base price without passthroughs) for the following commodity outpatient services: laboratory, radiology, physical therapy, all surgeries except those designated hospital based, specialty pharmacy and selected oncology services.
2. Community price all other services that are also provided by non-hospital providers
3. Establish fixed prices for services that are unique to hospitals including observation beds and emergency room services.

3. Performance Trends

A. Introduce regional and national cost PMPM benchmarks for efficiency measure.

1. Introduce regional cost PMPM benchmarks into BCBSM's 2008 efficiency measure.

2. Expand the factors used to calculate efficiency in 2008 to include short-stay admissions and admissions from the ER

B. Identify measures for assessing quality and use them in incentive payments at an appropriate weight.

1. Add angioplasty for AMI patients as a seventh measure for calculating incentive payments in 2008.

C. Identify programs that improve and enhance quality and use them in incentive payments at an appropriate weight.

1. Expand the number of hospitals that can participate in CQI-based incentives by eliminating the "all or nothing" prequalifying criterion in 2008.

D. Apply pay for performance principles to as many hospitals as possible.

1. PG5 hospitals will have to meet specific quality and utilization thresholds to receive their full reimbursement rates.

4. Capacity

A. State-level CON programs should be participated in to the fullest

B. BCBSM EON programs should be researched and established for selected services or provider types if cost-benefit analyses justify them

Exhibit U

Blue Cross
Blue Shield
of Michigan

27000 W. Eleven Mile Road
Southfield, Michigan 48034

March 31, 2009

Mark Johnson
Senior Vice President of Business Development
and Revenue Management
William Beaumont Hospital - Royal Oak
3601 West 13 Mile Road
Royal Oak, Michigan 48073

Re: Letter of Understanding

Dear Mark:

I am enclosing a copy of the countersigned Letter of Understanding that applies to Beaumont Hospitals' BCBSM Participating Hospital Agreement (PHA), TRUST Hospital Agreement, and Blue Care Network (BCN) Hospital Affiliation Agreement.

Thank you for your continued participation in these networks.

Sincerely,

Eric Kropfreiter
Senior Analyst
Provider Contracting

William Beaumont Hospitals and Blue Cross Blue Shield of Michigan Participating Hospital Agreement, TRUST Hospital Agreement and Blue Care Network Hospital Affiliation Agreement Letter of Understanding

This Letter of Understanding (LOU) amends and supplements certain provisions of the Blue Cross Blue Shield of Michigan (BCBSM) Second Amended and Restated Participating Hospital Agreement (PHA), the BCBSM Second Amended and Restated TRUST Hospital Agreement (TRUST Hospital Agreement), and the Blue Care Network (BCN) Hospital Affiliation Agreement (BCN-HAA) for non-Medicare members. This LOU is entered into by and between BCBSM, and William Beaumont Hospital (BH) on behalf its member hospitals (Hospitals). BH, BCBSM, and BCN are also collectively referred to in this LOU as "the Parties".

The PHA, TRUST Hospital Agreement, and BCN-HAA are hereinafter referred to as the "Standard Agreements". If any provisions of the LOU conflict with the terms and conditions of the Standard Agreements, the terms and conditions of the LOU shall prevail. Unless otherwise specified in this LOU, all other terms and conditions of the Standard Agreements, as they may be modified from time to time, will apply. As referenced in this LOU, the term "standard" means the agreement on file with the Michigan Office of Financial and Insurance Regulation (OFIR) which is in effect on the date of admission or outpatient service.

The provisions of this LOU shall apply to the BH member hospitals listed below:

Member Hospital	Facility Code
• William Beaumont Hospital - Royal Oak (RO)	00196
• William Beaumont Hospital – Troy (Troy)	00226
• William Beaumont Hospital – Grosse Pointe (GP)	00265

This LOU excludes services provided to BCBSM and/or BCN members that are subject to a separate agreement between Hospitals' and a third-party vendor (e.g., mental health carveouts, Joint Venture Hospital Laboratories, etc.). Hospitals will accept reimbursement for services covered by such separate agreements from the applicable third-party vendor in accordance with Hospitals' contract with the vendor.

Model Reimbursement Methodology (MRM), as used in this LOU, refers to the reimbursement provisions described in Exhibit B of the PHA. All references to the "standard update factor" refers to the standard MRM update factor applicable to hospitals whose reimbursement arrangements comply with the methodology specified in the PHA. All references to the "standard Pay-for-Performance program" refers to the standard MRM Pay-for-Performance program applicable to hospitals whose reimbursement arrangements comply with the methodology specified in the PHA.

As referenced in this LOU, fiscal year (FY) refers to the 12-month accounting period which begins January 1 and ends December 31.

I. **Prior Agreements**

This LOU, together with the Standard Agreements, shall supersede any and all prior agreements and understandings between the Parties, whether written or oral, regarding the matters herein, and shall constitute the entire agreement and understanding between the Parties.

II. **Term and Termination**

The provisions of this LOU shall be effective as of January 1, 2009, and shall continue for 36 months until December 31, 2011, for the Royal Oak and Troy hospitals, and for 48 months until December 31, 2012, for the Grosse Pointe hospital. The LOU may be terminated by either Party with one hundred twenty (120) days written notice unless both Parties agree to a date sooner than one hundred twenty (120) days, or unless there is a material breach, that is capable of cure, which remains uncured after 30 days notice to the breaching Party. Termination of the LOU does not terminate BH Hospitals' Standard Agreements. The terms and provisions of this LOU pertaining to each Hospital will terminate immediately in the event such Hospital's Standard Agreements are terminated (e.g., unable to meet BCBSM participation qualification standards) or if Hospital ceases to be owned or controlled by BH.

III. **Amendment**

This LOU may be amended only upon written agreement of the Parties. In the event that unforeseeable circumstances occur which materially affect the intent of this LOU, the Parties agree to make a good faith effort to resolve such matters in a timely manner. Any resulting modifications or clarifications to this LOU will be evidenced by a written agreement signed by both Parties.

IV. **PHA Reimbursement Provisions for Members' Covered Services**

A. **Product Migration**: For RO and Troy, the Parties agree to negate the impact of "product migration" (the upward shift from Members enrolled in BCBSM's Traditional product to BCBSM's PPO/POS and BCN's HMO products) so that BCBSM/BCN product migration will no longer be an issue requiring additional reimbursement consideration since the inpatient payment rates used for final settlement will be the same for all products. The Parties agree to establish blended PHA/TRUST/BCN rates using each Hospital's 2008 fiscal year DRG/Per Diem PHA prices and 2007 fiscal year utilization as the basis. Once the blended DRG/Per Diem operating and capital prices are determined, they will be updated in accordance with B. and C. below of this same Section.

B. **PHA Inpatient and Outpatient Annual Updates** [redacted]

C. **PHA Inpatient and Outpatient Reimbursement Provisions:** For the 2009 fiscal year:

1. RO and Troy: RO's and Troy's reimbursement rates will be based on the rates determined in Section A above and updated as indicated in Section B above, and then adjusted based on the implementation of the Market-based pricing initiative.

2. GP: GP's reimbursement rates will be based on the rates that were effective for FYE 2008 and updated as indicated in section B, above, and then adjusted based on the implementation of the Market-based pricing initiative.

V. **TRUST Reimbursement Provisions for Members' Covered Services**

A. **TRUST Inpatient Reimbursement Provisions:** For the 2009 fiscal year, and all subsequent fiscal years covered by this LOU, inpatient admissions for Covered Services reimbursed under the TRUST Hospital Agreement for RO, Troy and GP will be reimbursed at 100% of each Hospital's PHA level of reimbursement determined under this LOU (i.e., DRG settlement price). BCBSM may, however, adjust each Hospital's DRG rate in order to voucher a discount for services provided to TRUST members (e.g., vouchered at 90% of PHA). This adjustment, if any, is for claim processing purposes only. Each Hospital's aggregate inpatient DRG reimbursement will not be affected by a discount for product differentiation. Each Hospital's aggregate inpatient reimbursement will be settled based on the rates and methodologies described in the PHA and determined under this LOU (i.e., 100% of the PHA level of inpatient reimbursement used for final BCBSM settlement).

B. **TRUST Outpatient Reimbursement Provisions**: For the 2009 fiscal year, and all subsequent fiscal years covered by this LOU, Outpatient Covered Services reimbursed under the TRUST Hospital Agreement for RO, Troy and GP will be reimbursed at 100% of each Hospital's PHA level of reimbursement determined under this LOU (i.e., vouchered and settled at 100% of the PHA level of outpatient reimbursement used for final BCBSM settlement).

VI. **BCN Reimbursement Provisions for Members' Covered Services**
For the 2009 fiscal year, and all subsequent fiscal years covered by this LOU, inpatient admissions and/or outpatient Covered Services that are reimbursed under the BCN-HAA will be reimbursed at 100% of each Hospital's TRUST level of reimbursement determined under this LOU.

VII. **Catastrophic Cases:** For the term of this LOU, each Hospital shall remain eligible for additional catastrophic payments in accordance with the standard PHA and/or TRUST catastrophic payment reimbursement methodology, however, for RO and Troy only inpatient admissions with charges for Covered Services equal to or greater than [redacted] will be eligible for additional catastrophic payment.

VIII. **Uncompensated Care**

A. RO and Troy: [redacted] Consequently, for the term of this LOU, and on a fiscal year beginning basis, [redacted]

B. GP: Given that GP's reimbursement arrangement complies with the MRM, for the term of this LOU, and on a fiscal year beginning basis, [redacted]

IX. **Pay-for-Performance (P4P)**

[redacted] (i.e., same as hospitals classified as having accepted the MRM) subject to the following provision. For the January 1, 2009 through June 30, 2009 period, [redacted] Effective July 1, 2009, the [redacted]

X. **Rebasing**

[redacted] Regarding rebasing:

- RO and Troy will go through the rebasing process; however, they will be exempt from the implementation of rebased prices.
- GP will be [redacted] except that the additional patient service volume levels realized in FYE 2008 will be substituted for the 2007 base year utilization.

XI. **Other Provisions**

A. Reiteration of LOA: The Parties agree that the reimbursement rates that result from the provisions of this LOU incorporate financial consideration for the issues resolved by a Letter of Agreement (LOA) executed between the Parties in January, 2008 (e.g., pharmacy, COB, cardiac stents, etc.), these identical issues will not be negotiable during the term of this LOU.

B. Policy and Procedure Changes: During the term of this LOU, and upon notification by BH, if BCBSM or BCN institute unilateral reimbursement and/or operational changes that have an adverse material financial impact to BH Hospitals, the Parties agree to evaluate whether their mutual interests would be best served by modifying this LOU. Any resulting modifications to this LOU shall be made in writing and approved by both Parties..

C. BH agrees they will no longer pursue any additional payment related to any changes in the BCBSM Home Infusion Therapy HIT reimbursement rate and/or methodology that have been enacted prior to the effective date of this LOU.

D. Notification of Charge Increases: Each Hospital agrees to comply with [redacted] Each Hospital also agrees to immediately notify BCBSM of material charge increases that may occur during the course of the fiscal year. In the event BCBSM discovers upon retrospective review that the effective charge increase due to the changes in Hospital's charge master structure was greater than the charge increase(s) attested to, BCBSM reserves the right to recover the amount of reimbursement in excess of the attested charge increase as well as to immediately adjust Hospital's overall payment ratio for all services reimbursed on a percent of charge basis downward to mitigate continued overpayments for these services.

E. Administrative Price Adjustments: [redacted] BCBSM agrees to implement such price adjustment(s) during the first year of implementation in a "budget neutral" manner (i.e., the financial impact does not result in a material increase or decrease in Hospital's reimbursement) and that the established prices will be the basis for subsequent year updates.

F. Most Favored Discount: Beaumont Hospitals continue to guarantee that the discount represented in the BCBSM/BCN payment rates exceed the discount offered to other significant non-governmental payors to the same degree as existed in February 2006 when this discount differential was first formalized. Significant non-governmental payors is defined as a payor whose charges exceed 1.0% of BH's total gross patient service charges. The estimated differential is minimally ten percentage points. That is, is the overall BCBSM/BCN payment rate equals 35% of charges, the next best discount offered to a non-governmental payor would be 55% (i.e., they pay 45% of charges).

Upon signature, this LOU constitutes a legally binding agreement between BH, on behalf of all of its member Hospitals, and BCBSM. BH, its member Hospitals, and BCBSM will maintain the confidentiality of this LOU and will not disclose this LOU, or the contents of this LOU to any person or entity other than their agents, employees, or representatives who have a need to know. BH, its member Hospitals, and BCBSM will require their respective employees, agents or representatives to be bound by this provision. BH, on behalf of its member Hospitals, and BCBSM hereby agree to the terms of this LOU as evidenced by the signatures below.

William Beaumont Hospitals

AUTHORIZED REPRESENTATIVE

Mark Johnson
NAME (Print or Type)

Senior Vice President of Business Development & Revenue Management
TITLE

3/27/09
DATE

Blue Cross/Blue Shield of Michigan

AUTHORIZED REPRESENTATIVE

Kim Sorget
NAME (Print or Type)

Vice President, Provider Contracting and Network Administration
TITLE

3/30/09
DATE

Eff 01-10-09 Beaumont LOU v2 12-17-08

Exhibit V

Confidential

Blue Cross
Blue Shield
of Michigan

27000 W. 11 Mile Rd.
Southfield, Michigan 48034

April 30, 2007

CERTIFIED MAIL

Gerald J. Barbini
President & Chief Executive Officer
Allegan General Hospital
555 Linn Street
Allegan, MI 49010-1594

Subject: Revisions to the BCBSM Participating Hospital Agreement and BCBSM TRUST Participating Hospital Agreement

Dear Gerald J. Barbini:

The purpose of this letter is to notify you of changes to the reimbursement methodology for Peer Group 5 hospitals, as well as contract language revisions to the BCBSM Participating Hospital Agreement and BCBSM TRUST Participating Hospital Agreement. The revised agreements are effective for hospital fiscal years beginning on or after **July 1, 2007**, pending filing with the Michigan Office of Financial and Insurance Services.

The Participating Hospital Agreement Advisory Committee recommended the changes March 15, 2007. BCBSM developed these changes following input from our customers, hospitals and the Michigan Health & Hospital Association. We've provided periodic updates about the process to you through various communications. The BCBSM board approved these changes at their April 25th meeting; therefore, this letter is your official notification of the revised contract. We've included a summary of pertinent language and reimbursement changes.

We've enclosed the following documents to aid in your review of the changes:

- Table 1 summarizes contract language changes and Peer Group 5 hospital reimbursement changes to the Participating Hospital Agreement.
- Table 2 summarizes Peer Group 5 hospital reimbursement changes to the TRUST Participating Hospital Agreement.
- Strike-over and clean versions of pages i, 4, and 10 of the PHA.
- Strike-over and clean versions of Exhibit B of the PHA.
- Strike-over and clean versions of Exhibit B of the TRUST Participating Hospital Agreement.

Please keep these documents for your records. All changes will automatically apply to all hospitals and **no signature is required**.

If you have any question regarding these changes, please feel free to call me at 248-448-3905 or e-mail me at DDarland@bcbsm.com. You can also contact one of the following BCBSM staff members: Gerald Noxon at 313-983-2577 or GNoxon@bcbsm.com or Eric Kropfreiter at EKropfreiter@bcbsm.com.

We look forward to working with you under the revised PHA and TRUST Participating Hospital Agreement, and we thank you for your continued support.

Sincerely,

Douglas E. Darland, Director
Hospital Contracting

Enclosures

Blue Cross Blue Shield of Michigan

SECOND AMENDED AND RESTATED

PARTICIPATING HOSPITAL AGREEMENT

Revised – July 1, 2007

Master Index

This Agreement is proprietary and confidential. Exhibit B of this Agreement can be released to Hospital's agents, contractors or consultants only if these parties sign a statement agreeing not to disclose the Agreement to third parties. Hospital cannot disclose Exhibit B to any other third parties without the prior written consent of BCBSM.

15. [redacted]

Article II
Hospital Responsibilities

1. General Responsibility of Hospital to Members. Hospital will provide Covered Services to Members which are ordered by a licensed physician or other health care professional in the same manner and quality within the same time frames as those services provided to all other Hospital patients. Hospital shall not be required to provide any Covered Services that it does not customarily provide to others. Hospital will not deny admission or fail to provide Covered Services to any Member by virtue of the Member's BCBS coverage or discriminate against a Member because of his or her status as a Member.

2. Limited Responsibility of a Non-Network Hospital. A Non-Network Hospital, within the limitations of its scope of services, shall provide services to Members in exchange for payment by BCBSM as follows:

   a. For Members that utilize the TRUST hospital network or another hospital network open to all hospitals throughout the State that meet the applicable network qualification standards, BCBSM shall pay Hospital the lower of

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4. [redacted]

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. [redacted] (Exhibit B, Section III, H).

6. [redacted]

7. [redacted]

Using the above principles as a guide, BCBSM has developed a Model Reimbursement Methodology for hospitals [redacted] Key elements of this model are described below:

B. Foundational Payment Model

The following payment model is the basis for the BCBSM hospital Model Reimbursement Methodology:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

- [redacted]
- [redacted]

[redacted]

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C. [redacted]

[redacted]

3. [redacted]

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[redacted]

D. [redacted]

[redacted]

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Margin Levels

Hospitals Comprising Stated Percent of Full-GAAP Costs	Margin
[redacted]	[redacted]

5. [redacted]

6. [redacted]

E. Inpatient Payment

1. [redacted]

[redacted]

[redacted]

[redacted]

a. [redacted]

[redacted]

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c. [redacted]

d. [redacted]

e. [redacted]

f. [redacted]

g. [redacted]

h. [redacted] (Exhibit B, Section III, G).

i. [redacted]

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j. [redacted]

F. [redacted]

[redacted]

c. [redacted]

[redacted]

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[redacted]

2. [redacted]

[redacted]

3. [redacted]

G. [redacted]

[redacted]

a. [redacted]

[redacted]

c. [redacted]

d. [redacted]

[redacted]

[redacted]

2. [redacted]

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[redacted]

H. System Assessment and Recalibration

[redacted]

1. [redacted]

Degree of Change	Action Options
[redacted]	[redacted]

2. [redacted]

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IV. [redacted]

[redacted]

A. Inpatient Rates.

1. [redacted]

B. Outpatient Price Updates.

1. [redacted]

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2. [redacted]

[redacted]

[redacted]

C. Capital Prices.

[redacted]

V. Peer Group 5 Hospitals

A. Reimbursement Principles

[redacted]

3. [redacted]

B. Foundational Payment Model

The following payment model is the basis for the BCBSM Peer Group 5 hospital Model Reimbursement Methodology (MRM).

This is an illustration of the payment model only, given that many components are hospital specific.

[redacted]

(1) [redacted]

(3) [redacted]

[redacted]

C. Model Reimbursement Methodology Analysis and Implementation

[redacted]

b. If the MRM yields a decrease of less than or equal to ten points, or a decrease greater than ten points but with an operating margin less than 3 percent, the hospital's rates will be frozen until application of the standard annual update process brings the hospital's rates in line with the MRM. However, a freeze will only be allowed if the hospital is in compliance with the Most Favored Discount provision of this Section.

2. If the application of the MRM results in an ***increase*** in reimbursement rates, then the following will be applied.

a. [redacted]

b. Increases will only be allowed if the hospital is in compliance with the Most Favored Discount provision of this Section.

c. [redacted]

3. If the operating margin from the most recently available Audited Financial Statements is greater than 5 percent then, regardless of the results of the MRM, rates will be decreased to a level no greater than 125 percent of full GAAP cost, subject to the following.

a. If the hospital is in compliance with the Most Favored Discount provision of this Section, the maximum decrease in a single year will be 5

percentage points. If a greater discount is afforded to another private payor, a minimum decrease of 5 percentage points will be applied, and

b. The decrease will be limited to the extent that the change will not bring the hospital operating margin below the 3 percent level.

D. Other Implementation considerations and restrictions

1. PG 5 Hospital Risk Factor - BCBSM will consider a low volume adjuster if a hospital's utilization decreases by over 5 percent in any given year. The trigger for the utilization decrease would be measured by Equivalent Inpatient Admissions (EIPAs). For example, this would translate to a decrease of 300 EIPAs, assuming 6,000 EIPAs in the base year. Meeting this threshold would result in a corrective payment adjustment being added to the subsequent years' rates to assure adherence to the MRM principles. Payments will not be retroactive. This additional payment adjustment will be made only if the hospital is in compliance with the Most Favored Discount provision of this Section and the hospital operating margin is less than 3 percent. Decreases in EIPAs related to the discontinuation of a service will not be included in the calculation.

2. [redacted]

3. [redacted]

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4. [redacted]

5. [redacted]

6. Hospitals with annual BCBSM/BCN payments less than $3 million may be exempt from the MRM as long as they are in compliance with the Most Favored Discount provision of this Section. The $3 million level is based on 2006 BCBSM/BCN reimbursement and will be indexed annually based on the BCBSM annual update factor process.

E. Pay for Performance

[redacted]

F. Most Favored Discount

Hospital will attest and commit that the payment rates which it has provided to BCBSM under this Agreement for non-Medicare members are at least as favorable as the rates which it has established with all other non-governmental

PPOs, non-governmental HMOs or other non-governmental commercial insurers. On an annual basis, an officer of the Hospital, together with the Hospital's CPA will provide an attestation that the payment rate given BCBSM meets the terms of this provision. If such attestation from the Hospital's CPA proves to be prohibitively expensive, an alternative approach may be considered. Should BCBSM determine that there is a potential violation of this provision, it may engage an independent third-party auditor to review and audit Hospital's financial records to ascertain whether there has actually been a violation. If a violation of this Section has occurred, BCBSM reserves the right to recover the amount of excess reimbursement as well as to immediately adjust Hospital's reimbursement rates to mitigate continued overpayments.

This Section shall become effective no later than Hospital's fiscal year which commences on or after July 1, 2009. Failure to comply with the terms of this Section will result in Hospital not being afforded the PG 5 MRM, but instead, Hospital will only be entitled to reimbursement as a PG 4 Hospital.

Failure of Hospital to provide the attestation required pursuant to this Section will result in no increases in reimbursement rates under the PG 5 reimbursement MRM, if any such increase is warranted. Reimbursement rates will not be increased retroactively but will only apply to payments on a prospective basis.

G. Annual Update Process.

[redacted]

H. Non-Acute Services.

[redacted]

I. Transition Hospitals.

[redacted]

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[redacted]

1. [redacted]

2. [redacted]

[redacted]

J. Physician Expense

[redacted]

K. Shortfalls and Gross-Ups

[redacted]

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1. [redacted]

VI. Peer Group 6 and 7 Hospitals

[redacted]

VII. Alternative Reimbursement Arrangements

[redacted]

VIII. Reporting Information

Hospitals must submit the following information to BCBSM annually:

- [redacted]

Exhibit W

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

UNITED STATES OF AMERICA and the STATE OF MICHIGAN,	
Plaintiffs,	Civil Action no.: 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. 2:11-cv-15346-DPH-MKM
v.	
BLUE CROSS BLUE SHIELD OF MICHIGAN,	
Defendant.	

Troy, Michigan

Monday, October 8, 2012

Confidential Video Deposition of:

FREDERICK SCHAAL,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 201 West Big Beaver Road, Suite 500, Troy, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:10 a.m., when were present on behalf of the respective parties:

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Q Is that the idea that you've also mentioned, that Peer Group 5 hospitals have to have fewer than 100 licensed beds?
A Yes.
Q The next line says "6,000 Equivalent Admissions." And then "Takes into account outpatient volume." Do you see that?
A Yes.
Q What does that refer to?
A That refers to the number of admissions the hospital has each year.
Q Does that mean that Peer Group 5 hospitals have to have 6,000 equivalent admissions?
A No.
Q Fewer than 6,000 equivalent admissions?
A Fewer than 6,000.
Q Okay. The next bullet says "Full service, including emergency department." Do you see that?
A Yes.
Q Does that mean that Peer Group 5 hospitals have to have an Emergency Department?
A Yes.
Q And what does "full service" refer to?
A Providing a full range of services.
Q Are there types of services that you would

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consider in the full service?
A Yes.
Q What types of services?
A Emergency room, inpatient, outpatient, x-ray.
Q Anything else?
A Those are what come to mind.
Q The next bullet says "BCBSM discount at least as favorable as other nongovernmental payors." Do you see that?
A Yes.
Q What does that refer to?
A Saying that the rates need to be as favorable as other payers other than governmental.
Q And just so this is clear, "BCBSM" refers to Blue Cross Blue Shield of Michigan?
A Yes.
Q And is this sentence what -- strike that.
Is this saying that Peer Group 5 hospitals have to give Blue Cross Blue Shield of Michigan a reimbursement rate that is either less than or equal to the rate that other non-governmental payers receive at that hospital?
A Yes.
Q Is that -- are you familiar with the term "most favored nation clause"?

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A Yes.
Q What do you understand most favored nation clause to be?
A That Blue Cross has a discount at least as favorable as other non-governmental payers.
Q And is it okay if today I use the term "MFN" to refer to a clause that requires that Blue Cross Blue Shield of Michigan receive either the same or less -- or lower reimbursement rate than other non-governmental payers at that hospital?
A Yes.
Q Okay. When was the first time that you learned that there was an MFN requirement for a Peer Group 5 hospital?
A January 1st, 2010.
Q And that would be around the time that you started to become responsible for contracting for traditional, TRUST, and BCN products?
A Yes.
Q Who told you about the MFN requirement for PG 5 hospitals?
A I read it in the contract.
Q Is there one contract for Peer Group 5 hospitals?
A No.

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Q Which contract did you read the MFN requirement in?
A The PHA contract.
Q And what is the PHA?
A Participating Hospital Agreement.
Q And who does the contract -- the PHA bind?
A All hospitals.
Q All hospitals in Michigan?
A Yes.
Q And is there an MFN requirement for all hospitals in Michigan?
A No.
Q Is there an MFN requirement for all PG 5 hospitals in Michigan?
A Yes.
Q And is that clause in the PHA?
A Yes.
Q So you first learned of the MFN clause that applies to PG 5 hospitals when you read the PHA?
A Yes.
Q Did you discuss the MFN requirement with anyone at Blue Cross?
A No.
Q Did you ask anyone why there was an MFN requirement in the PHA as it applies to PG 5 hospitals?

Exhibit X

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

UNITED STATES OF AMERICA and the STATE OF MICHIGAN,	
Plaintiffs,	Civil Action no.: 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. 2:11-cv-15346-DPH-MKM
v.	
BLUE CROSS BLUE SHIELD OF MICHIGAN,	
Defendant.	

Troy, Michigan

Monday, October 8, 2012

Confidential Video Deposition of:

FREDERICK SCHAAL,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 201 West Big Beaver Road, Suite 500, Troy, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:10 a.m., when were present on behalf of the respective parties:

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A Okay.
Q For those three Peer Group 5s you've identified, why did you negotiate with each of them?
A Because they had an issue that they wanted addressed, so we discussed those issues, and the end result was a Letter of Understanding.
Q So is it your testimony that in each of those three cases the hospital came to you asking to negotiate something?
A Yes.
Q And within the framework of the PHA, how much latitude do you believe you have to do Letters of Understanding? What can you put in one?
A I do have the latitude to do a Letter of Understanding, and I can put into a Letter of Understanding financial terms.
Q What does that mean, when you say "financial terms," please?
MR. GILMAN: I just want to -- I don't think he had finished his answer.
BY MR. SANDBERG:
Q I'm sorry. If I cut you off, I'm sorry.
MR. GILMAN: Yeah.
THE WITNESS: I did not understand the question or --

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MR. GILMAN: Had you finished your answer? You said you could put in -- you said, "...I can put into a Letter of Understanding financial terms." I thought you were going to keep going.
THE WITNESS: And then any other terms that may be a remedy for the issue that they're facing.
BY MR. SANDBERG:
Q When you say "financial terms," what do you mean, please?
A It could be a change in reimbursement.
Q And how would you drift away from the PHA's formula for reimbursement?
A If the hospital came to me and said they had a financial issue or any type of issue that was impacting our relationship, we would be open to sitting down and talking about it; and if the end result was a LOU, that's what it would be.
Q Is there some threshold that a hospital would have to present to you to get you to create a Letter of Understanding?
A If a hospital sends me anything, I always look at everybody's issues. If it is an issue around financials or reimbursement, then I do entertain those discussions.
Q Were each of the three LOUs you did with PG 5

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hospitals financial issues?
A Yes.
Q Was there anything else besides financial issues in those three?
A No.
Q You also, I think, identified four non-PG 5 hospitals that you negotiated with over that same almost three-year period; is that correct?
A That's correct.
Q Is there a different process with those, compared to the PG 5s?
A Yes.
Q Please explain the difference.
A The process with Peer Group 1 through 4s, for those who have a LOU that expires, you have to sit down and negotiate a new arrangement with them or the agreement defaults back to the PHA.
Q And was that the case for all four of those hospitals, they had an expiring LOU?
A Yes.
Q Do you think you have any different range of discretion in working with a Peer Group 1 through 4 hospital than a Peer Group 5?
A No.
Q And, again, did each -- well....

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Other than an expiring LOU, has a Peer Group 1 through 4 hospital come to you with a request to make a change in their agreement?
A Yes.
Q Which one was that -- or ones? I don't mean to....
A Recently Hurley Medical Center.
Q And what was that about, please?
A They were looking for more money.
Q As hospitals sometimes do?
A That's usually why they call.
Q Anybody else you can think of?
A I would -- I believe from my hospitals, that would be the only, what we call off-cycle hospital that's contacted me.
Q And you, I think, used the word "recently." Do you know when that happened?
A End of the summer, this summer.
Q So in the last two or three months?
A Yes.
Q Have those negotiations taken place?
A Yes.
Q Are they done?
A No.
Q What -- in fact, is that hospital asking for a

Exhibit Y

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 What does that paragraph mean to you?
A Well, at that time, the Metropolitan -- **13:27:45**
Michigan Hospital Association, which does the overview for the contract language, was in their deliberations with Blue Cross. Blue Cross had that proposal in a most favored nations clause.
We did talk about that, not knowing the **13:27:59**
specifics of what the percentage or what the gap would be, that we would try to resist any most favored nation clause because that would -- that might curtail our ability to move some business.
So we didn't know what the facts were or **13:28:12**
the specifics were, but we objected to a most favored nation clause, period, so that we at least have the leverage or the ability to leverage our other payers against Blue Cross. But that was being done at the Michigan Hospital Association level, not necessarily at **13:28:27**
our negotiating level at that point.
Q And how would -- you said a most favored nation clause might curtail our ability to move some business. How might a most favored nation clause curtail your ability to move business from Blue Cross? **13:28:51**
A Well --
MR. STENERSON: Object to the form, incomplete hypothetical.

THE WITNESS: In its extreme, they could be onerous enough so that we wouldn't be able to reduce the discount enough or increase the discount enough to the other payer for them to spend the money to try to move the business. It could do that. **13:29:00**

We didn't have any specifics of it, if it was a 5 percent, a 10 or 20 or 30, whatever the number was, we didn't have any of that, but just the notion of a most favored nation clause gives Blue Cross more power than they already have, and we just object to that just on the surface. You know, they have enough bargaining power as it is. I don't want any more. **13:29:13** **13:29:28**

BY MR. LIPTON:

Q Can you give me an example of what an extreme or an onerous most favored nation clause might be?

A It --

MR. STENERSON: Object to the form. **13:29:35**

THE WITNESS: It depends on the other contracts. If the other contracts -- now, this is hypothetical -- was at 15 percent of the Blue Cross rates already, and they imposed a 20 percent, the floor, on the MFN, then I would have to renegotiate all the other contracts, thereby causing me maybe to lose some of that business, so it could be that onerous. **13:29:50**

But we didn't even want to take the

chance of even having the clause in there. I don't want that restriction in there to begin with. **13:30:04**

BY MR. LIPTON:

Q How would --

MR. DEMITRACK: Could we go off the record for a minute?

VIDEOGRAPHER: The time is now 1:29 -- **13:30:11**

MR. LIPTON: Can I finish? I have one more follow-up question on this.

MR. DEMITRACK: Okay. I just wanted to get some coffee.

MR. LIPTON: Could we go back on the record for just one second.

VIDEOGRAPHER: We're on the record.

MR. LIPTON: I'm sorry?

VIDEOGRAPHER: We never went off.

BY MR. LIPTON: **13:30:22**

Q Okay. Just one more follow-up question.

You mentioned a most favored nation clause from Blue Cross potentially giving Blue Cross more power than they already have. What did you mean by that? **13:30:30**

A Well --

MR. STENERSON: Object to the form, incomplete hypothetical.

THE WITNESS: -- Blue Cross, because of their size and their relationship with industry and businesses, they already had a significant amount of power. **13:30:34**

Putting this clause in the Blue Cross contract for all hospitals meant that that just gave them more power or restricted our ability to maneuver against them if we chose to do so, even more. **13:30:48**

And, again, we didn't know -- we didn't know at the time what the number was on it. It's just you're putting another restriction in our contract that says I can't do anything to remove business from Blue Cross and maybe put it into a more favorable payment rate. **13:31:02**

We objected to that. It's just that simple. It tied my hands even tighter than they're already tied. **13:31:16**

MR. LIPTON: Thank you. Can we go off the record for a moment.

VIDEOGRAPHER: The time is 1:30 p.m. This marks the ends of tape number 3. We are off the record. **13:31:27**

(Recess - 1:30 p.m. to 1:33 p.m.)

VIDEOGRAPHER: We are back on the record. The time is 1:33 p.m.

Exhibit Z

From: Simmer, Thomas M.D.
Sent: Tuesday, February 24, 2009 2:07 PM
To: Hetzel, Andy; Rossi, Lynda
Subject: RE: Time sensitive material for your review: Revised social mission article for use in MSMS publication

The do not want any player in the market to be so dominant as to dictate fees and the doctors lack the option of deparcipating because they would lose so much volume that they are out of business. They believe that they already make less money in Michigan because our fees are so low in comparison to surrounding states. They appreciate people like Tom George who they perceive is keeping the system from becoming even further out of balance.

The point is really the messaging—Individual Market Reform is good for doctors and patients, rather than IMR to avoid BCBSM losing money. So far, I don't think we have been as successful in getting that message out to them as Tom George has been in reminding them how much doctors need him to protect them from an overly powerful BCBSM.

I have tried very hard to build up physician support for IMR, but keep running up against this same issue.

From: Hetzel, Andy
Sent: Tuesday, February 24, 2009 6:20 AM
To: Simmer, Thomas M.D.; Rossi, Lynda
Subject: RE: Time sensitive material for your review: Revised social mission article for use in MSMS publication

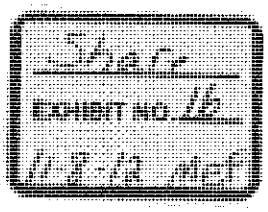
So if I read this right, it says that doctors' bottom line is that we need to be smaller so they can make more money.

And it implies that doctors would rather negotiate with Aetna or United Healthcare, than Blue Cross, because someone is always going to be the biggest carrier and if we fail, one of them will be.

R. Andrew Hetzel, APR

Vice President, Corporate Communications

Blue Cross Blue Shield of Michigan



313.225.6211 office

www.bcbsm.com

www.walkytalk.com

From: Simmer, Thomas M.D.
Sent: Monday, February 23, 2009 10:34 PM
To: Share, David M.D.; Rossi, Lynda; Hetzel, Andy; Berry, Pamela; Scott, Sherry
Cc: Purdy, Carol; Hand, Kristie
Subject: RE: Time sensitive material for your review: Revised social mission article for use in MSMS publication

I have spoken with many, many physicians on this subject. Bottom line: they do not want BCBSM to have more power. They very much fear that we abuse our already excessive market share. In particular, they are concerned that BCBSM will be able to dictate fees because no physician could survive without participating with BCBSM, despite lower fees than they think are fair and reasonable.

They are not at all sympathetic with our protesting that we are going to lose money---especially since they think we have huge reserves and are making more money than any other business in the state.

The key argument, I believe, is that the lack of IMR has left insurers with only one choice---sell policies with very high deductibles so as to avoid attracting high cost cases. This leaves their patients for no coverage for vital services. This harms both the patients and the doctors.

From: Share, David M.D.
Sent: Monday, February 23, 2009 3:31 PM
To: Rossi, Lynda; Hetzel, Andy; Berry, Pamela; Simmer, Thomas M.D.; Scott, Sherry
Cc: Purdy, Carol; Hand, Kristie
Subject: RE: Time sensitive material for your review: Revised social mission article for use in MSMS publication

From the point of view of the MSMS leadership they hope that there is active dialogue between BCBSM, MSMS and other stakeholders in crafting IMR legislation. They understand the need for reform but absent active dialogue they are skeptical about BCBSM's intentions at the outset.

From: Rossi, Lynda
Sent: Monday, February 23, 2009 3:24 PM
To: Share, David M.D.; Hetzel, Andy; Berry, Pamela; Simmer, Thomas M.D.; Scott, Sherry
Cc: Purdy, Carol; Hand, Kristie
Subject: RE: Time sensitive material for your review: Revised social mission article for use in MSMS publication

Do you think we could resolve some of the tension if we approached IMR differently this year?

From: Share, David M.D.
Sent: Wednesday, February 18, 2009 7:30 AM
To: Hetzel, Andy; Berry, Pamela; Simmer, Thomas M.D.; Scott, Sherry
Cc: Rossi, Lynda; Purdy, Carol; Hand, Kristie
Subject: RE: Time sensitive material for your review: Revised social mission article for use in MSMS publication

I've continued to mull it over. There are two significant points of tension now b/n MSMS and BCBSM: IMR and PCMH designation in PGIP. Some Board members tend toward the agitated side (including the President). If any perceive me as being on the Board to represent BCBSM rather than physicians it could have a negative impact. So, my thinking is: why take a chance? If Tom can sign the letter it would be safer. Is there a need to publish this letter in the current issue? Seems if Tom doesn't weigh in before the deadline this AM (9:30) can it wait til the next issue? It seems the letter's content isn't time limited, though the printing deadline for this issue is. I'll be in a meeting starting at 8 and then in clinic seeing patients so I won't get to see email til after the decision is made.

Thanks

David

From: Hetzel, Andy
Sent: Tuesday, February 17, 2009 11:12 PM
To: Share, David M.D.; Berry, Pamela; 'dshare@umich.edu'; Simmer, Thomas M.D.
Cc: Rossi, Lynda; Purdy, Carol; Hand, Kristie
Subject: Re: Time sensitive material for your review: Revised social mission article for use in MSMS publication

My thought is that this letter works coming from either Dr. Share or Dr. Simmer. Tom, if you will put your name to this letter to alleviate Dr. Share's concerns, please advise us ASAP. Dr. Share, because you have approved the letter I would ask for your consent to sign it under your name if we can't secure Dr. Summer's authorization in time to meet the MSMS

deadline.

Many thanks.

Andy Hetzel

From: Share, David M.D.
To: Berry, Pamela; dshare@umich.edu ; Simmer, Thomas M.D.
Cc: Hetzel, Andy; Rossi, Lynda; Purdy, Carol; Hand, Kristie
Sent: Tue Feb 17 22:22:33 2009
Subject: RE: Time sensitive material for your review: Revised social mission article for use in MSMS publication

hmmm, I thought I'd replied earlier this evening but when I looked for my "sent" message I didn't find it.

I think the article is fine and you can use my name (see title below)

but I'd like to hear from Andy and Tom about whether they agree with my concern that it would be better to have Tom submit/sign the article not me so as to not link me as an MSMS Board member with an article which has a PR, BCBSM promotion ring to it. If it were just about quality of care it would fit for me to write such a letter. But since it is touting all of the good works BCBSM does in the community (legitimate, worth touting), it might interfere with the role I currently play which is that of a trusted Board member who happens to both practice medicine and have involvement with BCSBM's quality improvement projects and strategy. As it is I think I am perceived as having a conflict of interest in theory but a neutral, unbiased viewpoint in practice. I wouldn't want to undermine that perception.

That said, I realize I may be splitting hairs, so I'm glad to leave the decision about this political nuance to Andy and Tom

Thanks

David

David Share, MD, MPH

BCBSM Senior Associate Medical Director, Healthcare Quality

B794

27300 West Eleven Mile Road

Southfield, Michigan 48034

248.448.6142

dshare@bcbsm.com

From: Berry, Pamela
Sent: Tuesday, February 17, 2009 5:41 PM
To: Share, David M.D.; dshare@umich.edu
Cc: Hetzel, Andy; Rossi, Lynda; Purdy, Carol; Hand, Kristie
Subject: Time sensitive material for your review: Revised social mission article for use in MSMS publication

Dr. Share – Related to that article you had reviewed and approved early last month, we just heard back from MSMS that they want to run it in the March issue of their magazine, which is being typeset now – and that they would like to run it as a letter to the editor from you. I made a few edits from when you first looked at it, based on some changes that Andy made in the social mission messaging in the Partners in Health Care report. Could you let me know if you need me to make any additional changes by 9:30 a.m. tomorrow? I apologize for the short turnaround request but they need the finalized article as soon as possible in order to make their deadline for the March issue. (See email from Sheri below.)

Also, I wanted to double check on your title – I told them it was Associate Medical Director for Blue Cross Blue Shield of Michigan – so if you want it to read differently, let me know.

From: Sheri W. Greenhoe [mailto:SGreenhoe@msms.org]
Sent: Tuesday, February 17, 2009 4:57 PM
To: Berry, Pamela
Subject: Re: Article and letter to editor on BCBSM's social mission for MSMS publication

Hi Pam....Can you please resend both articles in their final forms asap? The Social Mission one is most urgent...I can fit it as a Letter to the Editor in the upcoming Mar-April magazine, now being typeset. Thanks.

And, I will be glad to add you to our Friday email list, so you'll receive our routine news notices. Thanks.

Sheri

Sheri Greenhoe
Director, Communications
Michigan State Medical Society
and Director, MSMS Foundation
120 W. Saginaw Street
East Lansing, MI 48823
sgreenhoe@msms.org

517-336-7603
www.msms.org

From: Share, David M.D.
Sent: Monday, January 12, 2009 1:39 PM
To: Purdy, Carol; Simmer, Thomas M.D.
Cc: Berry, Pamela; Rossi, Lynda; Scott, Sherry
Subject: RE: MSMS/MOA Article on BCBSM's Social Mission

Perfect!

Nicely done

I have no suggestions for improvement

Thank you

David

From: Purdy, Carol
Sent: Monday, January 12, 2009 1:58 PM
To: Berry, Pamela
Cc: Latvis, Laurie; Sawalski, Robert
Subject: RE: Medical publications contacts

Per our discussion, you let me know that you would forward the article on BCBSM's social mission to our contacts at MSMS and MOA after we have heard from Dr. Simmer. I have copied Laurie on this as well as I believe she has also spoken with Fred about this and someone at MSMS as well. Thank you!

P.S. Please let us know when the article will be published, etc.

fanderson@mi-osteopathic.org (Fred Anderson, MOA)

sgreenhoe@msms.org (Sherri Greenhoe, MSMS)

From: Hand, Kristie
Sent: Tuesday, December 16, 2008 4:27 PM
To: Purdy, Carol
Cc: Berry, Pamela; Hubbell, Patricia; Aubuchon, Linda
Subject: RE: Medical publications contacts

Hi Carol,

We'll need to know what kind of story they would like. Will they just use our PAN grant efforts story? Or are they going to use our information to craft their own? Pam Berry can work on an article if need be, but not until next week or so. Please let me know more details so we can accommodate your request.

Thanks,

Kristie Hand

Manager, Publications

Market Communications

Blue Cross Blue Shield of Michigan

600 E. Lafayette, mailcode 0245

Detroit, MI 48226

313-225-8423

fax: 313-225-6764

khand@bcbsm.com

www.bcbsm.com

From: Purdy, Carol
Sent: Thursday, December 11, 2008 2:11 PM
To: Hand, Kristie
Cc: Hubbell, Patricia; Berry, Pamela; Sawalski, Robert
Subject: RE: Medical publications contacts

HI Kristie,

I spoke with Sherri Greenhoe at MSMS about placing an article in their electronic newsletter and/or magazine on BCBSM's social mission. She was very nice and receptive to reviewing a draft. She asked that I let Rob know of our discussion as they touch base periodically. I did let her know that I would be working with Pam on his team to draft the article. I just left a message for Fred from MOA and will let you know what I hear back from him. Please let me know if you have any questions. Thanks!

From: Hand, Kristie
Sent: Friday, December 05, 2008 1:08 PM
To: Purdy, Carol
Cc: Hubbell, Patricia
Subject: Medical publications contacts

Hi Carol,

As promised here are the contacts for the MSMS, MOA and MHA publications.

ssaylor@msms.org (stacie saylor, MSMS)

fanderson@mi-osteopathic.org (Fred Anderson, MOA)

kdowney@mha.org (Kevin Downey, Michigan Health & Hospital Association)

Kristie Hand

Manager, Publications

Market Communications

Blue Cross Blue Shield of Michigan

600 E. Lafayette, mailcode 0245

Detroit, MI 48226

313-225-8423

fax: 313-225-6764

khand@bcbsm.com

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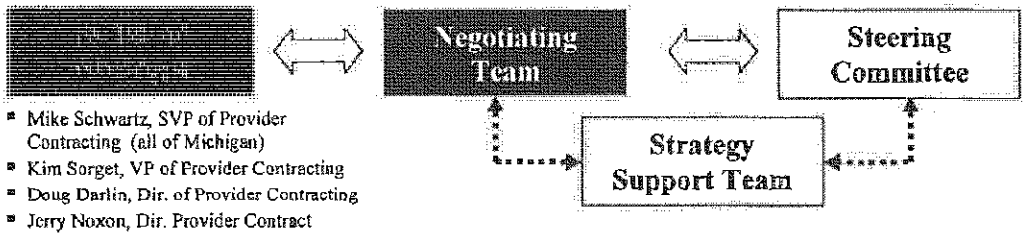
Exhibit BB

BCBS Michigan Negotiations
July 1, 2005 Meeting Summary

1. Meeting Attendees:

- Dave Buckley, St. John Health
- Mark Eustis, Ascension Health
- Rich Felbinger, Borgess Health Alliance
- Pat McGuire, St. John Health
- Noah Rosenberg, Rosenberg & Kaplan
- Bob Smith, Ascension Health
- Steve Smith, Accretive Health

2. Review of Roles and Responsibilities – Bob Smith kicked-off the meeting with a quick review of the respective roles and responsibilities of HM resources and third parties.

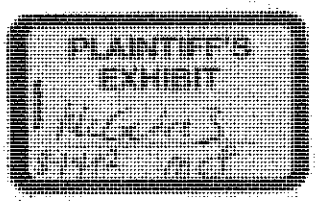


- Mike Schwartz, SVP of Provider Contracting (all of Michigan)
- Kim Sorget, VP of Provider Contracting
- Doug Darlin, Dir. of Provider Contracting
- Jerry Noxon, Dir. Provider Contract

Michigan HM Negotiating Team
- Rich Felbinger, Chief Financial Officer, Borgess Health Alliance (Kalamazoo, MI)
- Patrick McGuire, Chief Financial Officer, St. John Health (Warren, MI)
- Mark Eustis, Pres. GLMA Operating Group, Ascension Health (St. Louis, MO)
- Noah D. Rosenberg, Rosenberg and Kaplan (Beverly Hills, CA)

Steering Committee
- Patrick Dyson, Exec. Vice President, Borgess Health Alliance (Kalamazoo, MI)
- Norma Hagenow, President & CEO, Genesys Health System (Grand Blanc, MI)
- Elliot Joseph, President & CEO, St. John Health (Warren, MI)
- Patrick Murtha, President & CEO, St. Joseph Health System (Tawas City, MI)
- Fleury Yelvington, President & CEO, St. Mary's Medical Center (Saginaw, MI

Strategy Support Team
- Linda Stancill, CFO, St. Joseph Health System (Tawas City, MI)
- Gary Chawk, CFO, St. Mary's Medical Center (Saginaw, MI
- John Keuten, CFO, Genesys Health System (Grand Blanc, MI)
- Bob Smith, Senior Director, Ascension Health
- Dave Buckley, St. John Health
- Accretive Health (Steve Smith/Troy Roth)
- Chris Rossman, Foley & Lardner
- HM In-house counsel



3. Goal of Negotiation Process – Noah Rosenberg

REDACTED

a.

b.

c.

4. Review of BCBS Proposal to MHA – Pat McGuire provided a quick overview of the recent BCBS proposal to the MHA. The MHA will convene a 'senior summit' to address a number of concerns including:
   - Givebacks ($$) should be in base reimbursement not in form of signing bonuses and incentive payments.
   - Timing. BCBS is effectively agreeing that they have been underpaying Michigan hospitals for years yet proposal has a four (4) year process to reach full implementation.
   - Medicaid funding – BCBS position is that it is not their problem.
   - Incentive model for demonstrating value compares Michigan hospitals to each other rather than to national benchmarks.

   Question: Does proposal cover all BCBS products (i.e. hospital, physician, workers comp)?

   Noah Rosenberg requested REDACTED REDACTED **Need to identify follow-up responsibility.**

5. BCBS Communication – The group recommended that a letter be sent to BCBS in advance of the 7/22 meeting outlining the process and our expectations. Specifically:
   - Identify Negotiating Team members and emphasize decision-making authority of the team
   - Emphasize that our team as the authority to make all decisions on behalf of five Michigan HMs and ask that they put a team at the table with same power to make decisions.
   - Set ground rules and expectations for how the process will be managed
   - Expectation that standard rate increases will be in effective 7/1/05 during the negotiation process and that BCBS will make final negotiated rate increases be retroactive to 7/1/05.
   - Letter will be singed by a) all Michigan HM CEOs and b) Mark Eustis as President of GLMA Operating Group.

   Bob Smith will draft letter and forward to Negotiating Team for review and input in advance of 7/11 call with CEOs (2:30 pm ET).

6. HM Communication and PR Strategy – Noah Rosenberg provided [redacted]
   - Bob Smith will distribute a copy of the binder to all the CFOs.
   - A comprehensive communication strategy will be developed including decision on the need to engage a third party to oversee execution (e.g. The Rossman Group) pending the outcome of first meeting with BCBS (7/22).

7. Role of Local/In House Legal Counsel – [redacted]

   a. Chris Reaman (Foley & Lardner) – [redacted]

   b. Antitrust Opinion Letter – [redacted]

8. Commercial Payer Diversification Strategy – It was suggested that the Michigan HMs proactively engage in discussion with other payers as a means a) to reduce their long term dependence on BCBS Michigan and b) create additional leverage with BCBS during the negotiating process. Specific points and follow-up discussed:

   a. BCBS Most Favored Nation (MFN) – Goal should be to remove from contract language because MFN clause effectively neutralizes our ability to create leverage by developing other payer relationships.

   b. Aetna Relationship – Aetna's recently announced purchase of Michigan TPA (PPO-M?) is a sign that they have made strategic decision to enter the Michigan market. Recommendation was made that we initiate dialogue with Aetna to express our interest in working with as they rollout their products.

9. Health Ministry Margin Analysis – A substantial portion of the meeting was devoted to reviewing the analyses recently completed by each HM under the direction of **Dave Buckley** and **Steve Smith**. Team is in the process of rolling forward for FY06. A number of important issues and conclusions were discussed:

a. Paradigm Shift – Key outcome of the process must be to get away from BCBS telling us how to calculate our margin on their book of business to us being in a position to tell BCBS what we need from them to support our HM operations and mission in the state of Michigan.
   - Noah Rosenberg also recommends [redacted]

b. Using a fully loaded cost model in aggregate the Michigan HMs made less than 1.0% operating margin on BCBS business in FY04.
   - Loss was concentrated on our inpatient business (-4.9%)
   - Outpatient business was profitable (6.2%) but BCBS has already started to implement a number of changes that will dramatically ratchet down OP reimbursement in coming years (e.g. Lab/Rad/OP surgery fee screens).
   - Lab is particularly problematic due to how HMs are reimbursed for hospital lab services (i.e. equal to reference lab fee schedules) and contract structures (i.e. Trust = statewide fee schedule + add-on and BCN = Lab "cap")

c. Physician Reimbursement – Employed physicians represent a significant portion of the losses on our BCBS book of business (~ $9 million loss). This is particularly problematic for Providence Hospital. Things we should communicate to BCBS are:
   - BCBS physician fee schedules are low – many independent MDs do not participate in Michigan
   - We want the state-wide BCBS fee schedule plus a premium for our employed physicians (e.g. 120% of fee schedule)
   - Trust fee schedule is lower than PHA fee schedule
   - We want the same reimbursement for our employed physicians regardless of product (i.e. same schedule for PHA, Trust and BCN)

The group emphasized the importance of being confident in the accuracy of the numbers prior to meeting with BCBS representatives. **Bob Smith** agreed to send an e-mail to the five CFOs instructing them to complete a detailed review of the margin analysis and findings for their respective HM.

It was also noted that BCN reimburses differently across HMs (i.e. Genesys and St. John are capitated, Borgess is not capitated). A goal should be to end up with a consistent/standard reimbursement structure for all five Michigan HMs.

10. Workers Comp Business – BCBS Michigan has a wholly-owned for-profit workers comp business ('Accident Fund'). Workers comp business was not included in the HMs margin analysis work. Very important that we understand volume or BCBS workers comp business and how it is currently being reimbursed. CFOs believe there is a separate state-wide fee schedule but need to confirm. Noah Rosenberg speculates that [redacted]

REDACTED

Steve Smith agreed to research and get answers to the following questions:

- REDACTED
- How is workers comp currently being reimbursed?
- What is the HMs workers comp volume?
- REDACTED
- What kind of margin are we making on the workers comp business (margin analysis)?

REDACTED

11. BCBS Michigan Business – It was agreed that we need to gain a better understanding of BCBS' book of business in Michigan:
    - Leased networks?
    - Administrative Services Only (ASO)?
    - How does their business breakdown by region?
    - Underwriting vs. Processing claims?

    Additional Analysis: What percentage of BCBS business is handled currently by Ascension hospitals in Michigan?
    - Admissions
    - ER Visits
    - Provider Paymenments

12. BCBS Membership Trends – Sense from the group that there is very little benefit structure difference between the PHA and Trust products. Theory on the Trust product is that the network is more 'exclusive' and that Trust members are younger and healthier but that is not the case. Also clarified that POS business is same as PPO (Trust) business. **Recommendation was made that one of our 'asks' should be guaranteed participation in all BCBS products.**

    Suggestion was also made that the HMs contact some local insurance brokers to better understand differences in benefit plan design across products and also assess enrollment trends across products. **Need to assign responsibility for follow-up.**

13. Additional Issues Discussed:

    a. Collectability/Revenue Stream – Cash flow analysis does not suggest there are any major issues at this time.

    b. Denials/Underpayments – **Steve Smith** agreed to analyze and report findings.

c. Coordination of Benefits – Proper COB will typically generate 3-8% of net revenue particularly in areas where you have a high percentage of dual spouse employment. **Steve Smith** agreed to analyze and report findings.

d. Administrative Changes to Contract – [redacted]

e. Outlier Payments – **Dave Buckley** and **Steve Smith** agreed to analyze to determine if there are any material issues.

f. BCBS Reimbursement relative to other payers – **Dave Buckley** and **Steve Smith** agreed to do a quick side-by-side analysis of BCBS reimbursement and margin relative to Medicare and other payers to test hypothesis that BCBS is actually one of the HMs worst payers.

g. Contract Language and Structure – [redacted] **Steve Smith** agreed to provide a list of other billing and administrative issues.

h. Intelligence on Spectrum Health (Grand Rapids, MI) – Group believes that Spectrum Health is the only system in Michigan that formally departicipated from BCBS due to stalled negotiations. Anecdotal evidence suggests the tactic appears to have been successful. **Rich Felbinger** agreed to see if he could get any additional detail to share with the team.

Negotiating Teams Preliminary List of Issues and Asks:

1. A standard Ascension Health Michigan contract (master) with HM-specific contract addendums
2. Contract Language and Structure Changes [redacted]
3. Revise and clarify the process for measuring and making changes – BCBS can not have unilateral ability make changes that impact our HMs financially or administratively.
4. HMs must have BCBS eligibility guarantees.
5. Product line protections – HMs have the right to participate in all BCBS products.
6. Understanding of BCBS' direction and thinking on new product development and benefit design (e.g. high co-pay products could create collection challenges for HMs).
7. Physician Compensation – changes in reimbursement structure and/or fee schedule to address losses on our employed physician network

8. Standard reimbursement structure across all BCBS products (hospital and physician reimbursement) – costs HMs the same to deliver care regardless of product.
9. REDACTED

REDACTED

Communications and Next Steps

1. July 11 conference call at 2:30 pm ET with Steering Committee (CEOs) and Negotiating Team to review a) preliminary negotiating strategy and b) proposed communication to BCBS in advance of first meeting (7/22).

2. July 12th Presidents Council – Mark Eustis to update Ascension Health senior leadership on status of work and preliminary list of 'asks' from BCBS.

3. July 15th conference call with Negotiating Team to review follow-up analyses and prepare for first meeting with BCBS (7/22). Time TBD.

4. BCBS Meeting #1 (July 22nd, 1:00 – 3:00 pm ET @ St. John Health): Goal is to present our case for change and provide a high level overview of the types of things we will be asking for. We will not be providing BCBS with anything in writing in advance of the first meeting. A written proposal will be made to BCBS in advance of meeting #2.

5. BCBS Meeting #2 (August 17th, 1:00 – 3:00 pm ET @ St. John Health): Objectives and approach TBD based on outcome of meeting #1 and response to written proposal.

6. We are in the process of scheduling additional conference calls with the Steering Committee before and after meeting #2.

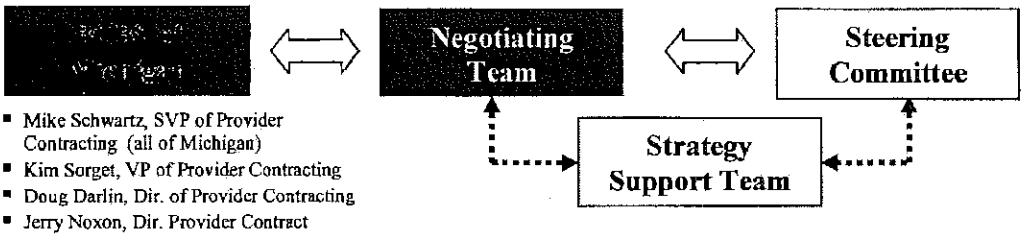
Exhibit DD

BCBS Michigan Negotiations
July 1, 2005 Meeting Summary

1. Meeting Attendees:

- Dave Buckley, St. John Health
- Mark Eustis, Ascension Health
- Rich Felbinger, Borgess Health Alliance
- Pat McGuire, St. John Health
- Noah Rosenberg, Rosenberg & Kaplan
- Bob Smith, Ascension Health
- Steve Smith, Accretive Health

2. Review of Roles and Responsibilities – Bob Smith kicked-off the meeting with a quick review of the respective roles and responsibilities of HM resources and third parties. The group decided to formally add Bob Smith (Ascension Health) and Steve Smith (Accretive Health) to the Negotiating Team.



Michigan HM Negotiating Team
- Mark Eustis, Pres. GLMA Operating Group, Ascension Health (St. Louis, MO)
- Rich Felbinger, Chief Financial Officer, Borgess Health Alliance (Kalamazoo, MI)
- Patrick McGuire, Chief Financial Officer, St. John Health (Warren, MI)
- Noah D. Rosenberg, Rosenberg and Kaplan (Beverly Hills, CA)
- Robert Smith, Senior Director, Ascension Health
- Steve Smith, Senior Vice President, Accretive Health

Steering Committee
- Patrick Dyson, Exec. Vice President, Borgess Health Alliance (Kalamazoo, MI)
- Norma Hagenow, President & CEO, Genesys Health System (Grand Blanc, MI)
- Elliot Joseph, President & CEO, St. John Health (Warren, MI)
- Patrick Murtha, President & CEO, St. Joseph Health System (Tawas City, MI)
- Fleury Yelvington, President & CEO, St. Mary's Medical Center (Saginaw, MI

Strategy Support Team
- Linda Stancill, CFO, St. Joseph Health System (Tawas City, MI)
- Gary Chawk, CFO, St. Mary's Medical Center (Saginaw, MI
- John Keuten, CFO, Genesys Health System (Grand Blanc, MI)
- Bob Smith, Senior Director, Ascension Health
- Dave Buckley, St. John Health
- Accretive Health (Steve Smith/Troy Roth)
- Chris Rossman, Foley & Lardner
- HM In-house counsel

3. Goal of Negotiation Process – Noah Rosenberg REDACTED

REDACTED

a.

b. REDACTED

c.

4. Review of BCBS Proposal to MHA – Pat McGuire provided a quick overview of the recent BCBS proposal to the MHA. The MHA will convene a 'senior summit' to address a number of concerns including:
   - Givebacks ($$) should be in base reimbursement not in form of signing bonuses and incentive payments.
   - Timing. BCBS is effectively agreeing that they have been underpaying Michigan hospitals for years yet proposal has a four (4) year process to reach full implementation.
   - Medicaid funding – BCBS' position is that it is not their problem.
   - Incentive model for demonstrating value compares Michigan hospitals to each other rather than to national benchmarks.

   Question: Does proposal cover all BCBS products (i.e. hospital, physician, workers comp, other facilities)?

   Noah Rosenberg requested REDACTED REDACTED **Need to identify follow-up responsibility.**

5. BCBS Communication – The group recommended that a letter be sent to BCBS in advance of the 7/22 meeting outlining the process and our expectations. Specifically:
   - Identify Negotiating Team members and emphasize decision-making authority of the team
   - Emphasize that the team as the authority to make all decisions on behalf of five Michigan HMs and ask that they put a team at the table with same power to make decisions.
   - Set ground rules and expectations for how the process will be managed
   - Expectation that standard rate increases will be in effective 7/1/05 during the negotiation process and that BCBS will make final negotiated rate increases be retroactive to 7/1/05.
   - Letter will be signed by all Michigan HM CEOs and Mark Eustis as President of GLMA Operating Group.

   Bob Smith will draft letter and forward to Negotiating Team for review and input in advance of 7/11 call with CEOs (2:30 pm ET).

6. HM Communication and PR Strategy – Noah Rosenberg provided [redacted]
   - **Bob Smith** will distribute a copy of the binder to all the CFOs.
   - A comprehensive communication strategy will be developed including decision on the need to engage a third party to oversee execution (e.g. The Rossman Group) pending the outcome of first meeting with BCBS (7/22).

7. Role of Local/In-House Legal Counsel – [redacted]

   a. Chris Rossman (Foley & Lardner) – [redacted]

   b. Antitrust Opinion Letter – [redacted]

8. Commercial Payer Diversification Strategy – It was suggested that the Michigan HMs proactively engage in discussion with other payers as a means a) to reduce their long term dependence on BCBS Michigan and b) create additional leverage with BCBS during the negotiating process. Specific points and follow-up discussed:

   a. BCBS Most Favored Nation (MFN) – BCBS' recent proposal to MHA includes MFN language. Goal should be to remove from contract language because MFN clause effectively neutralizes our ability to create leverage by developing other payer relationships.

   b. Aetna Relationship – Aetna's recently announced purchase of Michigan TPA (PPO-M?) is a sign that they have made strategic decision to enter the Michigan market. Recommendation was made that we initiate dialogue with Aetna to express interest in working with them they rollout their products. **No specific follow-up assigned.**

9. Health Ministry Margin Analysis – A substantial portion of the meeting was devoted to reviewing the analyses recently completed for each HM under the direction of **Dave Buckley** and **Steve Smith**. Team is in the process of rolling forward for FY06. A number of important issues and conclusions were discussed:

   a. Paradigm Shift – Key outcome of the process must be to transistion from BCBS telling us how to calculate our margin on their book of business to us being in a position to tell BCBS what we need from them to support our HM operations and mission in the state of Michigan.
      - Noah Rosenberg recommended [REDACTED]

   b. Using a fully loaded cost model, in aggregate the Michigan HMs made less than 1.0% operating margin on BCBS business in FY04.
      - Loss was concentrated on inpatient business (-4.9%)
      - Outpatient business was profitable (6.2%) but BCBS has already started to implement a number of changes that will dramatically ratchet down OP reimbursement in coming years (e.g. Lab/Rad/OP surgery fee screens).
      - Lab is particularly problematic due to how HMs are reimbursed for hospital lab services (i.e. PHA equal to reference lab fee schedules) and contract structures (i.e. Trust = statewide fee schedule + add-on and BCN = Lab "cap")

   c. Physician Reimbursement – Employed physicians represent a significant portion of the losses on our BCBS book of business (~ $9 million loss). This is particularly problematic for Providence Hospital. Things we should communicate to BCBS are:
      - BCBS physician fee schedules are low – many independent MDs do not participate in Michigan
      - Trust fee schedule is lower than PHA fee schedule yet it costs the same to deliver care
      - We want the state-wide BCBS fee schedule plus a premium for our employed physicians (e.g. 120% of fee schedule)
      - We want the same reimbursement for our employed physicians regardless of product (i.e. same schedule for PHA, Trust and BCN)

   The group emphasized the importance of being confident in the accuracy of the numbers. **Bob Smith** agreed to send an e-mail to the five CFOs asking them to complete a detailed review of the margin analysis and findings for their respective HM prior to 7/22 meeting with BCBS..

   It was also noted that BCN reimburses differently across HMs (i.e. Genesys and St. John are capitated, Borgess is not capitated). A goal should be to end up with a consistent/standard reimbursement structure for all five Michigan HMs.

10. Workers Comp Business – BCBS Michigan has a wholly-owned for-profit workers comp business ('Accident Fund'). Workers comp business was not included in the HMs margin analysis work. Very important that we understand volume of BCBS workers comp business and how it is currently being reimbursed. CFOs believe there is a separate state-wide fee schedule but need to confirm. Noah Rosenberg speculates that REDACTED

REDACTED

Steve Smith agreed to research and get answers to the following questions:
- REDACTED
- How is workers comp currently being reimbursed?
- What is the HMs workers comp volume?
- REDACTED
- What kind of margin are we making on the workers comp business (margin analysis)?

REDACTED

11. BCBS Michigan Business – It was agreed that we need to gain a better understanding of BCBS' book of business in Michigan:
    - Leased networks?
    - Administrative Services Only (ASO)?
    - How does their business breakdown by region?
    - Underwriting vs. Processing claims?
    - Out of state business?
    - Custom programs?

    Additional Analysis: What percentage of BCBS business is handled currently by Ascension hospitals in Michigan?
    - Admissions
    - ER Visits
    - Provider Payments

12. BCBS Membership Trends – Sense from the group that there is very little benefit structure difference between the PHA and Trust products. Theory on the Trust product is that the network is more 'exclusive' and that Trust members are younger and healthier but that is not the case. Also clarified that POS business is same as PPO (Trust) business. **Recommendation was made that one of our 'asks' should be a right for all Ascension facilities to participate in all BCBS products.**

    Suggestion was made that the HMs contact some local insurance brokers to better understand differences in benefit plan design across products and also assess enrollment trends across products. **Need to assign responsibility for follow-up.**

13. Additional Issues Discussed:

a. Collectability/Revenue Stream – Cash flow analysis does not suggest there are any major issues at this time.

b. Denials/Underpayments – **Steve Smith** agreed to analyze and report findings.

c. Coordination of Benefits/Third Party Liability – Proper COB will typically generate 3-8% of net revenue particularly in areas where you have a high percentage of dual spouse employment. **Steve Smith** agreed to analyze and report findings.

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g. Contract Language and Structure – REDACTED REDACTED REDACTED **Steve Smith** agreed to provide a list of other billing and administrative issues.

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Essential Elements/Preliminary Asks for Future BCBS of Michigan Agreement:

1. A standard Ascension Health Michigan contract (master) with HM-specific contract addendums
2. Contract Language and Structure Changes REDACTED REDACTED

3. Revise and clarify the process for measuring and making changes – BCBS can not have unilateral ability make changes that impact our HMs financially or administratively.
4. HMs must have BCBS eligibility and payment guarantees with no BCBS ability to unilaterally deduct/offset dollars owed to a facility.
5. Retention of all coordination of benefit and third party liability revenue.
6. Product line protections – HMs have the right to participate in all BCBS products.
7. Understanding of BCBS' direction and thinking on new product development and benefit design (e.g. high co-pay products could create collection challenges for HMs).
8. Mandatory disclosure by BCBS in writing of all ASO/Leased Network clients.
9. Physician Compensation – changes in reimbursement structure and/or fee schedule to address losses on our employed physician network
10. Standard reimbursement structure across all BCBS products (hospital and physician reimbursement) – costs HMs the same to deliver care regardless of product.
11. REDACTED

Noah Rosenberg provided REDACTED **See attachment at end of document.**

Communications and Next Steps

1. July 11 conference call at 2:30 pm ET with Steering Committee (CEOs) and Negotiating Team to review a) preliminary negotiating strategy and b) proposed communication to BCBS in advance of first meeting (7/22).

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6. We are in the process of scheduling additional conference calls with the Steering Committee before and after meeting #2.

Blue Cross Contract Talking Points

REDACTED

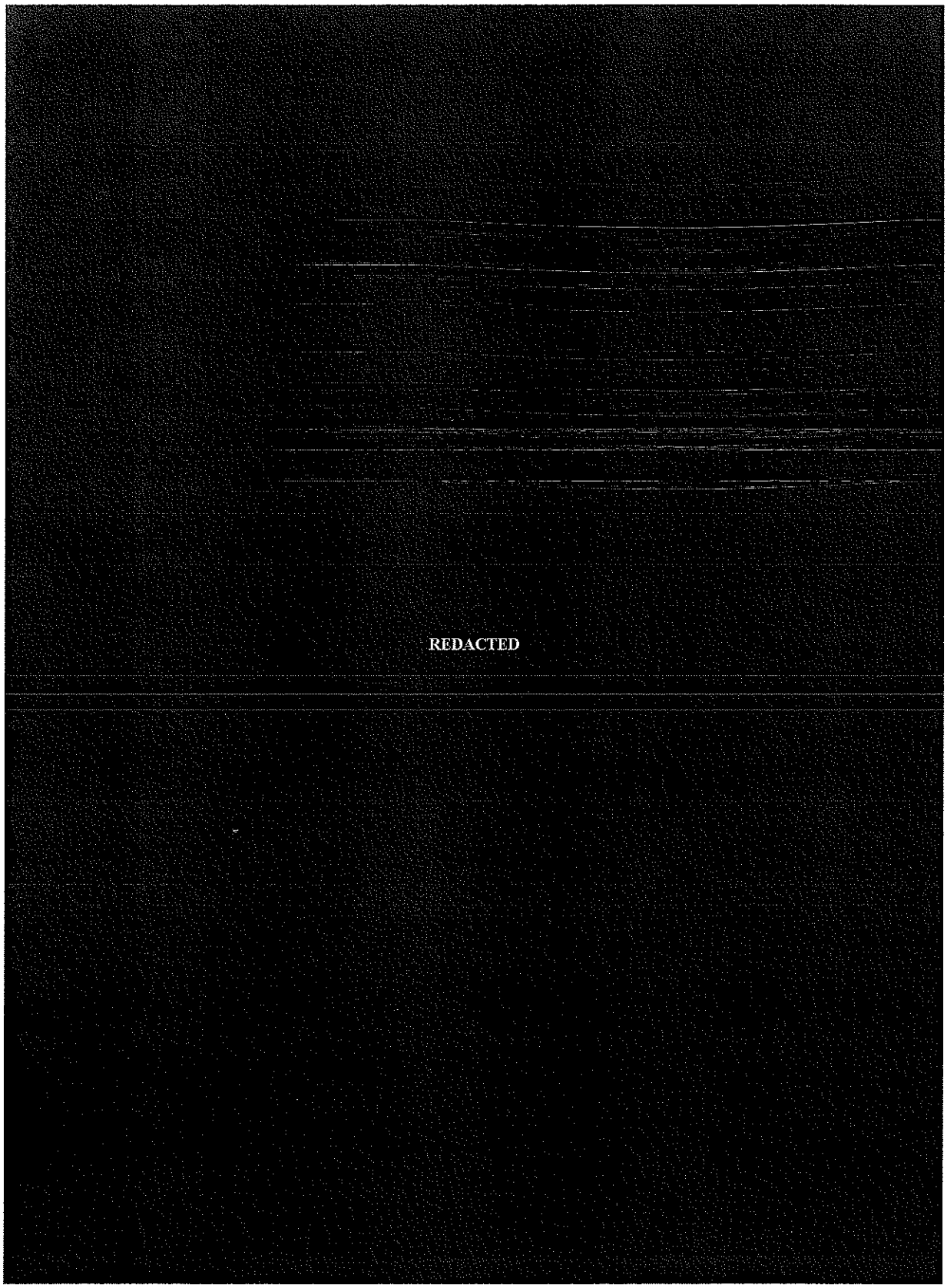

Exhibit EE

Milewski, Robert

From: Darland, Doug
Sent: Monday, April 14, 2008 2:50 PM
To: Milewski, Robert
Subject: FW: Allegan General Hospital - PG5 Status

Bob, the emails below will give you a little bit of background on Allegan (and you'll see that my opening line was in jest in response to his comments). I bolded a couple lines and items that may be helpful, especially where it shows they would take a similar year 1 hit whether they remain PG5 or not. And the hit is in fact substantial. Approximately $450,000 compared to their prior year operating margin of $1.2M. That will make anyone mad. For perspective though, Charlevoix is taking a bigger hit, $480,000 and their operating margin was negative last year.

Two things we discussed last week, briefly:

1. Most favored discount (preferably with a differential) is "required" to consider a variance to the Model
2. Our typical treatment for a PG5 moving to PG4, it's been a few years since the last one, is to move them to an "appropriate" inpatient price immediately. Usually it's been based on some type of area average. On the outpatient side we typically would hit them at least as hard as Allegan's first year hit, and then move them to around [redacted] over a few years. The PG5 Model calls for them to [redacted]

Allegan's first year change is from [redacted] - Doug

From: Darland, Doug
Sent: Monday, February 25, 2008 2:47 PM
To: 'Harning, Richard'
Subject: RE: Allegan General Hospital - PG5 Status

Rick, we will have to be particularly tough now, to make sure there is no charge of favoritism.

I do have the material you sent to me and regret I have not been able to spend as much time with it as I would have liked up to this point. I can offer a few comments for your information and consideration, and I will be back to you more formally as soon as possible. In the mean time, you can provide any feedback on my comments if you wish.

The primary focus of your letter was on having your hospital retain its peer group 5 status. Your statement about the equivalent admissions threshold being based on a two year average is not correct. 2006 is the primary base year for the threshold determination, though we did agree to "consider" prior years to make sure 2006 was not particularly aberrant. In your case, you have had several years over the threshold, and once a peer group assignment has changed based on this criterion the threshold changes to 5700. The reason being to avoid hospitals bouncing back and forth once the initial determination is made (using 2006).

Another focus of your material was the impact that your psych unit has on your total admissions. Not sure what to say about this issue at this point other than they are in fact to be included in the calculation.

While the peer group assignment certainly has a significant impact on your 2008 reimbursement rate, you would be seeing a similar decrease in your rate even as a PG5 hospital.

PG4 treatment (1st year as previously described): [redacted]

PG5 treatment ("freeze" i.e. no update allowed) [redacted]

The longer term impact of PG4 vs PG5 is more substantial, but certainly based on our contract your hospital is

4/14/2008

M-24

currently and correctly assigned to PG4. As I said, I will get a more formal letter to you in the near future. - Doug

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From: Harning, Richard [mailto:RichardHarning@aghosp.com]
Sent: Thursday, February 21, 2008 5:21 PM
To: Darland, Doug
Subject: Allegan General Hospital - PG5 Status

Good afternoon Doug. It's Rick Harning from Allegan General Hospital. Hey, I found out my sister (Claire Schmidt) now works for Blue Cross Blue Shield in your same building on Eleven Mile. She started in January and she works with the workers' compensation utilization claims review (she's an RN). I am not sure who she reports too though. Boy, it's a small world.

I wanted to follow-up with my correspondence I sent to you dated January 16th, 2008. Our hospital leadership team is implementing a cash crisis management program and I was hoping to give our Board of Directors an update on this along with an update on our status with Blue Cross Blue Shield at our upcoming Board Meeting scheduled for this Tuesday, February 26th, 2008.

Any updates would be most appreciated. Thank you and have a nice day.

Richard Harning, MBA
Vice President and CFO
Allegan General Hospital
555 Linn Street
Allegan, MI 49010
Phone # 269-686-4284
Fax # 269-686-4303
Email = richardharning@aghosp.com

Exhibit FF

From: David Smith [mailto:dave@healthdave.com]
Sent: Thursday, April 17, 2008 8:25 AM
To: Sorget, Kim; Darland, Doug
Subject: RE: Marquette contract outline

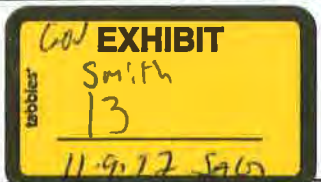
Not a problem, I just got off the phone with Gary and we can accept that. One item I didn't see was the re-tiering of the hospital in the future to account for the physician cost. If we can add that, I think we are good to go. Gary is around tomorrow so if you can get the LOU done today and over night it for signature tomorrow, we should be good.

Thanks. Call with any questions.

Dave Smith
Kearny Street Consulting, Inc.
Office 770-569-0869
Cell 770-329-9823
Fax 678-261-1666
dave@healthdave.com

From: Sorget, Kim [mailto:KSorget@bcbsm.com]
Sent: Thursday, April 17, 2008 8:18 AM

4/18/2008



To: Darland, Doug; David Smith
Subject: RE: Marquette contract outline

David, I agree with Doug. Not providing a favored pricing makes this a deal breaker. It was one of the primary reasons why we were able to support the reimbursement increase. KIM

From: Darland, Doug
Sent: Wednesday, April 16, 2008 4:59 PM
To: David Smith
Cc: Sorget, Kim
Subject: RE: Marquette contract outline

Sorry, I didn't catch that Dave. The guaranteed differential is really the cornerstone upon which our offer is based. I apologize for not catching it. I guess I looked though it entirely as it was completely unexpected. We started at 30, based on our initial meeting, agreed to go to 20, and finally settled at 15 in acknowledgement that the significant increase in our payments may have made the 20 points impossible to maintain.

This is critical to having gained BCBSM leadership support to approve the increase we have on the table. - Doug

---

From: David Smith [mailto:dave@healthdave.com]
Sent: Wednesday, April 16, 2008 4:49 PM
To: Darland, Doug
Cc: Sorget, Kim
Subject: RE: Marquette contract outline

Doug. Thanks, sorry I have been stuck at a client and on a call. This looks good except in my email yesterday we asked to remove the 15% differential language. The favor nation still applies in the base agreement however MGH has requested the buffer be removed.

Dave Smith
Kearny Street Consulting, Inc.
Office 770-569-0869
Cell 770-329-9823
Fax 678-261-1666
dave@healthdave.com

From: Darland, Doug [mailto:DDarland@bcbsm.com]
Sent: Wednesday, April 16, 2008 3:04 PM
To: David Smith
Cc: Sorget, Kim; Kropfreiter, Eric
Subject: Marquette contract outline

Dave, I got your call this morning and put the attached together for your review. I am asking Eric to start putting together the actual Letter of Understanding (LOU) that will incorporate these components. The LOU will then require BCBSM (Kim) and Marquette (Gary) sign-off. Thanks. - Doug

4/18/2008

Exhibit GG

From: Darland, Doug
Sent: Wednesday, November 14, 2007 2:22 PM
To: jlongbrake@huronmedicalcenter.org
Subject: Huron Medical Center - Requested Information...

Jeff, I have talked to my boss, Kim Sorget, and we are struggling with rationalizing an exception to the Model for your facility. One of the key factors is your reluctance to willingly embrace the most favored discount portion of our contract. This is very important to us, and though we understand you currently have contracts in place that may provide better discounts to others, some statement that you are committed to a (short) time-table that better aligns the discounts you provide to our various competitors with the BCBSM discount may be beneficial in allowing some variance. Also, I would like to see your 2007 actual and 2008 budgeted income statements, and the BCBSM assumption that is built into the 2008 budget. Thanks. - Doug

-----Original Message-----
From: Jeff Longbrake [mailto:jlongbrake@huronmedicalcenter.org]
Sent: Wednesday, November 07, 2007 7:34 PM
To: Darland, Doug
Subject: FW: Requested Information...

Doug:
Per our conversation...thank you for your assistance.
Jeff Longbrake
-----Original Message-----
From: Jeff Longbrake [mailto:jlongbrake@huronmedicalcenter.org]
Sent: Thursday, October 18, 2007 5:31 PM
To: 'ddarland@bcbsm.com'
Subject: Requested Information...

Doug:
I am providing the information we discussed in our phone conversation on October 16, 2007. I have provided in summary form, but can provide audited income statements and other documentation if needed. Thanks again for talking with us, as well as your past assistance.
Jeff Longbrake <<Blue Cross Operating Expense Analysis - BC Version.xls>>

Exhibit HH

Blue Cross
Blue Shield
of Michigan

27000 W. 11 Mile Rd.
Southfield, Michigan 48034

January 5, 2007

David R. Buckley
Corporate Director, Reimbursement
St. John Health
28000 Dequindre Road
Warren, Michigan 48092-2468

Subject: Countersigned Signature Pages for the BCBSM Participating Hospital Agreement and BCBSM TRUST Participating Hospital Agreement

Dear Dave:

I am enclosing a copy of the countersigned signature pages for the BCBSM Second Amended and Restated Participating Hospital Agreement (PHA) and the Second Amended and Restated TRUST Participating Hospital Agreement for St. John Health.

We look forward to working with you under the revised PHA and TRUST Participating Hospital Agreement, and we thank you for your continued support and participation.

Sincerely,

Eric Kropfreiter

Eric Kropfreiter
Senior Analyst
Provider Contracting

28000 Dequindre
Warren MI 48092

January 4, 2007

Eric Kropfreiter
Senior Analyst, Provider Contracting
Blue Cross Blue Shield of Michigan
Mail Code- B715
27000 W. Eleven Mile Road
Southfield, Michigan 48034-2200

Topic: BCBSM PHA Hospital Signature Pages- St. John Health Hospitals

Dear Eric;

Please find enclosed the signed signature pages for each St. John Health (SJH) hospital regarding the above agreement. PHA agreements are signed on behalf of each hospital by Patrick McGuire, SJH's Chief Financial Officer.

SJH hospitals include:

1) St. John Hospital & Medical Center
2) Providence Hospital & Medical Centers
3) Providence Park Hospital
4) St. John Macomb Hospital
5) St. John Detroit Riverview Hospital
6) St. John Oakland Hospital
7) St. John River District Hospital
8) St. John North Shores Hospital

After the BCSBM completes the execution of these agreements, please retain one set of agreements for your files and return the second set to my attention.

If you have any questions or comments regarding the enclosed information, please feel free to contact me at (586) 753-0099. My internet address is david.buckley@stjohn.org.

Sincerely,

David R Buckley

David R. Buckley
Corporate Director, Reimbursement
St. John Health
28000 Dequindre Road
Warren, Michigan 48092-2468

Enclosures

Blue Cross
Blue Shield
of Michigan

27000 W. 11 Mile Rd.
Southfield, Michigan 48034

November 14, 2006

Robert Casalou
Chief Executive Officer
Providence Park Hospital Novi (00231)
47601 Grand River Avenue
Novi, MI 48374

Subject: Signature Pages for the BCBSM Participating Hospital Agreement and BCBSM TRUST Participating Hospital Agreement

Dear Robert Casalou:

On June 30, 2006, we sent you copies of the revised BCBSM Second Amended and Restated Participating Hospital Agreement (PHA) and the Second Amended and Restated TRUST Participating Hospital Agreement approved by the BCBSM board of directors on June 13, 2006. At that time, the notification indicated that the agreement changes automatically applied and no signature was requested. However, we also stated it was our intention to obtain signatures from each hospital at a later date. Both agreements are available at BCBSM's web-DENIS website under Provider Publications and Manuals (> provider manuals > hospital inpatient > participation).

The purpose of this letter is to request your signature on the enclosed Signature Documents so that both the hospital and BCBSM no longer have to maintain our files to track agreement changes and Signature Documents going all the way back to the 1989 PHA and the 1988 TRUST Participating Hospital Agreement. Please note that your signature on the enclosed Signature Documents will have no effect on any hospital-specific contract amendments having a term that extends past the July 1, 2006 effective date of the agreements.

I'm sure you will agree that this effort is mutually beneficial and, therefore, we request that you sign the enclosed Signature Documents and return them to me by December 4, 2006 at the address indicated at the bottom of the Signature Documents. A countersigned copy of each will be returned to you.

If you have any questions regarding this request, please feel free to call me at (248) 448-7892 (or e-mail at ekropfreiter@bcbsm.com).

We look forward to working with you under the revised PHA and TRUST Participating Hospital Agreement, and we thank you for your continued support and participation.

Sincerely,

Eric Kropfreiter

Eric Kropfreiter, Senior Analyst
Provider Contracting

Enclosure

Blue Cross Blue Shield of Michigan

TRUST HOSPITAL

SECOND AMENDED AND RESTATED TRUST PARTICIPATING HOSPITAL AGREEMENT SIGNATURE DOCUMENT

IN WITNESS WHEREOF, the parties, wishing to be bound by the terms and conditions of BCBSM's ***Second Amended and Restated TRUST Participating Hospital Agreement***, have affixed their signatures on this Signature Document, which is incorporated by reference into the Agreement.

PROVIDENCE HOSPITAL	Providence Park Hospital Novi
HOSPITAL NAME (FEDERAL TAX NAME)	(dba, if applicable-for directory)

47601 Grand River Avenue
PRIMARY INPATIENT SITE ADDRESS (for directory)

Novi	MI	48374
CITY	STATE	ZIP CODE

248-465-4170
TELEPHONE NUMBER (for directory)

38-1358212
FEDERAL EMPLOYER IDENTIFICATION NUMBER

23-0019
NUMBER ASSIGNED BY MEDICARE FOR BILLING

00231
BCBSM HOSPITAL FACILITY CODE

July 1, 2006
EFFECTIVE DATE OF AGREEMENT

****

HOSPITAL REPRESENTATIVE	BCBSM REPRESENTATIVE
X Patrick McGuire	x Douglas E. Darland
AUTHORIZED REPRESENTATIVE	AUTHORIZED REPRESENTATIVE
Patrick McGuire	Douglas E. Darland
NAME (Print or Type)	NAME (Print or Type)
Chief Financial Officer	Director, Hospital Contracting and Policy
TITLE	TITLE
12-21-06	1/5/07
DATE	DATE

****

PLEASE RETAIN THE PREVIOUSLY MAILED COPY OF THE AGREEMENT FOR YOUR RECORDS

RECEIVED
JAN 05 2007
PROVIDER CONTRACTING DEPARTMENT

Please return this Signature Document to:

Provider Contracting - B715
Blue Cross Blue Shield of Michigan
27000 W. Eleven Mile Rd.
Southfield MI 48034-2200

Rev. TRUST HSP 7-1-06.doc

Exhibit II

Ascension Health and Blue Cross Blue Shield of Michigan
Participating Hospital Agreement, TRUST Hospital Agreement and
Blue Care Network Hospital Affiliation Agreement
Letter of Understanding

This Letter of Understanding (LOU) amends and supplements certain provisions of the Blue Cross Blue Shield of Michigan (BCBSM) Second Amended and Restated Participating Hospital Agreement (PHA), the BCBSM Second Amended and Restated TRUST Hospital Agreement (TRUST Hospital Agreement), and the Blue Care Network (BCN) Hospital Affiliation Agreement (BCN-HAA) for non-Medicare members. This LOU is entered into by and between BCBSM, BCN, and Ascension Health (AH) on behalf of certain of its member Michigan hospitals (Hospitals). Ascension Health, BCBSM, and BCN are also collectively referred to in this LOU as "the Parties".

The PHA, TRUST Hospital Agreement, and BCN-HAA are hereinafter referred to as the "Standard Agreements" If any provisions of the LOU conflict with the terms and conditions of the Standard Agreements, the terms and conditions of the LOU shall prevail. Unless otherwise specified in this LOU, all other terms and conditions of the Standard Agreements, as they may be modified from time to time, will apply. As referenced in this LOU, the term "standard" for the PHA and TRUST Hospital Agreement means the agreement on file with the Michigan Office of Financial and Insurance Regulation (OFIR) which is in effect on the date of admission or outpatient service. As referenced in this LOU, the term "standard" for the BCN-HAA means the agreement executed between Hospital and BCN and, if any, subsequently amended in accordance with the provisions of the agreement and in effect on the date of admission or outpatient service.

The provisions of this LOU shall apply to the AH Michigan member hospitals listed below:

Member Hospital	Facility Code
◦ Borgess Medical Center	00032
◦ Borgess Medical Center doing business as Borgess-Pipp Health Center (BPHC)	00156
◦ Genesys Regional Medical Center	00180
◦ Providence Hospital doing business as Providence Hospital and Medical Centers	00277
◦ Providence Hospital doing business as Providence Park Hospital Novi	00231
◦ St. John Hospital Corporation doing business as St. John Hospital and Medical Center	00116
◦ St. John Health System Detroit Macomb Campus doing business as St. John Macomb Oakland Hospital	00048
◦ St. John Hospital Corporation doing business as St. John North Shores Hospital	00248
◦ River District Hospital doing business as St. John River District Hospital	00056
◦ St. Mary's Medical Center of Saginaw, Inc. doing business as St. Mary's of Michigan Medical Center (SMMMC)	00028
◦ St. Joseph Health System Inc., doing business as Tawas St. Joseph Hospital (TSJH)	00209

For Hospitals not listed above (i.e., Borgess-Lee Memorial Hospital (Borgess-Lee) and St. Mary's of Michigan Standish Hospital (Standish)), the terms and conditions of the Standard Agreements, as they may be modified from time to time, will apply and they shall not be governed by the provisions of this LOU The terms and conditions of the BCBSM Long Term Acute Care Hospital Agreement signed by Borgess-Pipp shall govern payment for LTACH inpatient services. The term "Hospital" includes all of AH's Michigan member hospitals except for Brighton Hospital.

This LOU excludes services provided to BCBSM and/or BCN members that are subject to a separate agreement between Hospitals' and a third-party vendor (e g., mental health carveouts, Joint Venture Hospital Laboratories, etc.). Hospitals will accept reimbursement for services covered by such separate agreements from the applicable third-party vendor in accordance with Hospitals' contract with the vendor.

Model Reimbursement Methodology (MRM), as used in this LOU, refers to the reimbursement provisions described in Exhibit B of the PHA. All references to the "standard update factor" shall refer to the standard update factor under the MRM applicable to hospitals whose reimbursement arrangements comply with the methodology specified in the PHA.

As referenced in this LOU, fiscal year (FY) refers to the 12-month accounting period which begins July 1 and ends June 30. A fiscal year is designated by the calendar year in which it ends; for example, the 2009 fiscal year begins July 1, 2008 and ends on June 30, 2009.

I. **Prior Agreements**

This LOU, together with the Standard Agreements, shall supersede any and all prior agreements and understandings between the Parties, whether written or oral, regarding the matters herein, and shall constitute the entire agreement and understanding between the Parties. The previous LOU in place between AH and BCBSM that was effective July 1, 2005 (the "Old LOU") shall have no force or effect after June 30, 2008. Notwithstanding the above, the Agreement entered into among BCBSM, BCN and Providence Hospital and Medical Centers effective January 21, 2005, regarding Providence Hospital and Medical Centers - Providence Park, shall continue in effect until September 5, 2008, on and after which date it shall have no force or effect.

II. **Term and Termination**

The provisions of this LOU shall be effective as of July 1, 2008, and shall continue for 60 months until June 30, 2013. Except as provided herein, this LOU may not be terminated by either Party prior to June 30, 2013, unless both Parties agree, or unless there is a material breach that is not cured within 30 days' written notice to the breaching Party. Termination of the LOU does not terminate Hospitals' Standard Agreements. The terms and provisions of this LOU pertaining to each Hospital will terminate immediately in the event such Hospital's Standard Agreements are terminated (e.g., unable to meet BCBSM participation qualification standards) or if Hospital ceases to be owned or controlled by AH. AH agrees to continue each Hospital's Standard Agreements for the period of July 1, 2008 through June 30, 2013, unless there is a material breach by BCBSM that is not cured within 30 days' written notice to BCBSM. BCBSM agrees to continue each Hospital's Standard Agreements for the period of July 1, 2008 through June 30, 2013, unless there is a material breach by AH that is not cured within 30 days' written notice to AH, or Hospital fails to meet BCBSM participation qualification standards.

Unless one of the Parties sends a notice of intent not to renew this LOU that is received by the other party on or before December 31, 2012, this LOU shall automatically renew for one additional year, from July 1, 2013 through June 30, 2014. The notice of intent not to renew shall conform to the requirements of PHA Article V, Section 14. If this LOU continues beyond June 30, 2013, each Hospital will receive the standard update factors for a MRM hospital, and the standard update factors will be applied to the applicable price components of BCBSM payments used for final BCBSM settlement in the fiscal year ending in 2013

This LOU will continue to renew for subsequent years, ending June 30, 2015 and thereafter, unless one of the Parties sends a notice of intent not to renew this LOU that is received by the other party on or before December 31 before the date as of which this LOU would expire. If the LOU continues in subsequent years, the standard update factors for a MRM hospital will apply to the price components used for final BCBSM settlement in the immediately preceding year.

III. **Amendment**

This LOU may be amended only upon written agreement of the Parties. In the event that unforeseeable circumstances occur which materially affect the intent of this LOU, the Parties agree to make a good faith effort to resolve such matters in a timely manner. Any resulting modifications or clarifications to this LOU will be evidenced by a written agreement signed by both Parties.

IV. **Lump Sum Payment**

Upon the execution of this LOU by both Parties, a payment [redacted] In recognition of claims incurred in FY 2009 will promptly be made by BCBSM to AH. This lump sum payment will be allocated among the Hospitals in accordance with Exhibit A of this LOU. Payment will be made to each Hospital as a FY 2009 BCBSM Interim Payment ("BIP") adjustment and will be included, along with a BCBSM liability amount equal to the FY 2009 BIP adjustment, as part of each Hospital's FY 2009 year end settlement process. The Parties agree the lump sum payment amount is a one time payment and will not become part of the Hospital's payment rates.

V. **PHA Reimbursement Provisions for Members' Covered Services**
(Note, Uncompensated Care and Pay-for-Performance are addressed in Sections IX. and X. of this LOU)

A. **PHA Inpatient Reimbursement Provisions - Excluding Borgess/Pipp Health Center**

1. 2009 Fiscal Year PHA Inpatient Reimbursement Provisions: Except for Borgess/Pipp Health Center (BPHC), for the 2009 fiscal year, each Hospital's previous fiscal year ending [redacted] price components [redacted] will be updated by the standard update factor for a MRM hospital plus [redacted] and a 0.5% allowance in recognition of AH's favored discount commitment). For example if [redacted] BPHC's inpatient reimbursement rates will be determined in accordance with C. below.

2 2010 Fiscal Year and Subsequent Fiscal Year PHA Inpatient Reimbursement Provisions: Except for BPHC, for the 2010 fiscal year and for all subsequent fiscal years covered by this LOU, [redacted] BPHC's inpatient reimbursement rates will be determined in accordance with C. below.

B. **PHA Outpatient Reimbursement Provisions - Excluding Borgess/Pipp Health Center and Tawas St. Joseph Hospital**

1. 2009 Fiscal Year: Except for BPHC and Tawas St. Joseph Hospital (TSJH), [redacted] BPHC's outpatient reimbursement rates will be determined in accordance with C. below and TSJH outpatient reimbursement rates in accordance with D below.

   a) Price-Based Services: For the 2009 fiscal year, each Hospital's outpatient [redacted] will be updated at the beginning of the fiscal year in accordance with the MRM [redacted] Concurrently, BCBSM agrees to further adjust [redacted] by an additional increment so the level of reimbursement [redacted] results in a level of reimbursement that is [redacted] greater than the standard MRM update methodology alone would yield [redacted] and a 0.5% allowance in recognition of AH's favored discount commitment).

   b) Outpatient Payment Ratio: For the 2009 fiscal year, each Hospital's previous fiscal year ending outpatient payment ratio will be updated using the standard MRM methodology and applying the standard update factor for a MRM hospital plus [redacted] CRNA allowance and a 0.5% allowance in recognition of AH's favored discount commitment). For example [redacted]

2. 2010 Fiscal Year and Subsequent Fiscal Years: Except for BPHC and TSJH, each Hospital's previous fiscal year ending outpatient payment rates used for final BCBSM settlement will be updated as follows. BPHC's outpatient reimbursement rates will be determined in accordance with C. below and TSJH's outpatient reimbursement rates in accordance with D below.

   a) Price-Based Services: For the 2010 fiscal year and for all subsequent fiscal years covered by this LOU, each Hospital's [redacted] in accordance with Section IX of this LOU). Each Hospital will also receive any outpatient fee schedule increases in accordance with the MRM.

b) Outpatient Payment Ratio: For the 2010 fiscal year and for all subsequent fiscal years covered by this LOU, each Hospital's outpatient payment ratio will be updated annually at the beginning of the fiscal year by updating each Hospital's previous fiscal year ending outpatient payment ratio using the standard MRM methodology and applying the standard update factor for a MRM hospital (e.g., [redacted] etc.).

C. **PHA Inpatient and Outpatient Reimbursement Provisions - Borgess/Pipp Health Center**

Borgess/Pipp Health Center's (BPHC) reimbursement for inpatient acute care admissions and/or outpatient Covered Services that are reimbursed under the PHA will continue to be based on Peer Group 5 (PG5) reimbursement policies and in accordance with the following provisions:

1. 2009 Fiscal Year: For the 2009 fiscal year, BPHC's previous fiscal year ending payment ratio used for final BCBSM settlement will be updated [redacted] and applying the standard update factor for a MRM PG5 hospital plus [redacted] CRNA allowance and a 0.5% allowance in recognition of AH's favored discount commitment). For example [redacted]

2. 2010 Fiscal Year and Subsequent Fiscal Years: For the 2010 fiscal year and for all subsequent fiscal years covered by this LOU, BPHC's previous fiscal year ending payment ratio used for final BCBSM settlement will be updated annually using the MRM for a PG5 hospital and applying the update factor for a MRM PG5 hospital (e.g., [redacted], etc.).

D. **PHA Outpatient Reimbursement Provisions - Tawas St. Joseph Hospital**

Consistent with the previous LOU outpatient reimbursement methodology, TSJH will be categorized for BCBSM purposes as an "outpatient exception hospital". TSJH's reimbursement for PHA outpatient services will continue at a controlled charge payment ratio as a PG5 hospital rather than being price-based in accordance with the MRM. The following provisions will apply:

1. 2009 Fiscal Year: For the 2009 fiscal year, TSJH's previous fiscal year ending outpatient payment ratio used for final BCBSM settlement will be updated [redacted] and applying the standard update factor for a MRM PG5 hospital plus [redacted] and a 0.5% allowance in recognition of AH's favored discount commitment). For example [redacted].

2. 2010 Fiscal Year and Subsequent Fiscal Years: For the 2010 fiscal year and for all subsequent fiscal years covered by this LOU, TSJH's previous fiscal year ending outpatient payment ratio used for final BCBSM settlement will be updated annually using the MRM for a PG5 hospital and applying the update factor for a MRM PG5 hospital (e.g., [redacted], etc.).

VI. **TRUST Reimbursement Provisions for Members' Covered Services**
(Note. Uncompensated Care and Pay-for-Performance are addressed in Sections IX. and X. of this LOU)

A. TRUST Acute Care DRG Reimbursement Provisions: For the 2009 fiscal year, and all subsequent fiscal years covered by this LOU, Inpatient acute care admissions for Covered Services that are DRG reimbursed under the TRUST Hospital Agreement will be reimbursed at 100% of each Hospital's PHA level of reimbursement determined under this LOU (i.e., DRG settlement price). BCBSM may, however, adjust each Hospital's DRG rate in order to voucher a discount for services provided to TRUST members (e.g., vouchered at 90% of PHA). This adjustment, if any, is for claim processing purposes only. Each Hospital's aggregate inpatient DRG reimbursement will not be affected by a discount for product differentiation. Each Hospital's aggregate inpatient reimbursement will be settled based on the rates and methodologies described in the PHA and determined under this LOU (i e , 100% of the PHA level of inpatient reimbursement used for final BCBSM settlement).

B. TRUST Psychiatric and Rehabilitation Inpatient Reimbursement Provisions: For the 2009 fiscal year, and all subsequent fiscal years covered by this LOU, [redacted]

C. TRUST Outpatient Reimbursement Provisions:

1. 2009 Fiscal Year: Except for TSJH, each Hospital's previous fiscal year ending TRUST outpatient payment rates used for final BCBSM settlement will be updated as follows. Outpatient TRUST Covered Services for TSJH will be reimbursed in accordance with c) below.

   a) Price-Based Services: For the 2009 fiscal year, each Hospital's outpatient [redacted] will be will be updated at the beginning of the fiscal year in accordance with the MRM [redacted] Concurrently, BCBSM agrees to further adjust [redacted] by an additional increment so the level of reimbursement [redacted] results in a level of reimbursement that is [redacted] greater than the standard MRM update methodology alone would yield [redacted] and a 0.5% allowance in recognition of AH's favored discount commitment).

   b) Outpatient Payment Ratio: For the 2009 fiscal year, each Hospital's TRUST outpatient payment ratio will be the same as each Hospital's PHA outpatient payment ratio.

   c) Tawas St. Joseph Hospital: TSJH's reimbursement for TRUST outpatient Covered Services will be the same as TSJH's PHA outpatient level of reimbursement.

2. 2010 Fiscal Year and Subsequent Fiscal Years: Except for TSJH, each Hospital's previous fiscal year ending outpatient payment rates used for final BCBSM settlement will be updated as follows. Outpatient TRUST Covered Services for TSJH will be reimbursed in accordance with c) below.

   a) Price-Based Services: For the 2010 fiscal year and for all subsequent fiscal years covered by this LOU, each Hospital's outpatient [redacted] will be will be updated annually at the beginning of the fiscal year in accordance with the MRM (i.e., [redacted]) components are updated annually in accordance with Section IX of this LOU). Each Hospital will also receive any outpatient fee schedule increases in accordance with the MRM.

   b) Outpatient Payment Ratio: For the 2010 fiscal year and for all subsequent fiscal years covered by this LOU, each Hospital's TRUST outpatient payment ratio will be will be the same as each Hospital's PHA outpatient payment ratio.

   c) Tawas St. Joseph Hospital: TSJH's reimbursement for TRUST outpatient Covered Services will be the same as TSJH's PHA outpatient level of reimbursement.

VII. **BCN Reimbursement Provisions for Members' Covered Services**
(Note, Uncompensated Care and Pay-for-Performance are addressed in Sections IX. and X. of this LOU)
Except for Genesys Regional Medical Center, for the 2009 fiscal year, and all subsequent fiscal years covered by this LOU, inpatient admissions and/or outpatient Covered Services that are reimbursed under the BCN-HAA will be reimbursed at 100% of each Hospital's TRUST level of reimbursement determined under this LOU. The Parties agree that the BCN contractual and reimbursement provisions for GRMC will be in accordance with the written agreement(s) between GRMC and BCN and not this LOU.

VIII. **Catastrophic Cases**
For the term of this LOU, each Hospital [redacted]

IX. **Uncompensated Care**
For the term of this LOU, and on a fiscal year beginning basis, each Hospital shall [redacted]

[redacted]

X. **Pay-for-Performance (P4P)**

For the term of this LOU, [redacted] It is noted BPHC's P4P program is specific to PG5 hospitals (e.g., must meet the established measures to gain the full level of reimbursement).

XI. **Rebasing**

[redacted]

XII. **Favored Discount**

AH attests, on a hospital-specific basis, its 2008 fiscal year payment rates for covered hospital services under its PHA, TRUST Hospital Agreement, and BCN-HAA are, in aggregate, at least 10 percent less than the next best payment rates it has established with any other commercial insurer for products of similar scope and design. For the term of this LOU, AH guarantees that BCBSM's differential will continue, on a hospital-specific basis, to be at least 10 percent less than the next best payment rates it has established with any other commercial insurer. If BCBM wishes to verify compliance with the foregoing, a mutually agreed upon third party auditor will be used whose cost will be borne by BCBSM if AH is found to be in compliance with this paragraph. If AH is found to be out of compliance with this paragraph, the cost of the third party auditor will be borne by AH. Comparison of payment rates will be made on an overall basis and not on a specific service line basis, such as comparing only inpatient rates. In the event there is a breach of this provision, BCBSM prospectively will adjust its payments to the hospital and remove the 0.5% allowance previously built into the hospital's inpatient and outpatient prices for the years' that the hospital is out of compliance with this Section. Adjustments will be applied as an offset to the hospital's annual update factor for the upcoming year. This adjustment shall not be made if the hospital, prior to the start of the year to which the adjustment is to be made, renegotiates its contracts with the commercial insurer so that the rates are in compliance with this paragraph. This provision does not apply to prices negotiated with commercial insurers that are related to the Hospitals' and/or AH or, where Hospitals' and/or AH is a majority owner in whole or in part.

XIII **Other Provisions**

A. Administrative Price Adjustments: Each Hospital recognizes [redacted]. BCBSM agrees to implement such price adjustment(s) during the first year of implementation in a "budget neutral" manner (i.e., the financial impact does not result in a material increase or decrease in Hospital's reimbursement) and that the established prices will be the basis for subsequent year updates. A material financial impact limit will be defined as a forecasted change of $250,000 in the aggregate for all impacted Hospitals. If AH wishes to verify compliance with the foregoing, a mutually agreed upon third party auditor will be used whose cost will be borne by AH if BCBSM is found to be in compliance with this paragraph. If BCBSM is found to be out of compliance with this paragraph, the cost of the third party auditor will be borne by BCBSM.

B Quality Programs: For the term of this LOU, each Hospital may participate in any quality program offered by BCBSM as long as Hospital meets participation requirements and accepts, if any, applicable defined financial provisions. This includes eligibility for the Regional Benchmark Comparison throughout the term of this LOU.

C Providence Park Hospital Novi: The Parties agree that on September 5, 2008, BCBSM will transition the current separate rate structure between Providence Hospital and Medical Centers and Providence Park Hospital Novi to the same BCBSM payment rates as Providence Hospital and Medical Centers. Adjustments will be considered in the distribution of the lump sum payments and/or recognition of update factors between Providence Hospital and Medical Centers/Providence Park Hospital Novi and other AH hospitals as part of this agreement as long as they are proposed on a budget neutral basis.

D. Joint Initiatives: BCBSM is willing to support a joint initiative with AH to improve claim adjudication and reduce administrative burden to both parties.

E. Product Migration: The Parties agree that based on the inpatient reimbursement provisions of this LOU and the Standard Agreements that "product migration" (the upward shift from Members enrolled in the Traditional product to the PPO/POS and HMO products) is no longer an issue that requires additional reimbursement consideration since the inpatient payment rates used for final BCBSM settlement are the same for all products.

F. Genesys Regional Medical Center – Operating Rooms: Based on licensure, certain operating rooms (OR's) at Genesys Regional Medical Center (GRMC) are freestanding and will remain freestanding for BCBSM reimbursement purposes unless there is a change in licensure to hospital status (i.e., licensed as hospital operating rooms). In the event hospital status is obtained, BCBSM agrees to reimburse GRMC at the prevailing statewide BCBSM hospital surgical fee level for outpatient services provided in these OR's. BCBSM also agrees to discuss the establishment of a surgical passthrough factor for surgical services provided in these OR's.

Upon signature, this LOU constitutes a legally binding agreement between AH, on behalf of all of its member Michigan Hospitals, BCBSM, and BCN. AH, its member Michigan Hospitals, BCBSM, and BCN will maintain the confidentiality of this LOU and will not disclose this LOU, or the contents of this LOU to any person or entity other than their agents, employees, or representatives who have a need to know AH, its member Michigan Hospitals, BCBSM, and BCN will require their respective employees, agents or representatives to be bound by this provision. Ascension Health, on behalf of its member Michigan Hospitals, BCBSM, and BCN hereby agree to the terms of this LOU as evidenced by the signatures below

Ascension Health

AUTHORIZED REPRESENTATIVE

Patricia Maryland, Dr.PH
NAME (Print or Type)

Ministry Market Leader, Michigan
TITLE

10-22-08
DATE

Blue Cross Blue Shield of Michigan

AUTHORIZED REPRESENTATIVE

Kim Sorget
NAME (Print or Type

Vice President, Provider Contracting and Network Administration
TITLE

10/27/08
DATE

Blue Care Network of Michigan

AUTHORIZED REPRESENTATIVE

Jeanne Carlson
NAME (Print or Type

President and Chief Executive Officer
TITLE

10/28/08
DATE

Eff. 07-01-08 AH LOU v4 10-13-08 ETK doc

Exhibit A

Allocation of Lump Sum Payment
(See Section IV. of this LOU)

Member Hospital	Facility Code	FY 2009 Lump Sum Payment
Borgess Medical Center	00032	[redacted]
Genesys Regional Medical Center	00180	
St. Mary's of Michigan Medical Center	00028	
Tawas St. Joseph Hospital	00209	
St. John Hospital & Medical Center	00116	
St. John Macomb-Oakland Hospital	00048	
St. John River District Hospital	00056	
St. John North Shores Hospital	00248	
Total FY 2009 Lump Sum Payment		

Payment will be made to each Hospital as a FY 2009 BCBSM Interim Payment ("BIP") adjustment and will be included, along with a BCBSM liability amount equal to the FY 2009 BIP adjustment, as part of each Hospital's FY 2009 year end settlement process. The Parties agree the lump sum payment amount is a one time payment and will not become part of the Hospital's payment rate(s)

Exhibit JJ

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

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

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

Detroit, Michigan

Wednesday, November 14, 2012

Confidential Video Deposition of:

DOUGLAS DARLAND,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan 48226, before Quentina R. Snowden, CSR-5519, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 10:00 a.m., when were present on behalf of the respective parties:

said, we're preparing for a meeting on how to, you know, protect our members, how to protect our market share, how to make sure that we get the best discount that we can get. And so, when hospitals bring up points, you know, we need to bring up counterpoints. One of our interests, of course, is to -- is to sell our coverage to members. And so I was using this as -- as a potential -- another aspect to build into the contract that said, you know, we can -- you know, you only get the standard update, however, if you're going to be able to guarantee that -- that our share of the Beaumont business doesn't shrink, you know, we would be willing to give you X.

So it's just a negotiating tactic to figure out how to rationalize giving them as little as possible, when you know you're not going to get out of there without giving them something over the standard update.

Q Okay.

A They're a pretty -- I say "They", you know, they, we -- Beaumont's very -- a very important provider in the Blue Cross network, and so -- and they're smart. And so they have good points that they bring up. And so we need to be able to address those points and try to capitalize on opportunities.

Q At the bottom of the first page of page (sic) five, you wrote, "As long as we continue to account for 55 percent of Beaumont's gross revenue, we should be able to afford --" in quotes "-- a more generous payment rate increase."

Do you see that?

A Yes, I do.

Q And so were you saying basically as long as Beaumont kept the rate -- discount differential at the current levels, that -- that Blue Cross was willing to afford a more generous payment rate increase for that?

MR. GILMAN: Objection, form, foundation.

THE WITNESS: Yeah, that's what this says, I think. But again, it's -- it's a tactic. It's just a piece of -- of the negotiation.

BY MR. KRAMER:

Q Okay. Let me ask you, please, to turn to the second page of Exhibit 5, where you wrote there, in the top bullet point at the top of the page -- I'll also note it says "page 2 of 3", but we received two pages, 1 and 2 of Exhibit 5 and no page 3; so just to be clear on that.

Anyway, getting back to that bullet point, it says, "Additional update over standard update

conditional on retention of current discount differential, BCBSM versus other commercial."

Would you explain what that signified, please?

A Yeah. Sorry I keep repeating myself. But it's the same answer; and that is, you know, providing some rationale for having to give them an update over the typical standard update, which was probably in the two and a half to 3 percent range.

Q Why did you need a rationale for that, sir?

A Well, my job was to get the best deal, the best discount that we could -- that I could. And I can't remember what kind of approval process that we had in place back in 2004, but by -- whether it was formal or informal, any increment that -- that I allowed that was over standard update, had to have some type of a justification. You know, we have a standard update of 2.5 percent. Why on earth did you give them 3 percent? Well, there's lots of reasons. They're an important provider in our network. They're -- they need to remain financially viable, you know, those types of things. And so when I come back to my leadership and say, yes, the standard is 2.5 percent, I had to give them 3 percent, here's why I had to give it to them, but here's also some

benefits of having gotten it -- given it to them. You know, we still have a good working relationship with them. We still have a great discount. We still have this high quality provider in our network that our members love, that sort of thing.

Q And the MFN clause was one of the justifications you were providing as a rationale for the additional update over the standard update?

MR. GILMAN: Objection, form.

THE WITNESS: Yes.

BY MR. KRAMER:

Q Okay. And let me go back to the point where you were proposing an MFN clause at the top of page 2 of Exhibit 5. In fact, you call it a mega most favored nation clause there.

Why were you proposing that, sir?

MR. GILMAN: Objection, form, foundation.

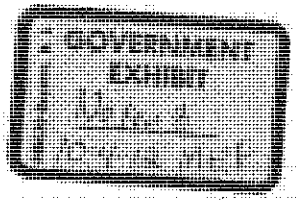
THE WITNESS: I would say I was proposing it because Dennis Herrick brought it up and, you know, attached some value to that. And so, we're, you know, taking advantage of -- of addressing the things that the people on the other side of the table think are valuable.

BY MR. KRAMER:

Exhibit KK

Discussion Points on Alternative Proposal

- Three year agreement
- Accept current proposal through December 31, 2008
- Calculate rates to yield a margin of 7 percent on hospital operations on BCBSM book of business
- Cost data to be used – June 30, 2008 Audited Financial Statements
  - We won't have a Medicare cost report until November 2008
  - We won't have front sheets until March 2009
- Standard model hospital updates
- Incentive
  - Is the incentive on top of the 7 percent?
  - If not, then incentive is not paid but participation in all quality programs is expected
- PG5 hospitals excluded



Discussion Points on Current Offer

- Significantly greater reimbursement than the model
- Model level of annual updates
- Moves uncompensated care to current
  - Skipping two years of lower uncompensated care (2006 and 2007)
- Using best available data (2006) provides greater than 10 percent margin
- Addresses Losses on CRNA's
- Relief from administrative burden of outlier audits
- $5 million up front payment (lump sum)
- Payment for Most Favored Discount (1/2% for 10 point spread)
- Payments that compare favorably to other hospitals in their geographic region

On letterhead

Dated May 6, 2008

To Pat McGuire

Dear Pat,

This letter completes the proposal that was presented to Ascension Health (AH) on April 3, 2008 by Blue Cross Blue Shield of MI (BCBSM) regarding contract terms for the three years beginning July 1, 2008. With the information that you provided on April 30, 2008, I can now propose the following terms for your consideration:

Hospitals Included

- St. John Hospital and Medical Center
- Providence Hospital (Southfield)
- St. John Macomb/Oakland Hospital
- River District Hospital
- Providence Park Hospital
- Tawas St. Joseph Hospital
- Borgess Medical Center
- Borgess Pipp
- Genesys Regional Medical Center
- St. John North Shores Hospital
- St. Mary's Medical Center of Saginaw

Term

- Three years beginning July 1, 2008 and ending June 30, 2011

Lump Sum Payment

- $5,000,000 to be paid July 1, 2008

Annual Updates

- Standard update (same as hospitals classified as having accepted the model PHA)

Other Reimbursement Terms

- Update uncompensated care (UC) on a fully current basis. For 2008, information was supplied that would indicate a material increase in UC for 2008 however this information is obviously not final and needs to be reviewed once it is final. Accordingly, BCBSM will use 2007 UC to set the rates and add one half percent on an interim basis to the overall prices to cover the increase in UC from 2007 to 2008. At year end, BCBSM will calculate the actual UC using AH audited numbers for 2008 to be used at final settlement. Our calculations estimate the value of moving the UC forward by two years has a total impact of $16.5 million (a year one impact of $11 million and a year two impact of $5.5 million).

- Increase the 2008 update by .004 points (a 3 percent update would increase to 3.4 percent) to address the shortfall that AH is experiencing in CRNA's performing services for BCBSM members. While the information supplied indicated that the loss on CRNA's was closer to $4 million, we believe it is reasonable to support half of the loss (.004 equals approximately $2 million) in year one and then reevaluate the loss when we review the data from the rebasing calculations to determine if more support would be appropriate.
- Favored Discount – While a 10 point difference (per your April 30 communication) is not the level of favored discount commitment that BCBSM had hoped, we are willing to add an additional .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.

Other Issues - BCBSM

- Rebasing will occur by year end 2008 with reimbursement changes taking effect in July 2009. BCBSM will commit to honor the above increases if rebasing brings overall payout to the Ascension hospitals in Michigan (not to be implemented on a hospital by hospital basis) down, but will honor an increase as a result of rebasing if doing so would increase overall payout to Ascension hospitals in Michigan (straight rebasing with no additional add on's).
- Outlier payment will be made part of the base rates. In order to do this, a one time increase to the hospital update of .006 will be added for the year beginning July 1, 2008. After July 1, 2008, no outlier payments will be processed through the claim system and no audits of outlier cases will be performed.
- Hospitals classified as Peer Group 5 (Standish and Borgess-Lee) will have their reimbursement calculated consistent with the revised PHA Peer Group 5 methodology.

Other Issues – AH

- BCBSM cannot agree that **any** future change in reimbursement made by BCBSM will be adjusted to keep overall reimbursement levels no less than the levels outlined above, however, BCBSM will consider budget neutral implementation of any **material** changes that it implements which affects AH.
- AH is welcome to participate in any quality program offered by BCBSM as long as AH meets the participation parameters and accepts the defined financial terms of the quality program.
- Providence Park Hospital, when it becomes fully operational will not automatically receive the same reimbursement rates as Providence–Southfield. BCBSM believes that certain efficiencies should be obtained from a new hospital that would justify a lower payment structure than the older Southfield hospital.
- BCBSM is willing to support a joint initiative with AH to improve claim adjudication and reduce administrative burden to both parties.
- AH requested that rates be adjusted in order to prevent any reduction in reimbursement due to migration in BCBSM products. Based on the current LOU between AH and BCBSM along with the format of the model PHA, this is no longer an issue.

- Upon reaching the end date of this LOU (June 30, 2011), AH will accept standard updates. Standard is defined differently for hospitals which have accepted the model PHA and those that have not. AH could be considered either depending on the outcome of the rebasing analysis.
- The OR's at GRMC are freestanding based on their license and therefore will need to remain freestanding for BCBSM reimbursement purposes.
- The GRMC ED charge issue is a separate issue from the rate negotiations, however if the supporting workpapers used to generate the charge attestation was provided BCBSM could evaluate this matter quickly and come to a resolution along with the finalization of this LOU.
- All terms and conditions of the existing LOU cease to exist once a current agreement is reached. A new LOU will be executed which will constitute the entire agreement and understanding between the Parties.

Here is the plan I suggest we follow.

We will finalize the letter as drafted for your signature. We will also modify the graph with the various offers thus far, removing our negotiations tolerance level. Jerry will bring them over at 8:30. Hopefully we will have a break between the 8:00 and 9:00 meeting to review with you.

Jerry and I talked about a blend of what Mike and Kevin suggested to you, with some modifications. The counter proposal to talk to, but not in the letter will be to have them accept our offer that would be in effect until 1/1/09. Once we receive their audited financial statements by year end (for FYE 6/30/08) we would rebase their costs and determine a model payment level and provide a guarantee of a 7% margin on our business for year one only. If they are able to reduce their costs further they can improve their margin and if they don't they their margin is only there for one year. If their costs up they will not be able to maintain the margin. We believe this could be less costly than what they are asking, but might be a little more than where we are with our current offer and most likely less than Kevin might want to put on the table.

We don't support coming up with covering physician costs or a unique Ascension P4P program. It would take months in working with them to ever TRY and finalize such a program. Jerry will put together some talking points and bring with him at 8:30 on this alternative as well as some talking points relative to how we believe our current offer is good.

Exhibit LL

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

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

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

Detroit, Michigan

Wednesday, October 24, 2012

Confidential Video Deposition of:

KENNETH DALLAFIOR,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan 48226, 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:

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is a Rick Burgess's statement because he sells national accounts and we had groups that took entire states out and gave them to another carrier.

So, at that point, it comes into play at that point we have to do something to figure out how to be and overcome those things in the respective national account business.

Q And my question for you though, is if Blue Cross/Blue Shield of Michigan had any disconnt erosion, would you agree that that can't be taken lightly?

A I think it's an element of our business we have to be mindful of, yes.

Q You mentioned some employer groups carving out other states with respect to Blue Cross/Blue Shield of Michigan. Do you know if Blue Cross/Blue Shield of Michigan wins accounts just for Michigan and these are national accounts where other -- in other states the employer uses other health care -- third health insurance plans?

A Say the question one more time, because I'm not sure I --

Q You described situations where Blue Cross/Blue Shield of Michigan may be the control plan, but other states are carved out.

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A Uh-huh.

Q Correct?

A It's happened on a few occasions.

Q Right. And I'm asking you, are you aware of situations where another plan, maybe a control plan in a different state and Michigan is carved out and that employer group goes with Blue Cross/Blue Shield of Michigan?

A So, because this is -- I'm just making sure I understand. You're -- you're saying where another state, Blue Plan is the control plan?

Q No, there's -- let's say Aetna is the -- represents -- is the health insurer for most of the business --

A Okay.

Q -- in other states, but in Michigan the employer group carves the State of Michigan out and goes with Blue Cross.

A Oh, and gives it to Blue Cross/Blue Shield of Michigan. We don't have any of those groups.

Q None?

A Boy, not that I -- uh-uh. No. We don't have any groups like that. In fact, we tried to get Delta Airlines to do that, when they moved the business -- when they went from Northwest to Delta and they would

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not do it. Because they said, your discounts aren't good enough and it isn't worth us doing that. I've got -- you know, there's documentation where we asked them specifically just -- we asked Cumulus who bought Citadel Broadcasting, same question. They would not carve the Michigan population out and give it to Blue Cross/Blue Shield. So I know there's two large national accounts that would not give us the Michigan-only business on the premise of that question.

MR. GRINGER: We need to change the tape.

VIDEO TECHNICIAN: We're off the record at 5:08.

(Off the record at 5:08 p.m.)

VIDEO TECHNICIAN: We're back on the record. We're beginning tape four of the deposition at 5:17.

(Back on the record at 5:17 p.m.)

BY MR. GRINGER:

Q Mr. Dallafior, thank you for your patience today. Just a couple more questions from the United States.

Are you aware of any benefits Blue Cross receives from its use of most favored nation clauses

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in its hospital contracts?

MR. HARRIS: Object to the form, foundation.

THE WITNESS: No.

BY MR. GRINGER:

Q Are you aware of Blue Cross's use of MFN clauses saving its customers any money?

A No.

MR. GRINGER: Nothing further from the United States. I'm going to pass you over to Mr. Lipton, who has --

MR. HARRIS: Just while we're making the switch, just so the record is complete, and we can not have further dialogue on this, at the U of M deposition, Mr. Matheson objected to incomplete hypothetical. In the Oakwood deposition, Ms. Noteware (ph) objected. These are just some examples. At the -- at the Borgess deposition, Mr. Lipton did, joined by Mr. Joyce. At the Botsford deposition, counsel for the witness did. And at the Crittenton deposition, is it Mr. Hane (ph) or Ms. Hane (ph), I'm not familiar, did.

So, just so the record is clear, I'll continue to make the objection as I see fit.

MR. LIPTON: I just want to make sure

Exhibit MM

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.	:	
BLUE CROSS BLUE SHIELD OF MICHIGAN,	:	2:11-cv-15346-DPH-MKM
Defendant.	:	

Troy, Michigan

Monday, October 8, 2012

Confidential Video Deposition of:

FREDERICK SCHAAL,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 201 West Big Beaver Road, Suite 500, Troy, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:10 a.m., when were present on behalf of the respective parties:

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Q Can you think of any way that the MFN has benefited the patients that are treated at the hospitals that are subject to the MFN?
A No.
Q Can you think of any way that the MFN has benefited Aetna's customers?
A No.
Q Can you think of any way the MFN has benefited people on Medicare?
A No.
Q Can you think of any way that the MFN has benefited Blue Cross other than ensuring it has better discounts than its competitors?
A No.
MR. GILMAN: Objection, form.
BY MR. MATHESON:
Q If the MFN doesn't help, why do you penalize hospitals that don't comply with it?
MR. GILMAN: Objection, form, foundation.
THE WITNESS: I don't know if it helps or not. It's supposed to get us the best discount, and I'm assuming that's what it does.
BY MR. MATHESON:
Q Do you believe the MFN -- that the PHA -- sorry. Strike that.

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Do you believe the PHA provides for financial consequences for hospitals that fail to comply -- for Peer Group 5 hospitals that fail to comply with this provision?
A There is language in there, which we've read a few times today already, that talks about what happens if a hospital does not attest to the MFN.
Q And have you, yourself, made decisions that certain hospitals will suffer financial consequences for failure to comply with the MFN in the Peer Group 5 contract?
A The Three Rivers was an example that we discussed.
Q Why did you choose to impose a financial consequence on Three Rivers Hospital due to its failure to comply with the MFN?
A Because it was -- that process was written in the contract, on what to do if that situation arised.
Q What purpose did you believe it served to enforce the contract in that circumstance?
A It was just a contract enforcement.
Q But you don't enforce all the provisions of the PHA in all circumstances, do you?
A Not always.
Q You only enforce it when you believe it makes

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business sense; is that right?
A That's correct.
Q Why did it make business sense to impose a financial consequence on Three Rivers Hospital for failing to attest to its compliance with the most favored discount provision of the PHA?
A Because it was written in the agreement and there weren't any other situations I was aware of where the hospital was struggling financially, it was going to go out of business. There's many things and issues that a hospital faces when you're negotiating or opening up agreements. You've got to listen to the whole story. Their only issue was the MFN at that time.
Q Did you believe imposing a financial consequence on Three Rivers might encourage them to attest to compliance with the most favored discount provision of the PHA?
MR. GILMAN: Objection, form.
THE WITNESS: It's a possibility.
BY MR. MATHESON:
Q Is that why you did it?
A No. I did it because it's in the contract.
Q So you didn't have any particular reasou or end you were serving when you imposed that financial consequence; is that right?

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A No.
MR. GILMAN: Objection, form, foundation.
BY MR. MATHESON:
Q You didn't take into account Blue Cross's competitive position against other commercial insurers in the state of Michigan; right?
A Never take that into consideration. I look at the hospital's financial situation. If the hospital was going to close their doors tomorrow because of 1 percent, I may have made the business decision not to impose the 1 percent. I look at a multiple of things when I negotiate and administer contracts. I do not -- I do not just stick somebody because I was having a bad day. Okay?
Q Is one of the things that you take into consideration when you're choosing to enforce or refrain from enforcing the terms of the PHA the impact that your actions would have on Blue Cross's competitive position vis-a-vis its commercial insurance competitors?
A No.
Q Do you think it's appropriate to take that into account when deciding whether or not to enforce the terms of a contract?
A I don't know if it's appropriate or not. I don't do it.

Exhibit NN

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

Volume 1

Detroit, Michigan

Tuesday, October 16, 2012

Confidential Video Deposition of:

KIM SORGET,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:05 a.m., when were present on behalf of the respective parties:

have been one or two, at most?
MR. GILMAN: Objection, form, foundation.
THE WITNESS: That was prior to me being responsible for contracting, for the most part.
BY MR. KRAMER:
Q How did a collaborative approach lead to the opportunity to attain or retain favored pricing, sir?
A As a collaborative approach, it was our intent to have a strong working relationship with the industry, where you work together to address the needs of the population at large.
Q Okay. And given that collaborative approach, how did that lead to the opportunity to attain or retain favored pricing?
A It assured that we would be able to provide the service -- or programs that we do that maybe our competition doesn't to improve the quality and access of care in the state.
Q And in what way would that lead to attaining or retaining favored pricing?
MR. GILMAN: Objection, form.
THE WITNESS: I can't answer that question, as is.
BY MR. KRAMER:
Q Okay. Would it be the case that Blue Cross

basically was looking to work with the hospitals if the hospitals, in turn, worked with Blue Cross to assure Blue Cross that it had favored pricing?
A It was intended to be a collaborative relationship.
Q To that end?
A No.
Q In part?
A I don't think so. We never reached agreement on it for the 1 through 4s.
Q Okay. Did you with the PG 5s?
A Yes, we did, at a much later date than this.
Q As of June 2005, hospitals had not yet rejected an MFN in the PG 1 through 4 PHA; is that right?
A I can't recall.
Q Let me ask you, please, to turn to the fourth page of Exhibit 3, under the heading "Next Steps." There's -- after the sentence, "The committee agreed to move forward with the BCBSM collaborative approach," there's a record of a discussion that reports, in part, "...concern was raised relative to adding 4 to 7 percent to the revenue impact base, noting an increase of this size impacts BCBSM's underwritten premiums by 2 percent."

Do you see that?
A Yes.
Q Could you explain, please, first of all, does this refer to an increase in the hospital reimbursement level by 4 to 7 percent?
A I'm not clear by reading this what it really means.
Q Well, can you -- do you think that's correct, given what the document, Exhibit 3 itself, is talking about in terms of a potential increase to the hospitals?
A I don't believe this is probably correctly articulated. My only comment was, if we raised the reimbursement, it will cause rates to increase. Whether these amounts are achieved or not, I don't know.
Q And when you say it would raise reimbursement, "it will cause rates to increase," do you mean premium rates?
A I don't know how they determine premium rates. It wasn't my area of responsibility.
Q Okay. Is it your understanding that what is being stated there would be that an increase of 4 to 7 percent of hospital reimbursement would result in an increase in Blue Cross's underwritten premiums by 2 percent?
A All I can say is I read what's here. I can't

determine the accuracy or credibility of it. I don't recall this language at this point and what the intent was, other than I said earlier, if you increase the reimbursement, it would have some impact.
Q On premiums?
A Could -- premiums. Self-funded customers would also be impacted.
Q And, indeed, the discussion noted on Exhibit 3, on the fourth page, it goes on to state, "It was also expressed that self-insured customers would have significant problems with the premium increased, as they are expressing they cannot afford additional increases."
When there is an increase in hospital reimbursement, is it the case that self-insured customers pay that reimbursement increase lockstep, subject to any stop loss?
MR. GILMAN: Objection, form, foundation.
THE WITNESS: The sentence to me, at this point, doesn't make any sense. Self-funded customers, I don't believe, have premiums. I'm not an actuary or sell coverage, but --
BY MR. KRAMER:
Q Well, this is a draft, so I understand that.
Okay. Moving away from Exhibit 3 for a moment, is it the case, sir, that when hospital

reimbursement rates increase, that self-funded customers pay those increases?
MR. GILMAN: Objection, form, foundation.
THE WITNESS: Somebody is going to pay for it.
BY MR. KRAMER:
Q And it would be those customers; correct?
A It would be all customers in some shape or form or other.
Q All self-funded customers, when they experience hospital reimbursement rate increases?
A They would be impacted.
Q Is the answer yes to my question?
A Yes.
Q Finally, there's a sentence that notes that the "...addition to the base would move Blue Cross's...rates closer to competitors, decreasing Blue Cross's...competitive advantage with hospitals."
Could you explain what that point was that was being made at the meeting, please?
A Well, I think the point is, if we're going to increase reimbursement according to the Cohen model that was proposed, it would cause us to pay more money.
Q And move Blue Cross's hospital reimbursement rates closer to the higher levels of competitors?

A I don't know what the levels are of the competitors, but would increase our reimbursement, yeah.
Q And at least at the meeting, it was observed that those rates would be closer to competitors; is that right?
A I don't know who made that comment, but that's what's stated in these draft minutes.
Q Okay.
(Sorget Exhibit 4 was marked.)
BY MR. KRAMER:
Q Please familiarize yourself with the document marked as Exhibit 4, which is Bates BLUECROSSMI-03-000602 through '605, a four-page document with a title at the top stating "BCBSM Expected Outcomes Talking Points."
A (Reviewing Sorget Exhibit 4.)
Q Have you seen Exhibit 4 before, sir?
A It looks familiar. I don't see a date on it.
Q Let me ask you for a moment, please, to refer back to the second page of Exhibit 2, toward the bottom of the entry on the second page there, where, on the June 2005, there's mention of "Blue Cross...expected outcomes."
Would that help you to date the Exhibit 4?

A Not necessarily.
Q Okay. Would it appear that it may have been prepared in the course of negotiations back around June 2005?
A I -- I have no idea when it was created.
Q Okay. Let me ask you, do you have any reason to believe that would not be the case?
A No.
Q Okay. Let me ask you, at the first sentence of Exhibit 4 states, "With this proposal and the significant money BCBSM is putting into hospital reimbursement it is critical that we demonstrate to our group purchases the value for which they can expect to receive."
Would the proposal that's being referred to here be the proposal regarding a revised PHA agreement with the 4 to 7 percent increase?
A I can't speak to the 4 to 7 percent increase exactly, but I can say it has to do with the entirety of the PHA agreement.
Q Okay. And what would the reference to "significant money" be, then?
A I think a number that had been shared before was 199 million.
Q Okay. And based on the range of 4 to 7

percent, which went up to I believe 113 million, then that would be more than 7 percent; is that right?
A It --
MR. GILMAN: Objection, form, mischaracterizes prior documents.
THE WITNESS: I can't say that.
BY MR. KRAMER:
Q Okay. Let me ask you, please, to focus toward the bottom --
MR. KRAMER: Let's --
VIDEOGRAPHER: We're off the record at 10:05.
(Recess - 10:05 a.m. to 10:06 a.m.)
VIDEOGRAPHER: We are back on the record at 10:06.
BY MR. KRAMER:
Q Just to correct the percentage range I gave before. The document we reviewed earlier that raised the 2.1 to 5 percent, Exhibit 2, rather than a 4 to 7 percent, had the high end at 113 million.
So would it be correct that 199 million, sir, would be a higher range than 5 percent?
A I don't know that. It's 199 million. I don't recall what the percentage was.
Q Okay.

Exhibit OO

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

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

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

Detroit, Michigan

Wednesday, October 24, 2012

Confidential Video Deposition of:

KENNETH DALLAFIOR,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan 48226, 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:

product, the attributes of that product, where we don't laser the sick out or the claimant -- the high claimants. It's an advantage, and we have an advantage in how we can price and bring that product to the marketplace.

Q And for distribution channels, right-hand corner of the page, ending in 46 of Plaintiff Dallafior 2, there's some distribution channels identified?

A Yes.

Q And do you know how those distribution channels for middle and small group compare to the distribution channels for individual?

A Our individual or for the marketplace individual?

Q For the marketplace individual, if you know?

A No, I don't know how they -- across the marketplace.

Q What about for Blue Cross's individuals?

A So your question is how distribution channel partners that are listed here, how they work with our individual products?

Q No. My question is, are -- is there a difference in the actual distribution channel used with respect to individual business as compared to

middle and small group business?

A There are some -- there are some that are the same on this page and some that we interact differently as the individual business unit goes to market.

Q Which ones interact differently?

A Well, there's different levels of overriding compensation. There is -- so that's a big difference. That's probably the -- the one difference that I would state in regards to your question.

Q Do -- strike that.

All right. Let's move on from Plaintiff Dallafior 2. I'm going to hand you what we're going to mark as Plaintiff Dallafior 3.

(Plaintiff's Exhibit Dallafior Number 3 was marked for identification.)

BY MR. GRINGER:

Q And as I'm doing that, do you recall, we've been talking a little bit about components of costs. And so, I'm handing you what we're marking as Plaintiff Dallafior 3. It's one page, front and back, with a Bates number beginning with Blue Cross MI-99-01979789.

A Do you want me to read this or --

Q If you can take a minute just to familiarize

yourself with Plaintiff Dallafior 3, sir.

A (Reviewing.) Okay.

Q Do you recognize Plaintiff 3, sir?

A Do I recognize?

Q Plaintiff Dallafior 3, Exhibit 3?

A Yes.

Q What is it?

A It's a letter that we sent out to our customer, our BCN customer base during -- well, it says November 2nd, 2011, we sent it. And it was in regards to an update where we were in the negotiations with the Beaumont Health System.

Q And is that your signature on the second page of Plaintiff Dallafior 3?

A It's my electronic signature they use on letters for me.

Q And so this -- it's correct to say that Plaintiff Dallafior 3 is the letter from you and Mr. Klobuchar?

A As it's stated, yes, on here, uh-huh.

Q If I could ask you to turn to the first page of Plaintiff Dallafior 3, in the fourth paragraph you write, "Giving in to Beaumont's unreasonable demands for additional dollars without coupling them to outcomes-based performance metrics only harms our

customers by driving up what they and their employees pay for healthcare insurance."

Do you see that?

A I do.

Q What is the relationship between higher hospital rates and higher payments from your customers?

A Well, if we -- in the framework of the question for self-funded, do you want to start with that one; or do you want to go -- how would you --

Q Well, you wrote this to -- you sent Plaintiff Dallafior 3 to all customers whether --

A Are you a self-funded customer asking me that, or are you a fully-insured customer asking me that?

Q I'm an attorney with the Department of Justice asking you that question.

A I'm just trying to understand the context of your question.

Q You sent Plaintiff Dallafior 3 to all Blue Care Network customers regardless of whether they were self-insured or fully-insured; is that correct?

A That's correct.

Q What did you mean by -- when you wrote that paying Beaumont additional dollars would drive up your

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customers -- what your customers pay for healthcare and health insurance?
MR. HARRIS: Object to the form, foundation.
THE WITNESS: So, your question is what do we mean by that? The fact that the component of the network, in this case Beaumont Hospital, if we were to pay them more, that means those costs would be passed on, that portion, to the customer in either premium increases or in claims expense that they would incur for those claims that were -- those claims that were incurred at the Beaumont Health System.
BY MR. GRINGER:
Q And -- okay. And do you know whether Plaintiff Dallafior 3 was sent to every Blue Care Network customer in this entire State of Michigan?
A I didn't -- I wouldn't know if it went to all of them or not. My guess is that it probably did.
Q Is Beaumont Hospital -- well, first of all, where is Beaumont Hospital, if you know?
A It's in Royal Oak, Michigan.
Q And would you consider that part of the Detroit metropolitan area?
A Yes.
Q Is Beaumont Hospital an important network for

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Blue Cross to have in its network when marketing its products to residents of the Detroit metropolitan area?
MR. HARRIS: Object to the form.
THE WITNESS: Residents or employer --
BY MR. GRINGER:
Q Employer groups with employees who reside in the Detroit metropolitan statistical area.
MR. HARRIS: Object to the form.
THE WITNESS: Are they -- are you asking -- I want to ask you more specifically, if I could.
Are you asking if -- is it an important piece of the network in -- in the Detroit area?
BY MR. GRINGER:
Q Let's start there. Is Beaumont Hospital an important piece of Blue Cross's network in the Detroit metropolitan area?
A I think it's important. I wouldn't call it an imperative.
Q Why is it important?
A Because it provides access to a hospital system that might be a preference of some of our customers.
Q And you didn't want to pay Beaumont more than

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you had to here, correct?
A I would say -- I would answer that question, our customers don't want us to pay more of their money to Beaumont than necessary.
Q And why is that?
A Because healthcare costs are already too high and costs too much, and their premiums are too high or their costs as a self-funded plan is too high, and they would look to us to help them manage those costs down. And in this case, it would be with the Beaumont Health System.
Q As a health insurer, would Blue Cross, in your view, be at a disadvantage if its prices were ten percentage points higher than other health insurers at Beaumont in marketing its products to Detroit metropolitan area residents?
A We don't market a Beaumont product.
Q I'm not saying -- as -- would Blue Cross, in your view, be at a disadvantage if its prices were ten percent -- percentage points higher than other health insurers at Beaumont in marketing Blue Cross's health insurance products to Detroit area residents?
A On the self-funded side, I would say the answer is no. I mean, because they -- the employer group could choose not to use us and not to use

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Beaumont.
Q Well, if they didn't use you, you would be at a competitive disadvantage, right?
A They could or they could -- they also could set their benefit plan not to include Beaumont in a self-funded ERISA plan. And that was some of the strategies that customers were going to do. They were going to exclude access to it because of the discounts.
So Beaumont would not receive any of those -- those patients, claimants and payments for those claims.
Q And did that happen?
A No, because we resolved it.
Q So let me ask you this: Did you end up paying Beaumont more than you had been previously?
A We -- we entered into a relationship, from my understanding, and it's not my area or scope of responsibility, but what I understand the outcome of the negotiations were in the contract, was that we got an element of the Pay For Performance and something that would allow us to work with Beaumont to drive costs down, less utilization and be more efficient in the future, which would ultimately drive the cost of healthcare down, which is favorable to our customer

Exhibit PP

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

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

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

Detroit, Michigan

Thursday, November 15, 2012

Confidential Video Deposition of:

DOUGLAS DARLAND,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan 48226, 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:

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MR. GILMAN: Objection, form and foundation.
THE WITNESS: If I'm able to get less, then paying more would not be the best deal I can get.
BY MR. WALTERS:
Q Because if you end up paying more, Blue Cross's policyholders end up paying for that additional expenditure, right?
A Generally speaking, payments to hospitals are made by our customers.
Q Right. I mean, Blue Cross doesn't eat it somehow. The customers end up paying for it, right?
MR. GILMAN: Objection, form, foundation.
THE WITNESS: There have been occasious, Mark Bartlett could speak to this more precisely, I suppose, where we have used our reserves to -- to make payments to hospitals in certain situations.
BY MR. WALTERS:
Q But in the main -- if you're paying your hospitals more, then you're -- by definition your customer, your policyholders will pay for that in increased premiums?
MR. GILMAN: Objection, form.
THE WITNESS: Geuerally speaking, yes.

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BY MR. WALTERS:
Q And so that's why when you say you wouldn't be comfortable -- or wouldn't view it as appropriate simply to pay more in exchange for an MFN or MFN plus, that's the reason; do I understand that correctly?
A Connecting those two pieces together, as the only pieces of the puzzle on the table, yes, I would not be comfortable doing that, because I would not be protecting the assets of our customers.
Q And protecting -- I think you said Mark Johnson said that protecting the assets of your customers is one of -- you start I think early on in the deposition, one of Blue Cross's priorities. Do I recall that correctly?
A That was a statement that I recall from very early on when I started. And I also said I'm not sure that was the entire case, or something like that. But nonetheless, it is an important principle.
Q I was just about to ask you that. When you say protect the assets of your customers, what I understand you to mean by that, but correct me if I'm wrong, is that deliver the most value for the price, that is deliver -- the most value, the best deals for your customers; is that -- is that a fair characterization? If not, modify it.

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A I think that sounds fair.
Q Okay. Now, in addition to that being Blue Cross's charge, what other -- you said there was yet other objectives that you thought were also -- and could you speak to those.
A Well, as I've also mentioned, our mission of improving the health status of citizens of the State of Michigan, as an individual business, I suppose we need to be mindful of -- I guess that's the same thing I was going to say, mindful of being able to provide a valuable product in the marketplace. But I guess that's the same thing as protecting the assets of the customers to some degree.
I mean, there's certainly very general concepts that we need to be ethical in our treatment of -- in our dealings with -- with other parties.
Q The only reason I'm asking you is you seem to have something specific in mind, and I don't mean to belabor it.
A If I did have something specific in mind when I said that yesterday, I'm not sure what it was.
Q Okay. Fair enough.
MR. GILMAN: If you remember later, you can always remind him.
BY MR. WALTERS:

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Q Yeah. Sorry. Do I understand correctly that the -- you sought to achieve MFNs solely with the group -- peer group 5 hospitals; is that fair? As opposed to MFN pluses?
A I don't recall any MFN pluses. So I think that's correct.
Q Within --
A Within peer group 5.
Q Within peer group 5. Conversely do I understand that for all hospitals that were not peer group 5 hospitals, you sought to obtain MFN plus arrangements -- by that that's just shorthand so you and I are communicating that is to maintain a difference -- a differential between other payors and yourself in terms of discount rates?
MR. GILMAN: Objection. The question is vague. Could I -- I don't want to be accused of anything. But are you asking him if they sought MFN pluses with all non-peer group 1 through 4 or only sought MFN pluses when they sought --
BY MR. WALTERS:
Q Fair enough. What I'm asking is when you sought MFN arrangements, other than with group 5 hospitals, okay, non-group 5 hospitals, okay, when you sought them, did you seek them in the form of MFN plus

Exhibit QQ

Darland, Doug

From: Darland, Doug
Sent: Friday, November 12, 2004 3:30 PM
To: Seltz, Kevin; Schwartz, Mike
Subject: Beaumont update for meeting

In preparation for our discussion next week, here is a recap of recent discussions and proposals, as well as a few thoughts on proposal elements we may want to consider.

Beaumont Proposal: Based on BCBSM's commitment to provide a 5% margin for a three year period, and on our analysis of the current margin, along with the hospital's cost inflation projections, they have proposed the following.

2005 – [redacted] update (i.e. effective [redacted] increases accross the board)
2006 – [redacted] increase
2007 – standard update

comment: This is probably not a bad option, although we could probably knock a point off 2005 and a half point off 2006 and they would accept it just based on the stability it would provide. Or, we could accept something closer to their numbers, but insist on at least two more years at standard updates.

BCBSM Proposal (ignoring previous commitment of 5% margin): Apply the proposed new model PHA to Beaumont. Considering Beaumont's financial status, it is difficult to justify paying more to them than our model would allow.

2005 – approximate increase of 4% over 2004 (impact of implementing new model)
- plus signing bonus of approx [redacted]
2006 – standard update
2007 – standard update

Obviously, there is a large gap between our proposals.

Somehow, particularly since they brought it up, 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 between our proposals.

- Additional update over standard update conditional on BCBSM/BCN retaining base year share of gross revenue.
  - This means that we would expect to at least maintain our share of the Beaumont pie (measured as non-governmental gross revenue) if we are going to provide an additional update. The premise is that if Beaumont give HAP, e.g., a better discount than they are currently, Hap will translate that into better rates, more members, and a larger portion of Beaumont business. As long as we continue to account for 55% of Beaumont's gross revenue, we should be able to "afford" a more generous payment rate increase.

11/15/2004

GOVERNMENT'S EXHIBIT Darland 5

- Additional update over standard update conditional on retention of current discount differential, BCBSM vs other commercial
  - This is a mega-most favored nation clause. A simple most favored nation clause will do us little good as we know that Beaumont is never going to offer a discount that comes close to our current discount.

I met with Beaumont staff earlier this week, and we spent some time going over my new model implementation analysis, just to make sure it made sense. Frankly, I was almost hoping the review would reveal a flaw that would allow the model to actually result in an increase at the level they are requesting. No such "luck". I also took this opportunity to lay out an "unsanctioned proposal" for their consideration. I made it very clear it was only thoughts on a piece of paper at this point, but that an exchange of ideas between now and our next meeting would probably be helpful if we hope to resolve our stand-off. The proposal outline is as follows:

Proposal:

Based on YTD analysis, 2004 rates provide a [redacted] margin, i.e. [redacted] short of the [redacted] goal

1. **FYE 2005** – Standard update [redacted]
2. Complete a Blue Margin analysis based on final 2004 results (completed in August 2005)
3. Complete a payor mix analysis of 2004 gross revenues
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While this is somewhat short on implementation details, a little bit of creativity and analysis should be able to fill in the blanks over a couple of week period. Dennis will be most concerned with having something firm for 2005. What is nice about this proposal is that it provides an opportunity for us to at least come close to our previous commitment of a 5% margin, but makes it contingent on them continuing to deal more harshly with our competitors.

Another point that Scott continues to push, against Mark's advice, by the way, is that Beaumont really took a bath during the previous contract period. He continues to point to the "unforeseen circumstance" provision of the previous contract and request that we make up for some of their losses, including the Trad to TRUST shift they experienced for 2000 – 2003. This, I think, while somewhat legitimate, is not something that they can actually win on. Especially having waited this long to bring it up. However, it may provide another vehicle by which we can entice them into accepting a contract for 2005 - 200? that they may not otherwise. Let me explain:

The 2003 settlement resulted in a $14M "gain" at Beaumont. This means that our vouchered claim payments (which are used to bill our customers) were $14M higher than our final liability. Ultimately, this "gain" is returned to our customers, but at this point it has not yet been distributed. We could consider returning part of this gain to the hospital in exchange for more favorable contract terms in the future. There is virtually no real cost to this, as our customers would still receive a refund of say $10M, if we were to allow $4M to be paid back to Beaumont.

That's all I have for now. - Doug

11/15/2004

Exhibit RR

From: Darland, Doug <DDarland@bcbsm.com>
Sent: Monday, October 24, 2005 9:29 AM
To: Sorget, Kim <KSorget@bcbsm.com>; Noxon, Gerald <GNoxon@bcbsm.com>
Subject: RE: scan for D. Loepp

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 and Mike did not pursue this possibility. I thought it would have been well worth the investment. Mark mentioned it again when I was at Beaumont a couple weeks ago. 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. - Doug

---

From: Sorget, Kim
Sent: Monday, October 24, 2005 9:05 AM
To: Darland, Doug; Noxon, Gerald
Subject: FW: scan for D. Loepp
Importance: High

More fun. KIM

From: Schwartz, Mike
Sent: Monday, October 24, 2005 8:56 AM
To: Sorget, Kim
Subject: FW: scan for D. Loepp
Importance: High

Let's discuss—the good news and the bad news!

From: Loepp, Daniel J.
Sent: Wednesday, October 19, 2005 2:55 PM
To: Bartlett, Mark; Schwartz, Mike
Cc: Tattrie, Amy; Smith, Mary A.
Subject: FW: scan for D. Loepp
Importance: High

I had lunch with Ken Matzik the new CEO of Beaumont and he shared with me these two slides from the visit they had from UNITED. My sense is that we need to have a battle plan that includes advertising and PR and business plans to deal with this clear attack on us by United and all of the others for that matter. Attendees that come to mind include the three of us Les, Tom, Kevin and Andy Hetzel. Look forward to your thoughts. Thanks Dan

---

From: Loepp, Daniel J.
Sent: Wednesday, October 19, 2005 10:49 AM
To: Loepp, Daniel J.
Subject: FW: scan for D. Loepp
Importance: High

Johnson
EXHIBIT NO. 6
10-30-12 MEF

From: Davis, Tamre
Sent: Wednesday, October 19, 2005 9:55 AM
To: Loepp, Daniel J.

Cc: Hetzel, Andy
Subject: scan for D. Loepp
Importance: High

Hi Dan,

Andy asked me to scan and send to you. I am in the process of having 100 color copies made and will give them to Julie.

Thanks,

Tamre Davis
Executive Assistant to:
Andrew Hetzel, APR
Vice President, Corporate Communications
Blue Cross Blue Shield of Michigan
Mail Code 0210
600 Lafayette East
Detroit, MI 48226
(313) 983-2700
email: tdavis1@bcbsm.com

Exhibit SS

Blue Cross
Blue Shield
of Michigan

February 7, 2006

600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

Mark A. Johnson
Vice President-Revenue Management
Beaumont Hospitals
3601 W. 13 Mile Road
Royal Oak, MI 48073

Dear Mark:

The contents of this Letter of Agreement (LOA) will supplement and supersede our existing Letter of Understanding (LOU) related to the specific issues discussed herein.

- 2006 rates will receive standard updates plus the cap of [redacted] (the process by which the additional [redacted] are applied are described in the LOU).

- Rather than establishing 2006 bad debts in accordance with Section VI.E. of the LOU, they will be determined as follows:

  The 2006 bad debt amounts that are currently built into the 2006 Header File Rates (a per admission/diem amount for inpatient and as part of the passthrough/RCC amount for outpatient) will be adjusted in the following manner:

  A. **Inpatient** – The average bad debt expense for 2003-2005 will be used to calculate a per admission/diem rate for the Traditional product. The expense amount will not be reduced to cost, per previous agreements. The calculation should follow the normal protocols using case counts, case mix and Blue Cross Blue Shield of Michigan (BCBSM) traditional share. The PPO and Blue Care Network (BCN) amounts will be 90% of that calculated per admission/diem amount.

  B. **Outpatient** – The average bad debt expense for 2003 – 2005 (same as above) will be used to re-calculate the pass through rate for outpatient services and also the RCC for cost based services. The expense amount will not be reduced to cost per previous agreements.

Once these calculations are made to effect the 2006 year, the same fixed amounts will be used for the duration of our LOU without further inflationary adjustment.

- BCBSM and Beaumont Hospitals agree to follow the same margin analysis process that was used for 2006 when we analyze 2005 results for purposes of determining the 2007 inflationary update:
  - Use BCBSM "standard" Blue Margin analysis
  - Make adjustments to the "standard" process to address the following:
    - CRNA payment adjustment (using Blue Shield/BCN payments to offset BCBSM allocation of CRNA cost)

- Inclusion of psychiatric and rehabilitation
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- More precise recognition of clinic costs associated with medical education.
- Correction of inappropriately assigned BCBSM departmental charges due to front sheet limitations

- [redacted] Based on this recognition, Beaumont Hospitals agree to further serious consideration of BCBSM's Hospital Reimbursement Model.

- BCBSM will make a one time payment of [redacted] in recognition of the impact of the above margin analysis adjustments applied to prior years.

- Beaumont Hospitals will guarantee that the discount represented in the BCBSM/BCN payment rates continues to exceed the discount offered to other non-governmental payors to the same degree as it does as of the date of this LOA.

- Beaumont Hospitals will assure BCBSM/BCN participation of all employed physicians

- BCBSM will increase BIP to represent 100% of projected annual BCBSM liability

Please sign below to acknowledge your agreement with the contents of this LOA. Upon receipt of your counter-signed letter, I will obtain the authorizing BCBSM signature and return a fully executed agreement to you for your records. And thanks to you, Scott Flowerday, and Rich Odine for your cooperation in working through the margin analysis. With this additional groundwork in place, next year's review should be more straightforward.

Sincerely,

Douglas E. Darland, Director
Hospital Contracting & Policy

DED/pjl
(15:beaumontloa020306.doc)

Kim Sorget
Vice President
Provider Contracting & Pharmacy Services
Blue Cross Blue Shield of Michigan

Mark A. Johnson
Vice President
Revenue Management
Beaumont Hospitals

Exhibit TT

Darland, Doug

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Sent: Friday, November 12, 2004 3:30 PM
To: Seitz, Kevin; Schwartz, Mike
Subject: Beaumont update for meeting

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11/15/2004

Exhibit UU

Blue Cross
Blue Shield
of Michigan

600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

February 7, 2006

Mark A. Johnson
Vice President-Revenue Management
Beaumont Hospitals
3601 W. 13 Mile Road
Royal Oak, MI 48073

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Sincerely,

Douglas E. Darland, Director
Hospital Contracting & Policy

DED/pjl
(15:beaumontloa020306.doc)

Kim Sorget
Vice President
Provider Contracting & Pharmacy Services
Blue Cross Blue Shield of Michigan

Mark A. Johnson
Vice President
Revenue Management
Beaumont Hospitals

Exhibit VV

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

Volume 1

Detroit, Michigan

Tuesday, October 16, 2012

Confidential Video Deposition of:

KIM SORGET,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:05 a.m., when were present on behalf of the respective parties:

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Q Do you think you did?
A It looks familiar. I can't say for certain.
Q Okay.
A It's four years ago.
Q Would you expect, in a normal course, you would have reviewed the chronology to ensure that it was accurate before it went to Mr. Loepp?
A I would probably have at least had input to it.
Q And I take it you would be concerned that it be accurate?
A I am always concerned.
Q Let me ask you, please, to turn to the second page of Exhibit 17, first page of the chronology. At the bottom, where it states, in part in the last paragraph, "Still a three year term, but considers uncompensated care and bad debt based...on 2008 projections, provided a" 5% increase -- ".5% increase on a commitment to provide a 10% favored nation discount and agreed to rebase their costs after fiscal year 2008."
That was part of the proposal that you had provided in your May 6, 2008 letter to Ascension, marked as Exhibit 15 before; is that right?
A This is a very high level summary, yes.

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Q And where, in the sentence I read, it states the offer of May 6 "...provided a .5% increase on a commitment to provide a 10% favored nation discount," did that mean that the .5 percent increase was dependent on a commitment to provide a 10 percent favored nation discount?
A That's what it says there.
Q And do you have any reason to think otherwise than what it says there?
A No.
(Sorget Exhibit 18 was marked.)
BY MR. KRAMER:
Q Please familiarize yourself with Exhibit 18, marked as BLUECROSSMI-99-181167 through '177. And it appears to be the Letter of Understanding between Ascension and Blue Cross, dated ultimately on 10-28-08 by Miss Carlson, is the last signator on page '176, ending Bates.
And in the interest of time, sir, my questions are going to focus exclusively on the paragraph at the bottom of page 8 of the LOU, which ends in Bates '174, so my request would be to familiarize yourself generally with what that paragraph appears, and then if we can just ask questions there after I confirm that that is your signature on the signature page.

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A (Reviewing Sorget Exhibit 18.) Okay.
Q Is that your signature that appears at page 10 of the LOU, sir?
A Yes.
Q And is this the agreement that was reached by Blue Cross and Ascension, modifying the PHA back in October of 2008?
A This is their Letter of Understanding that we negotiated with them.
Q Thank you.
The favored discount paragraph that I asked you to focus on on page 8 of Exhibit 18 states, in the first long sentence there, that, "AH attests, on a hospital-specific basis, its 2008 fiscal year payment rates for covered hospital services under its PHA, TRUST Hospital Agreement, and BCN-HAA are, in aggregate, at least 10 percent less than the next best payment rates it has established with any other commercial insurer for products of similar scope and design."
Do you see that?
A Yes.
Q What was your understanding of what was meant by the clause, "for products of similar scope and design" there, sir?
A That jogs my memory to something I didn't

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perhaps realize. I'm not even sure I know what that means, "similar scope or design." But it jogs my memory relative to a comment or a question we had earlier regarding narrow networks. And whether that applies here or not, I don't know, by the terminology worded here.
Q And what makes you think there is some doubt on whether narrow networks would be applicable?
A I'm just not sure if it is or isn't. Similar scope and design, that can be wide open, a broad definition, and perhaps someone could interpret a narrow network to be similar design.
Q So I take it it's ambiguous to you on whether it would cover narrow networks?
A I can't be certain if they are in or out.
Q Okay. Was there any discussion that you ever had with Ascension on that issue?
A As it came -- no, not to my knowledge.
Q And did anyone reporting to you, to your knowledge, have discussion with Ascension about whether narrow networks were in or out under that provision?
A I don't recall having any discussions about narrow network or similar scope or design. I'm not sure where this language came from.
Q Is this language that you're not familiar with

Exhibit WW

From: Smith, Robert
To: McGuire, Pat (St. John/Detroit/SJHS); Felbinger, Richard; Buckley, Dave; Tucker, Allen; Maryland, Patricia A
Sent: 4/7/2008 12:10:26 PM
Subject: RE: Follow-up on last meeting

I suggest we defer responding until after we have updated Tony T. and Patricia has had dialogue with Bob Milewski.

Also, I do not think we should provide specific detail to their question about current spread between BCBSM and other commercial payers. Figuring out a way to maintain their current competitive advantage over other payers is obviously a key area of focus for them. I see no benefit to us in providing them with additional data on the subject. If/when we get back to a serious discussion around some type of MFN we can re-visit how much we are willing to share.

Al – meant to ask on this morning's call, do you have a sense for how BCBSM responded to Mark Decker's message about suspending MI HealthPlan wrap discussion due to impasse?

Bob

From: Noxon, Gerald [mailto:GNoxon@bcbsm.com]
Sent: Monday, April 07, 2008 9:56 AM
To: McGuire, Pat (St. John/Detroit/SJHS); Felbinger, Richard; Smith, Robert
Cc: Sorget, Kim
Subject: Follow-up on last meeting

Pat, Rich and Bob,

When we last met, there were a few open issues that by way of this e-mail I would like to try to make some progress on.

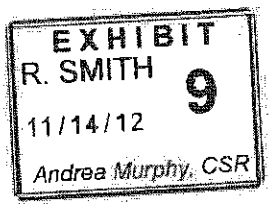
Pat asked for the Uncompensated Care (bad debt and charity care) to be recognized up to the current date. Can you please try to estimate what 2008 will look like compared to 2007 per the financial statements (of course charity is not on the financial statements, but please provide an estimate).

As we indicated, losses on CRNA are not something we have any data on. Can you please provide something that will give us an indication of what the losses the Ascension system is losing on CRNA's (either actual 2007 or estimate 2008).

We discussed the level of spread for Most Favored Nation and our willingness to pay a premium for a commitment on this. BCBSM is looking for a significant spread, however in order to make a meaningful proposal, it would be beneficial to understand what the current spread is. Is there any way you could estimate or give us a general understanding of what the current spread is so we can prepare a proposal on this issue?

Finally, at the conclusion of our last meeting we did not set up another meeting(s). Do you have some sense of when it would be good for your team to get back together with us?

If you have any questions or need anything from us, please don't hesitate to contact me.

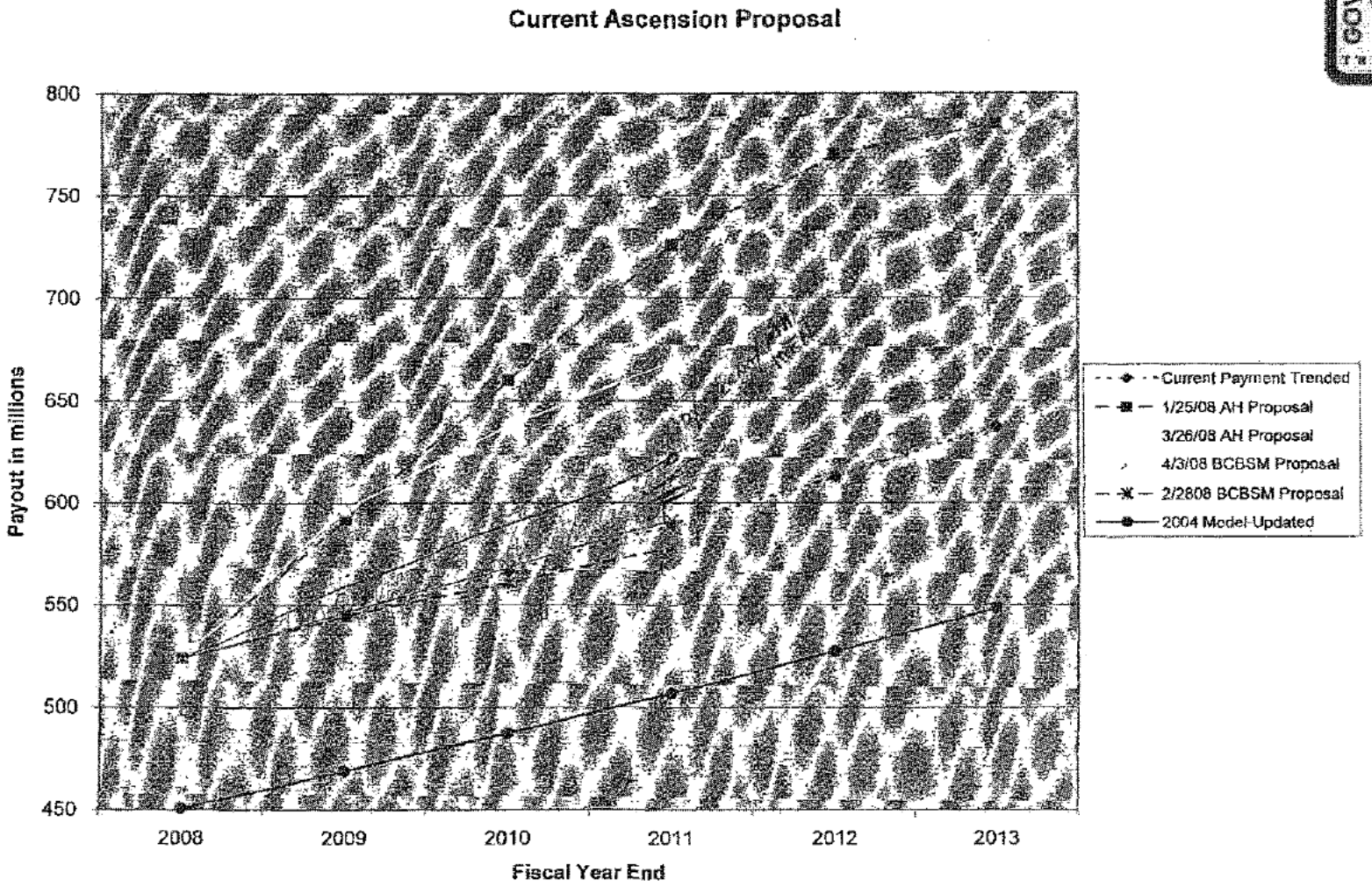


Thank you,

Jerry

The information contained in this communication is highly confidential and is intended solely for the use of the

Exhibit XX



4/17/2008

Ascension Meeting
Target Maximum Offer
4/24/2008

Summary of last (4/3/08) proposal from BCBSM:

- Standard (normal) updates
- [redacted] one time payment (signing bonus)
- Remove lag on uncompensated care (UC) calculation (use 2007 instead of 2005)
- Add outlier payments into the base prices
- Additional reimbursement for losses on CRNA's
- Rebasing will only go up (if warranted) and will not reduce payout to Ascension
- Most favored nation (MFN) clause

This proposal had an impact of $22 million over three years before consideration of the open issues (below).

Open issues at the end of the meeting were:

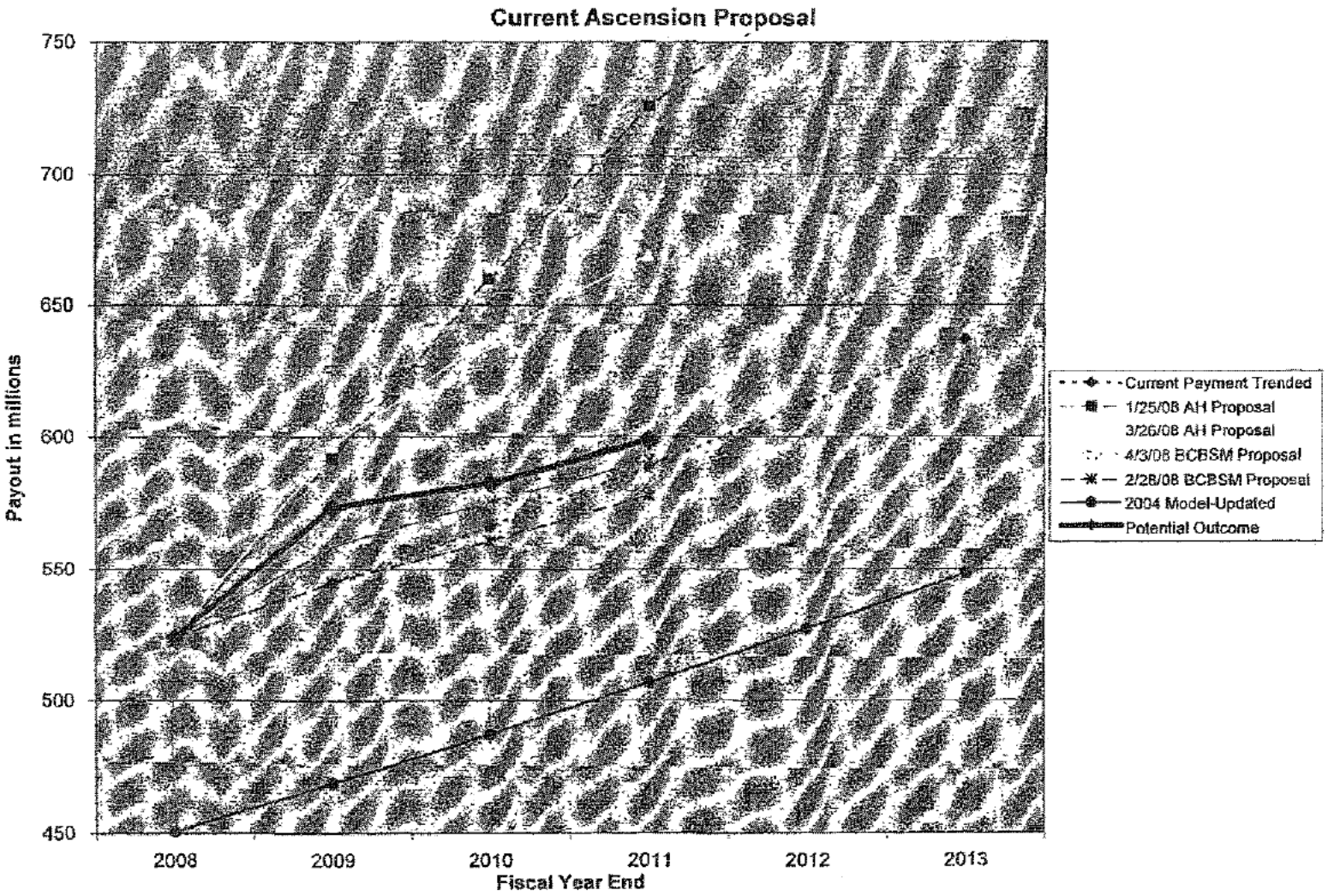
- Using 2008 data for UC versus 2007
- Understanding how much Ascension was losing on CRNA's
- Understanding the current spread (gap) between BCBSM and commercial payers

Under the premise that the meeting is to determine the Maximum that BCBSM is willing to offer Ascension Health the 4/3/08 proposal could be adjusted as follows:

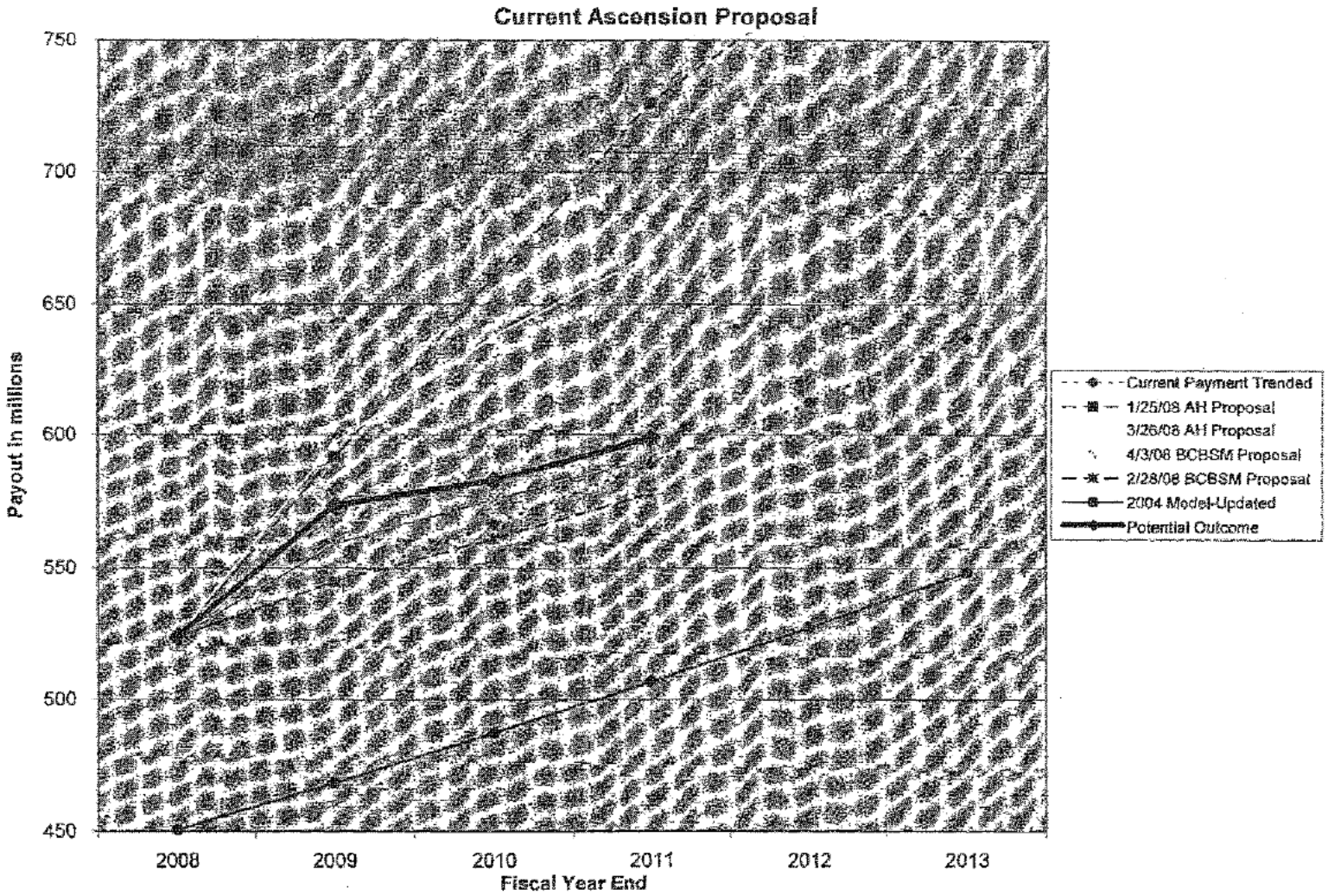
- Moving UC from 2007 to 2008 ($7M)
- Providing support for CRNA losses ($1M)
- Value of MFN (Max. 1.5% increase = up to $7M)
    - Point spread greater than 20 points = 1.5% increase
    - Point spread of 15 - 20 points = 1.0% increase
    - Point spread of 10 - 15 points = 0.5% increase
    - Less than 10 points is not worth an increase.

This would bring the value of our proposal up to $37 million over three years. I believe this is the maximum that BCBSM should consider. In terms of our position, going over $25 million would be disappointing.

There is no financial reason to provide Ascension Health with any premium. Our best estimate is that they are over the model by $30M, they are making a margin in total of 9 percent net income and 4 percent on operations, on our business they are making a margin of 7.7 percent and they are priced competitively in their respective markets. We have calculated that if the entire Ascension system departicipated, the increase in benefit cost would be $20 million. This assumes that members would go to the geographically closest hospital with the highest relative pricing (worse case scenario).



4/23/2008



4/23/2008

Ascension Meeting
Target Maximum Offer
4/24/2008

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Ascension
Determination of BCBSM Possible Outcome

	Current LOU	Ascension Proposal	Difference	
2006 Total I/P and O/P Liability	[redacted]			
2007 Standard update	4.40%			
Additional LOU update	3.00%			
2007 Liability	[redacted]			
2008 Standard update	4.125%			
2008 Liability	[redacted]	[redacted]		
BCBSM Proposal			1 Year Impact	Cumulative Impact
Year 1				
Lump Sum	0	[redacted]		
Uncompensated Care (to 2008)		14,616,578		
2009 Update	4.00%	4.00%		
Base increases				
Uncompensated Care (see above)		0.00%		
Outliers (6% equals current payout)		0.00%		
CRNA (est.)		0.20%		
Most Favored Nation-To Discuss		1.50%		
2009 Liability	[redacted]	[redacted]	28,519,721	28,519,721
Year 2				
Lump Sum	0	-		
Uncompensated Care		7,152,193		
2010 Update	4.00%	4.00%		
2010 Liability	[redacted]	[redacted]	7,506,318	36,026,039
Year 3				
Lump Sum	0	-		
2011 Update	4.00%	4.00%		
2011 Liability	[redacted]	[redacted]	370,371	36,396,410
Year 4				
Lump Sum	0	-		
2012 Update	4.00%	4.00%		
2012 Liability	[redacted]	[redacted]	385,186	36,763,596
Year 5				
2013 Update	4.00%	4.00%		
2013 Liability	[redacted]	[redacted]	400,593	37,164,189

Assume 4% as the annual standard, Model update for FYE after 2008

Proposal Summary 042308 xls

Ascension
Determination of BCBSM 4/3/08 Proposal Impact

	Current LOU	Ascension Proposal	Difference	
2006 Total I/P and O/P Liability	[redacted]			
2007 Standard update	4.40%			
Additional LOU update	3.00%			
2007 Liability	[redacted]			
2008 Standard update	4.125%			
2008 Liability	[redacted]	[redacted]		
BCBSM Proposal			1 Year Impact	Cumulative Impact
Year 1				
Lump Sum	0	[redacted]		
Uncompensated Care (to 2007)		7,464,385		
2009 Update	4.00%	4.00%		
Base Increases				
Uncompensated Care (see above)		0.00%		
Outliers (6% equals current payout)		0.00%		
CRNA (est.)		0.40%		
Most Favored Nation-To Discuss		0.00%		
2009 Liability	[redacted]	[redacted]	14,559,242	14,559,242
Year 2				
Lump Sum	0	-		
Uncompensated Care		7,152,193		
2010 Update	4.00%	4.00%		
2010 Liability	[redacted]	[redacted]	7,235,987	21,795,229
Year 3				
Lump Sum	0	-		
2011 Update	4.00%	4.00%		
2011 Liability	[redacted]	[redacted]	87,146	21,882,375
Year 4				
Lump Sum	0	-		
2012 Update	4.00%	4.00%		
2012 Liability	[redacted]	[redacted]	90,632	21,973,007
Year 5				
2013 Update	4.00%	4.00%		
2013 Liability	[redacted]	[redacted]	94,257	22,067,264

Assume 4% as the annual standard, Model update for FYE after 2008

Proposal Summary 042308.xls

Ascension
Determination of 3/26/08 Proposal Impact

	Current LOU	Ascension Proposal	Difference	
2006 Total I/P and O/P Liability	[redacted]			
2007 Standard update	4.40%			
Additional LOU update	3.00%			
2007 Liability	[redacted]			
2008 Standard update	4.125%			
2008 Liability	[redacted]	[redacted]		
Ascension Proposal			1 Year Impact	Cumulative Impact
Year 1				
Lump Sum	0	[redacted]		
2009 Update	4.00%	7.00%		
Base increases				
Most Favored Nation Clause		2.00%		
Outliers		2.00%		
CRNA		1.00%		
2009 Liability	[redacted]	[redacted]	51,897,143	51,897,143
Year 2				
Lump Sum	0	10,000,000		
2010 Update	4.00%	7.00%		
2010 Liability	[redacted]	[redacted]	29,272,686	81,169,829
Year 3				
Lump Sum	0	10,000,000		
2011 Update	4.00%	5.00%		
2011 Liability	[redacted]	[redacted]	18,722,985	99,892,814
Year 4				
Lump Sum	0	-		
2012 Update	4.00%	4.00%		
2012 Liability	[redacted]	[redacted]	2,795,713	102,688,527
Year 5				
2013 Update	4.00%	4.00%		
2013 Liability	[redacted]	[redacted]	2,907,541	105,596,068

Assume 4% as the annual standard, Model update for FYE after 2008

Proposal Summary 042308.xls

Ascension
Determination of BCBSM 2/28/08 Proposal Impact

	Current LOU	Ascension Proposal	Difference	
2006 Total I/P and O/P Liability	[redacted]			
2007 Standard update	4.40%			
Additional LOU update	3.00%			
2007 Liability	[redacted]			
2008 Standard update	4.125%			
2008 Liability	[redacted]	[redacted]		
Ascension Proposal			1 Year Impact	Cumulative Impact
Year 1				
Lump Sum	0	-		
2009 Update	4.00%	4.00%		
Base Increases				
Uncompensated Care		0.00%		
Outliers		0.00%		
CRNA-TBD		0.00%		
Most Favored Nation-To Discuss		0.00%		
2009 Liability	[redacted]	[redacted]	-	-
Year 2				
Lump Sum	0	-		
2010 Update	4.00%	3.00%		
2010 Liability	[redacted]	[redacted]	(5,446,629)	(5,446,629)
Year 3				
Lump Sum	0	-		
2011 Update	4.00%	3.00%		
2011 Liability	[redacted]	[redacted]	(5,827,892)	(11,274,521)
Year 4				
Lump Sum	0	-		
2012 Update	4.00%	4.00%		
2012 Liability	[redacted]	[redacted]	(450,981)	(11,725,502)
Year 5				
2013 Update	4.00%	4.00%		
2013 Liability	[redacted]	[redacted]	(469,020)	(12,194,522)

Assume 4% as the annual standard. Model update for FYE after 2008

Proposal Summary 042308.xls

Ascension
Determination of 1/25/08 Proposal Impact

	Current LOU	Ascension Proposal	Difference	
2006 Total I/P and O/P Liability	[redacted]			
2007 Standard update	4.40%			
Additional LOU update	3.00%			
2007 Liability	[redacted]			
2008 Standard update	4.125%			
2008 Liability	[redacted]	[redacted]		
Ascension Proposal			1 Year Impact	Cumulative Impact
Year 1				
2009 Update	4.00%	13.00%		
2009 Liability	[redacted]	[redacted]	47,134,286	47,134,286
Year 2				
2010 Update	4.00%	11.50%		
2010 Liability	[redacted]	[redacted]	46,270,157	93,404,443
Year 3				
2011 Update	4.00%	10.00%		
2011 Liability	[redacted]	[redacted]	43,327,407	136,731,850
Year 4				
Lump Sum	0	15,000,000		
2012 Update	4.00%	4.00%		
2012 Liability	[redacted]	[redacted]	20,469,274	157,201,124
Year 5				
2013 Update	4.00%	4.00%		
2013 Liability	[redacted]	[redacted]	5,688,045	162,889,169

Assume 4% as the annual standard, Model update for FYE after 2008

Proposal Summary 042308.xls

Ligon, Pamela

Subject:	Ascension Proposal - Target Maximum Offer - Kevin Seitz/Bob Milewski/Kim Sorget/Jerry Noxon
Location:	Kevin's Office @ T200/12th Floor
Start:	Thu 4/24/2008 9:00 AM
End:	Thu 4/24/2008 10:00 AM
Recurrence:	(none)
Meeting Status:	Accepted
Required Attendees:	Seitz, Kevin; Sorget, Kim; Noxon, Gerald
Optional Attendees:	Higgins, Lisa

When: Thursday, April 24, 2008 9:00 AM-10:00 AM (GMT-05:00) Eastern Time (US & Canada).
Where: Kevin's Office @ T200/12th Floor

~~*~*~*~*~*~*~*~*~*

Exhibit KKK

From: Connolly, Jeffrey
Sent: Thursday, September 06, 2007 8:45 PM
To: Milewski, Robert
Subject: Re: Charlevoix

Great...thanks Bob

----- Original Message -----
From: Milewski, Robert
To: Connolly, Jeffrey
Sent: Thu Sep 06 14:48:33 2007
Subject: Re: Charlevoix

I sat on the MHA board with Bill for years. I'd love to set up a time to meet with him and you!
Bob

----- Original Message -----
From: Connolly, Jeffrey
To: Milewski, Robert; Dallafior, Ken
Sent: Thu Sep 06 14:03:07 2007
Subject: Fw: Charlevoix

On the q/t...both Kelley and I know this ceo from our prior days...have a great relationship...he called. Take a read through...I doubt that priority will cancel...but it is good news regardless. Bob, have met with him yet? If not, I owe him a visit as well. I can arrange for both of us.

Thanks

----- Original Message -----
From: Monterusso, Kelley J.
To: Connolly, Jeffrey; Smith, Frank
Sent: Thu Sep 06 12:54:48 2007
Subject: Charlevoix

Hi – just wanted to give you both the heads up. I received a call from Bill Jackson, CEO of Charlevoix Hospital. They are meeting with Priority Health today and anticipate that they will be terminating their provider contract with Priority Health. The issue is that we just recontracted and the agreement states that Blues will get the best deal basically. Their contract with PH is substantially better then ours right now and PH is not willing to bring their discount down to our level. This has been going on since I was at Priority Health.

Bill called because there are two large accounts in Charlevoix that he will want us to go after in support of their terming the PH contract. He didn't mention the names – Frank, do you know what accounts those might be?? Also, this will impact Northern Michigan hospital because they have employees that go to that facility. Losing this hospital will be a bad move on PH's part. Bill has his meeting with PH today and we are scheduled to follow up in the morning. I will keep you posted.

Kelley

Exhibit LLL

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:

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Q Why did those of you in the hospital contingent not believe that a violation would occur?
A We were allowed three years to -- to meet the MFN clause of the agreement, and that appeared to be an adequate time frame, and then hospitals would comply.
Q Why did you believe hospitals would comply?
A They wanted to protect their Blue Cross reimbursement rate.
Q From being reduced?
A From being reduced.
Q The third bullet point on that, on page 18 of Exhibit 7, says, "Failure to provide attestation results in no increase in hospital rates." What did that mean?
A What that would mean is on your fiscal year, beginning of your fiscal year, the reimbursement rate is adjusted for an inflationary factor.
And if an organization had provided attestation for the prior year, then -- then they potentially could have their rates reduced or not increased in this case.
Blue Cross would call and remind hospitals as well that they hadn't completed their attestation statement. I know that for a fact.
Q Were you ever called to be reminded that --
A I was, just recently.

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Q And did you complete an attestation?
A I did.
Q Would you have been able to complete an attestation in 2007?
A No, I would not.
Q And why not?
A There were -- I believe at that time we had two contracts that were -- the discount was slightly greater than the Blue Cross discount.
Q And which contracts were those?
A At that time it was PPOM and Priority Health.
Q And did you at some point become able to sign an attestation?
A Yes.
Q And how did you get from a point where you weren't able to sign the attestation to a point where you did?
A PPOM called and said we need to discuss the contract, and when they showed up there was -- the discount was 5 percent. And that provided us -- we could sign the attestation because of -- because of PPOM.
Priority Health's reimbursement model was a little more convoluted than just a discount from charges, and we had to struggle and calculate that and

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there were some adjustments made there. That took longer, but we got to that point in about six months.
Q Did that result in Priority paying higher rates to...?
A Very -- yes, it did, but it was a minimal amount.
Q I'm going to ask you to look back on page 23. This is a slide entitled, "Implementation of MRM." Do you see that?
A I do.
Q And MRM, you told us earlier, was the Model Reimbursement Methodology?
A (Nodding head.)
Q Is that correct?
A I did, yes.
Q Okay. The slide starts, "If decrease." Do you see? And I guess my first question is if what --
A Yes, I see that.
Q And if what decreased?
A This is 23, okay. I was hoping there was some tie-in from 22, but there isn't.
Q Is that -- is this an if the methodology led to a lower rate from Blue Cross?
A If -- right. As we moved from the old PHA to the new PHA, if there was a decrease in the hospital's

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reimbursement rate from Blue Cross, and it was greater than 10 percent, and the hospital's operating margin was at least 3 percent at that time, the decrease would phase in over three years.
My recollection of that is that let's say your decrease was 12 percent, to make the math easy. You would -- you would experience a decrease of 4 percent a year for -- and then 4 percent more and 4 percent more until you were at the 12.
Would you like me to explain the next one?
Q I would like you to explain the next one. Thank you.
A If the decrease was less than or equal to 10 percent, or greater with 10 percent and an operating margin of less than 3 percent, the hospital rates would be frozen until update factors bring hospital rates in line. Okay.
In order to get to the reimbursement model, it may take some years, but in that case the rates would be as they were under the old PHA until -- until the calculation was such that they met this requirement in the new PHA. And I know that wasn't clear.
Q Under -- let me see if I can ask a couple of

Exhibit OOO

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.	:	

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:

A The only time that I negotiated with Blue Cross relative to Paul Oliver and Kalkaska was when the controlled charge issue, if you will, the new PHA for Peer Group 5's, where there was a cost plus arrangement for Peer Group 5's because Blue Cross was transitioning to that, a different logic.

And I wanted to retain the more beneficial Peer Group 5 controlled charges logic, and so that was the -- that was the point when I discussed -- negotiated with them.

Q And who did you discuss that with?

A That was with Doug Darland and Jerry Noxon.

Q And what happened?

A The --

MR. STENERSON: Object to the form.

THE WITNESS: The conversation took a total of maybe a minute and a half, so it was a very brief conversation, and I asked them to continue to extend the controlled charges arrangement.

They -- Doug agreed. Doug, as being the Director of Contracting, agreed. And then Jerry at that time said -- maybe a couple seconds later, I can't remember, but anyway, he said -- he spoke to Doug and said, "Don't forget they need to follow the most favored nation clauses."

And so then Doug said that to me, and I said, "Oh." And I -- my comment was, "That's okay as long as we can make it a transition." Or, in other words, "We're not there right now, but as long as we work in that direction, is that acceptable?" And so....

BY MR. GRINGER:

Q What do you mean you weren't there right -- right now?

A The most -- if you were to apply a most favored nation to Blue Cross's reimbursement versus other payers -- and it is Priority who we're speaking of; I don't know if that's a secret or not -- but Priority was not paying us that --

MR. STENERSON: Object to the DOJ lawyer signaling by head gestures to the witness.

MR. GRINGER: I have no idea what you're talking about, Mr. Stenerson.

BY MR. GRINGER:

Q So carry on.

A I don't, either.

MR. STENERSON: You shook your head "no" in response to the witness's question.

MR. GRINGER: I did not do that.

MR. STENERSON: I thought that's what I saw.

THE WITNESS: But, anyway -- now, you broke my train of thought. The....

MR. McCANN: Do you want the question --

MR. GRINGER: I'm sure that was --

MR. VORRASI: Do you want to read the question back?

MR. GRINGER: I'm sure that was Mr. Stenerson's purpose by interposing his comment, so --

MR. STENERSON: Move to strike.

THE WITNESS: Oh, it's -- okay, I got it now.

MR. STENERSON: Move to strike. That's completely inappropriate, Mr. Gringer.

MR. VORRASI: Hold on a minute. For the record, let's get the -- can we restate the question and start this over, please.

MR. GRINGER: Could you please read back my last question to Mr. Leach.

BY MR. GRINGER:

Q I have it. You said you weren't there right now with respect to the most favored nation clause.

A Correct.

Q What did you mean you weren't there right --

A The reimbursement rate at that point from

Priority was on that old fee schedule that we talked about earlier, that was, we felt, unacceptable to us, truthfully.

So Priority was paying us a fee schedule, which actually is the same as Munson's fee schedule, and Blue Cross was paying us the controlled charges logic, which was better than this fee schedule.

Q By "better," you mean more?

A More money, correct. This was a percent of charges deal from Blue Cross, controlled charges; and Priority was a fee screen given payment that was a statewide fee schedule, which was really unacceptable to a small provider in rural areas.

Q So Priority was paying you less?

A Correct.

Q And what did you tell Mr. Darland about that?

MR. STENERSON: Object to the form.

THE WITNESS: He said -- he said, after Jerry reminded him that don't -- you know, the comment was, "Yeah, you're okay to retain the controlled charges logic." And so we -- you know, him and I had a deal. Then Jerry interjected, "But don't forget they have to follow the most favored nation clause." And so then Doug looked at me or else restated it to me, and I said, "Okay. No problem."

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And I'm trying to even remember if I said it at that moment or I may have said it at a phone call later on, but I think I said it then. I said, "Is it okay if we transition to the parity, if you will?"

And he -- I don't remember if he said anything or he nodded, but it was in affirmative that, yeah, that's okay.

BY MR. GRINGER:

Q How was Munson planning on transitioning to parity?

MR. STENERSON: Object to the form, lacks foundation. He's not talking about Munson.

BY MR. GRINGER:

Q How were Paul Oliver and Kalkaska planning on transitioning to --

MR. STENERSON: Object to the form --

MR. GRINGER: Can I complete the question, please, Mr. Stenerson.

BY MR. GRINGER:

Q How were Paul Oliver and Kalkaska planning on transitioning to parity?

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

THE WITNESS: To increase their payment. We were -- we were pursuing to -- we were negotiating

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with Priority at the time to improve their payment rates. And so that interim step, as we talked about before, was that rural outpatient fee schedule, which was an improvement over their other lower paying fee schedule. It still wasn't where we wanted them to be, so they were still well below where we wanted to get them to.

BY MR. GRINGER:

Q And how did you plan to get them to where you wanted them to be?

A We planned to continue to negotiate with them whenever -- each year when the contract would come up, we would try it get an increased reimbursement logic.

Q In your view was there any relationship between retaining the controlled charges reimbursement methodology and complying with the most favored nations clause?

A Yes.

Q What was that relationship?

A It's -- that's the -- that's what they requested. That was the offset, if you will, to the -- if you want to continue to retain controlled charges, you have to agree to these provisions in the contract, which is a part of everyone's contract, of the entire PHA. This wasn't a specific Paul Oliver deal. This was

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the entire state's Peer Group 5's logic and it was built into the PHA.

Q The logic being the most favored nations clause?

A Correct.

MR. STENERSON: Move to strike, lacks foundation.

BY MR. GRINGER:

Q What was the logic in the PHA that you were referring to?

A The most favored nation clause.

Q And was it your understanding that to receive the continuation of the controlled charges methodology, you needed to be in compliance with the most favored nations clause?

MR. STENERSON: Object to the form.

THE WITNESS: Yeah, I believe that was a concern of ours. I think as long as we were showing, you know, a reasonable intent to move -- you know, to get them into parity, however we could do it, that was the goal.

And so we would have had to fight probably with Blue Cross had they audited us or whatever. I mean, it probably would have -- it didn't happen, but that could indeed have been an issue.

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BY MR. GRINGER:

Q Today are Paul Oliver and Kalkaska in compliance with the most favored nations clause?

A Yeah, within reason.

Q How did you obtain compliance?

MR. STENERSON: Object to the form.

BY MR. GRINGER:

Q How did you achieve compliance?

MR. STENERSON: Same objection.

THE WITNESS: We negotiated an improved payment rate.

BY MR. GRINGER:

Q Payment rate from whom?

A From Priority.

Q How did Blue Cross Blue Shield of Michigan's rate change as a result of the most favored nations clause?

MR. STENERSON: Object to the form.

THE WITNESS: They didn't change, with the exception of not -- with the exception of Kalkaska now reverting to the poor reimbursement logic, being that cost plus deal, and that was this most recent past year.

BY MR. GRINGER:

Q Does that have anything to do with the most

favored nations clause?
MR. STENERSON: Object to the form.
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 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.
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?
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 nations clause at Paul Oliver and Kalkaska?
MR. STENERSON: Object to the form, misstates his testimony.

THE WITNESS: Yes.
BY MR. GRINGER:
Q So, Mr. Leach, can you tell us a little bit about your discussions with Priority with respect to the price increases at Paul Oliver and Kalkaska.
A I think you're referring to the most favored nation clause or...?
Q I want to know about those discussions.
A We've --
MR. STENERSON: Object to the form.
THE WITNESS: We've tried to get Priority to pay a better payment rate so that we would cover the costs at those two facilities because, as I explained, their cost structure is much higher than the large mother ship at Munson, so it wasn't fair to them to lose money on Priority business. And so we were pushing them to make -- to get them -- make it profitable for us.
And so that was the pressure or the push all along, and it was before Blue Cross. And, I mean, it had nothing to do with really Blue Cross. We were just trying to get them there so we could cover our costs. So that was -- that's the answer. I -- go ahead.
The only other thing, and maybe I shouldn't answer the question until I'm asked, but I

assume you're asking about the most favored nation, or not?
BY MR. GRINGER:
Q Well, what -- did you ever bring that up to Priority?
A I never brought it up. It happened one time with a Priority representative, and her name was Melissa Sole. She was their Director of Contracting, and wore many other hats. And she brought it up to me, and she said -- and I couldn't tell you what year this was, but she knew that Blue Cross had these arrangements and that they were cognizant of the pressures that were there.
Q And what did you say?
A I said, "Great. Pay us more money." Show me the money.
Q Prior to agreeing to the most favored nations clause with Blue Cross Blue Shield of Michigan, were you trying to get Priority to pay you more?
A Yeah.
Q How were those discussions going?
A They kind of fell on deaf ears. The two -- those two small hospitals aren't very big and there's not a lot of volume. And so it was easy to kind of just look the other way because there just wasn't enough volume for them.

And we didn't -- honestly, we didn't spend an inordinate amount of time on it, either. I mean, Munson is where 95 percent of our business is driven from, so that's where we're most concerned about. Those other hospitals, we care about them, but we -- you know, it just wasn't a lot of money.
So we'd ask them each year, and they would say, okay, yeah, here's another 2 percent or whatever, but it wasn't moving quick enough, so....
Q After you agreed to the most favored nations clause with Blue Cross, were you able to get Priority to pay more money at Paul Oliver and Kalkaska?
MR. STENERSON: Object to the form, lacks foundation.
THE WITNESS: Well, it was a byproduct. I mean, it was -- we were taking baby steps to get there anyway. So, I mean, we went to the other, you know, rural fee schedule, so that was an improvement, and then we got an additional bump subsequent to that.
I would say that the Blue Cross piece helped us get there but we were trying to get there anyway, so....
BY MR. GRINGER:
Q When you say the Blue Cross piece helped you there, what are you referring to?

Exhibit QQQ

CIVIL INVESTIGATIVE DEMAND FOR
DOCUMENTS AND INFORMATION
(BCBSM MOST FAVORED NATION DISCOUNT)

Mercy Health Partners, Lakeshore Campus

SPECIFICATION #: Submit all documents from ~~January 1, 2004~~ April 1, 2008 to the present relating to the company's negotiations with BCBSM or any other payer. Including:

- documents relating to if / company's evaluation of the negotiations, including whether and on what terms the company has considered or would consider contracting with the payer, and the impact or potential impact on the company from not contracting with the payer.

DOCUMENT DESCRIPTION: Provide Health
(Set 8)

DATE(S):

CONFIDENTIAL

MHLH0001685

Priority Health Discussions
September 16, 2008

Proposal for HMO and PPO Books of business

1. Move Hackley to MGHP terms, effective upon signing.
2. Increase the new combined OP fee schedule on January 1, 2009 by 1% (with the exception of standard priced codes);
3. Continue 3% Incentive for both facilities;
4. Increase DRG rate, Observation rate, and OP fee schedule (with the exception of standard priced codes) by PPI for General Med/Surg Hospitals, on January 1, 20010 and January 1, 2011.
5. For Lakeshore:
    a. Effective upon signing, move to DRG+6,500;
    b. Effective upon signing, move to rural OP Fee Schedule and Observation rate of $1,200/case;
    c. 10% rural Hospital Incentive
    d. Increase DRG rate, Observation rate, and OP fee schedule (with the exception of standard priced codes) by PPI for General Med/Surg Hospitals, on January 1, 2010 and January 1, 2011

Expectations:

- Flat to small increase in Market
- Flat to small decreases in volumes
- Want to move the outlier from $45,00 to 55,000
- Believe this offer is a 4/5-5% increase
- PCMH: Letter of agreement to move our Network to the model agreed to in 2009
    a. Goal is to increase PCP reimbursement by 30-35% over next 3 years
    b. Multiple methods
    c. Decrease the number cap codes in 2009 making them FFS
    d. Small Increase in Cap in 2009
    e. Introduce a Care Coordination fee in the future (probably a cap amount)
- PPI last January was 4%
- Next meeting in 2 weeks

Follow Ups

- PH to send OP fee schedule to Mike and Mark for analysis
- Mike and Mark to evaluate the impact of the change in outlier
- Linda noted that our expectation was the equalization of Hackley and Mercy plus 5 %.
- Priority agrees we can adjust to assist Lakeshore with favored nation clause.

Priority Health Discussions
September 16, 2008

Proposal for HMO and PPO Books of business

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Mercy Health Partners
Priority Health Negotiations
Calendar 2008 Annualized For Negotiations - From Business Objects and PCON

	Mercy Campus	Hackley Campus	Lakeshore Campus	Total
Inpatient Charges	14,149,885	6,492,206	203,098	20,845,189
Outpatient Charges	24,679,404	33,576,556	1,188,574	59,444,534
	38,829,289	40,068,762	1,391,672	80,289,723
Inpatient Payments	7,094,422	3,670,114	141,804	10,906,340
Outpatient Payments	9,633,688	14,427,846	547,805	24,609,339
	16,728,110	18,097,960	689,609	35,515,679
Incentive Payments		715,516	27,652	743,168
		3.95%	4.01%	
Total Payments	16,728,110	18,813,476	717,261	36,258,847
Proposed Increases				
DRG Base Increase	354,721	183,506	7,090	545,317
DRG HH&HLH increase to Mercy Base	-	70,579	11,002	81,581
DRG Weight Increase	58,884	7,964	312	67,160
O/P General Fee Increase	481,684	721,392	27,390	1,230,467
O/P Fee Hackley & Lake up to Mercy	176,296	1,765,968	67,051	2,009,316
Incentive	-	(180,980)	41,377	(139,603)
Total Proposed Payment Increase	1,071,586	2,568,430	154,222	3,794,238
% Proposed Payment Increase	6.41%	13.65%	21.50%	10.46%
Payment %				
Inpatient	50.14%	56.53%	69.82%	52.32%
Outpatient	39.04%	42.97%	46.09%	41.40%
Total	43.08%	45.17%	49.55%	44.23%
To close the GAP on BC for Lakeshore			49.15%	
			683,971	MFD Gap
Assumed Rate Increases				
DRG Base Increase	5.00%	5.00%	5.00%	
DRG HH&HLH increase to Mercy Base	n/a	1.92%	7.76%	
DRG Weight Increase	0.83%	0.22%	0.22%	
O/P General Fee Increase	5.00%	5.00%	5.00%	
O/P Fee Hackley & Lake up to Mercy	1.83%	12.24%	12.24%	
Incentive	0.00%	-1.00%	5.00%	

Inpatient Cases	964	603	36
		6,032	
		6,148	
		116	
		69,948	
		1,100	
		76,943	
	14,678	10,767	5,642
	9,993	23,927	15,217

Mercy Health Partners
Priority Health Negotiation Analysis
FYE 6/30/08

	Mercy Campus	Hackley Campus	Lakeshore Campus	Total
Inpatient Charges	14,625,231	7,967,848	203,098	22,796,177
Outpatient Charges	26,211,156	29,659,767	1,188,574	57,059,497
Total Charges	40,836,387	37,627,615	1,391,672	79,855,674
Inpatient Payments	7,383,674	4,504,311	141,804	12,029,789
Outpatient Payments	10,256,854	12,744,802	547,805	23,549,461
Total Claim Payments	17,640,528	17,249,113	689,609	35,579,250
Incentive Payments	529,216	715,516	27,952	1,272,684
Incentive %	3.00%	4.15%	4.05%	
Total Payments	18,169,744	17,964,629	717,561	36,851,933
Proposed Increases				
DRG Base Increase	369,184	225,216	7,090	601,489
DRG HH&HLH increase to Mercy Base	-	86,621	11,002	97,623
DRG Weight Increase	61,284	9,774	312	71,371
O/P General Fee Increase	512,843	637,240	27,390	1,177,473
O/P Fee Hackley & Lake up to Mercy	-	1,559,964	67,051	1,627,015
Incentive	-	(172,491)	41,377	(131,115)
Total Proposed Payment Increase	943,311	2,346,324	154,222	3,443,857
% Proposed Payment Increase	5.19%	13.06%	21.49%	9.35%
Payment %				
Inpatient	50.49%	56.53%	69.82%	52.77%
Outpatient	39.13%	42.97%	46.09%	41.27%
Total	43.20%	45.17%	49.55%	44.55%
To close the GAP on BC for Lakeshore			49.15%	
			683,971	MFD Gap
Assumed Rate Increases				
DRG Base Increase	5.00%	5.00%	5.00%	
DRG HH&HLH Increase to Mercy Base	n/a	1.92%	7.76%	
DRG Weight Increase	0.83%	0.22%	0.22%	
O/P General Fee Increase	5.00%	5.00%	5.00%	
O/P Fee Hackley & Lake up to Mercy	0.00%	12.24%	12.24%	
Incentive	0.00%	-1.00%	6.00%	

Inpatient Cases	964	737	36
		6,032	
		6,148	
		116	
		85,492	
		1.100	
		94,041	
	15,171	10,811	5,642
	10,640	17,293	15,217

From: Mike Wallis
To: Gary Allore; Linda Bailey; Mark Gross
Date: 10/20/2008 4:19 PM
Subject: Priority Health Overall Increase
Attachments: PH Analysis Overall Increase 10-08.xls

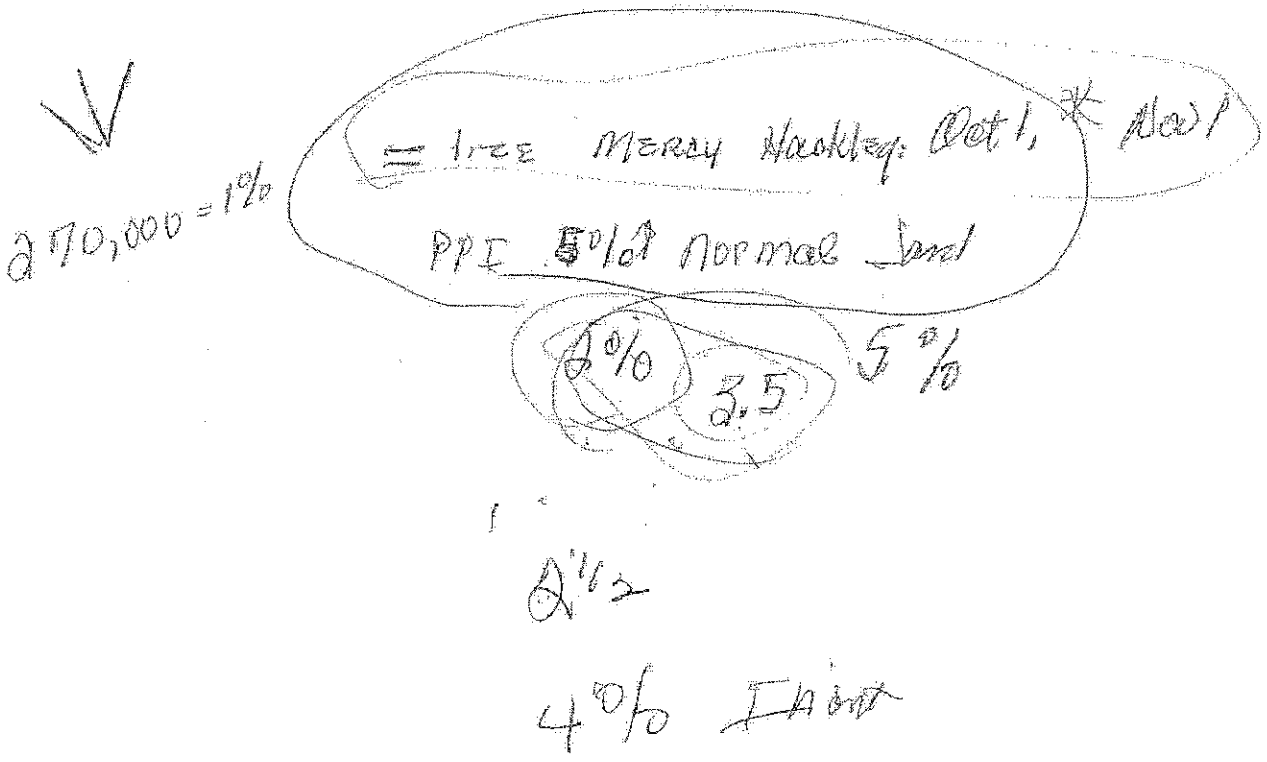
I have attached an analysis of the overall increase we have calculated from PH's proposed rates. Overall, it appears to be a 4.65% increase for all combined campuses. The Gap to be closed for the BC MFD at Lakeshore is ~$700,000. I will bring hard copies to LDI for discussion.

COPY

6148.00

Follow up

Following week



Mercy Health Partners
Priority Health Negotiation Analysis
FYE 6/30/08

	Mercy Campus	Hackley Campus	Lakeshore Campus	Total
Inpatient Charges	21,937,848	7,967,848	203,098	30,108,794
Outpatient Charges	39,316,734	29,659,767	1,188,574	70,165,075
Total Charges	61,254,582	37,627,615	1,391,672	100,273,869
Inpatient Payments	11,075,510	4,529,523	141,804	15,746,837
Outpatient Payments	15,385,282	12,756,720	547,805	28,689,807
Total Claim Payments	26,460,792	17,286,243	689,609	44,436,644
Incentive Payments	793,824	715,516	27,952	1,537,292
Incentive %	3.00%	4.14%	4.05%	
Total Payments	27,254,616	18,001,759	717,561	45,973,935
Proposed Increases				
DRG Base Increase	110,755	45,295	1,418	157,468
DRG HH&HLH increase to Mercy Base	-	87,106	11,002	98,108
DRG Weight Increase	91,927	9,829	312	102,068
Outpatient Fee Increase	281,551	1,561,423	67,051	1,910,025
Incentive	-	(172,862)	41,377	(131,486)
Total Proposed Payment Increase	484,232	1,530,791	121,160	2,136,183
% Proposed Payment Increase	1.78%	8.50%	16.88%	4.65%
Payment %				
Inpatient	50.49%	56.85%	69.82%	52.30%
Outpatient	39.13%	43.01%	46.09%	40.89%
Total	43.20%	46.42%	49.55%	44.32%
To close the GAP on BC for Lakeshore			50.43%	
			701,785	MFD Gap
Assumed Rate Increases				
DRG Base Increase	1.00%	1.00%	1.00%	
DRG HH&HLH increase to Mercy Base	n/a	1.92%	7.76%	
DRG Weight Increase	0.83%	0.22%	0.22%	
Outpatient Fee Increase	1.83%	12.24%	12.24%	
Incentive	0.00%	-1.00%	6.00%	
Inpatient Cases	964	737	36	

	6,032	
	6,148	
	116	
	85,492	
	1,100	
	94,041	
22,757	10,811	5,642
15,960	17,309	15,217

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Inpatient Charges	14,149,885	6,192,206	203,098	20,545,189
Outpatient Charges	20,701,842	18,912,070	1,188,574	40,802,486
	34,851,727	25,104,276	1,391,672	61,347,675
Inpatient Payments	7,094,422	3,520,114	141,804	10,756,340
Outpatient Payments	8,445,988	8,134,116	547,805	17,127,909
	15,540,410	11,654,230	689,609	27,884,249
Incentive Payments		715,516	46,952	762,468
		6.14%	6.81%	
Total Payments	15,540,410	12,369,746	736,561	28,646,717
Proposed Increases				
DRG Base Increase	70,944	35,201	1,418	107,563
DRG HH increase to Mercy Base	-	67,695	-	67,695
DRG Weight Increase	58,884	7,639	312	66,834
Outpatient Fee Increase	154,562	995,616	67,051	1,217,229
Incentive	-	(116,542)	41,377	(75,166)
Total Proposed Payment Increase	284,390	989,608	110,158	1,384,155
% Proposed Payment Increase	1.83%	8.00%	14.96%	4.83%
Payment %				
Inpatient	50.14%	56.85%	69.82%	52.35%
Outpatient	40.80%	43.01%	46.09%	41.98%
Total	44.59%	46.42%	49.55%	45.45%
DRG Base Increase	1.00%	1.00%	1.00%	
DRG HH increase to Mercy Base	n/a	1.92%	???	
DRG Weight Increase	0.83%	0.22%	0.22%	
Outpatient Fee Increase	1.83%	12.24%	12.24%	
Incentive	0.00%	-1.00%	6.00%	

Inpatient Cases	964	603	36
		6,032	
		6,148	
		116	
		69,948	
		1,100	
		76,943	
	14,678	10,269	5,642
	8,761	13,489	15,217

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Expectations:

- Flat to small increase in Market
- Flat to small decreases in volumes
- Want to move the outlier from $45,00 to 55,000
- Believe this offer is a 4/5-5% increase
- PCMH: Letter of agreement to move our Network to the model agreed to in 2009
    a. Goal is to increase PCP reimbursement by 30-35% over next 3 years
    b. Multiple methods
    c. Decrease the number cap codes in 2009 making them FFS
    d. Small Increase in Cap in 2009
    e. Introduce a Care Coordination fee in the future (probably a cap amount)
- PPI last January was 4%
- Next meeting in 2 weeks

Follow Ups

- PH to send OP fee schedule to Mike and Mark for analysis
- Mike and Mark to evaluate the impact of the change in outlier
- Linda noted that our expectation was the equalization of Hackley and Mercy plus 5 %.
- Priority agrees we can adjust to assist Lakeshore with favored nation clause.
- General surgeons are unhappy with their rates.

Linda Bailey - 2008-2009 Contract

From: <Steve.Williams@priorityhealth.com>
To: <BaileyLJ@trinity-health.org>
Date: 11/7/2008 3:53 PM
Subject: 2008-2009 Contract
CC: <mgross@hackley-health.org>, <ALLOREG@trinity-health.org>, <mwallis@hackley-health.org>, <Jill.McCarthy@priorityhealth.com>, <Dave.Werner@priorityhealth.com>

Linda:

We received your message and appreciate your prompt and thoughtful response. I wanted to take a few moments to share our current thinking on provider reimbursement overall and to propose a second year rate request.

Five issues inform our reimbursement approach to providers today.

1. Medical cost inflation
2. Cost shifting to patients/members and membership losses
3. Michigan's economy
4. Priority Health funding of infrastructure and PCMH initiatives
5. Priority Health's current financial position

Let me discuss each briefly.

1. Over the past several years, medical trends have been running in the 7-10% range. As you are aware, increases to health plans and thus employer groups, are driven by two elements—contractual cost increases and utilization rates. New technology, new procedures and new drugs also contribute to increases in total costs. All of these are passed along to employer groups in the way of premium increases. While we appreciate the perspective of hospitals, it is important to understand that health plans must pass along cost increases for all provider types and pharmaceuticals. If we pay hospitals 5% more per year in contractual increases and use increases 4%, the overall increase is 9% as these are additive. With hospital inpatient and outpatient costs accounting for 40% of overall premium costs, this adds nearly 4% to premium. New technology, physician utilization increases and new drugs typically add another 7-10 percent to cost and at 60% of premium, another 4-6% to premium. Thus, our medical trends have been running at 7-10%, 2-3 times the rate of inflation. I hope you can appreciate how much each percentage point impacts our premium trends

2. Even if we were prepared to pass along these kinds of premium trends, employers are no longer prepared to accept them. Thus, as you are aware, they are shifting additional cost to employees or moving to other plans to reduce their premium costs. Priority has lost a significant number of employer accounts in the past two years and while we have stabilized in recent months, we are faced with a number of large group losses on January 1, 2009. Many of these groups are being lost to Blue

Cross. Each time a group moves from Priority to the Blues, it forces payment down to many physicians and further consolidates their enormous market share advantage. (We assume that hospital rates are near parity.) But even when we maintain a group, it is often with higher deductibles and out of pockets for members. As you are well aware, cost shifting has a negative impact on your collection rates, thus raising your costs even more. And reduced benefits are having an impact on use rates, thus negatively affecting facilities with high fixed expenses. For employers and plans, this reduction is positive. For facilities and physicians, it is causing increasing concern. This vicious cycle is one we are all caught up in, but we would respectfully submit that simply raising your rates is increasingly having diminishing returns with all of the cost shifting.

3. You are well aware of the impact the economy is having on all of our businesses. The impact this is having to the plan is two-fold: More and more employers are closing or dropping health benefits, thus reducing the insured pool. This has the impact of increasing the ranks of the uninsured and those on Medicaid—neither of which is good for you or us. In recognition of the need to tighten our belts, we are being forced to hold our administrative budget absolutely flat. The only increases we will pass along to employers in 2009 is for medical expense.

4. Priority Health has led the market in funding PHOs like Lakeshore and we have led the market in PFP payments for years. Until recently, our physician fees also outstripped Blue Cross in virtually every specialty. We are aware that this gap has narrowed for some specialties (though not for all; our fee schedule overall is still 4-6% above Trust). We have also joined with progressive physician groups like yours to support implementation of the patient centered medical home and it is our intent to shift additional funding to primary care over the next three years. In part, some this funding must frankly be redirected from facilities and procedures to the cognitive codes. If we don't do this, primary care will continue to decline—an outcome that will be even worse for plans, patients, employers and the delivery network as a whole.

5. Finally, we are facing a challenging year this year and our budget and premium planning cycle reflects continued challenges in 2009. As you may be aware, Blue Cross has been systematically under pricing the market for the past 2-3 years and we expect this to continue in 2009 and perhaps even into 2010. This has put tremendous pressure on our premium rates to remain competitive. Still, as I mentioned earlier, we continue to lose business to the Blues and it appears that we will have a net loss in the health plan in 2008. We are hopeful that we can, through enormous efforts we are undertaking inside the plan, turn around our medical cost ratio, which is currently running at 90 percent. This is a difficult task in any environment but it is made that much harder when we are forced to pay providers more and more in unit cost increases.

Lakeshore Health Network and Priority Health have a long and enduring relationship that has been good for both parties. We have supported your efforts in many ways over the years and we support the merger of the two facilities. Our willingness to bring Hackley rates up to those at Mercy, we believe, is a demonstration of that support. But it also limits the amount we can pay the combined entity for 2009. I respectfully ask that LHN accept our most recently offer as fair and reasonable given the points I discussed above. I would further offer a second year increase in 2010 of PPI plus 1%. Hopefully this gives both of us a means to fix payments for the next two years to allow us time to bring costs and trends into line.

I am available at your request to discuss these matters more fully at your convenience.

Steve Williams

Director
Network Strategy and Provider Performance
Priority Health
1239 East Beltline Ne
Grand Rapids, MI 49525

616-464-8269
616-560-2649

From: Linda Bailey [mailto:BaileyLJ@trinity-health.org]
Sent: Friday, November 07, 2008 8:33 AM
To: Dave Werner; Jill McCarthy; Steve Williams
Cc: Mark Gross; Mike Wallis; Gary Allore
Subject: 2008-2009 Contract
Importance: High

Gary, Mark, Mike and I have had the opportunity to review the letter of intent and your offer. We still have a significant gap to fill. We asked for the additional 5% and still feel that is a fair request, but given your response we recognize that this request may not be possible at this point but we still have a $600,000.00 gap that we need to fill in some way.

Your offer did bring the Hackley Campus up to the Mercy Rates that begins to stabilize their position. The offer does not bring even a market increase to the Mercy Campus, therefore leaving us the gap described above. We need to further discuss opportunities to close that gap.

Thank you for your consideration of our request. Linda

Linda J Bailey
Executive Director
Lakeshore Health Network
1560 E. Sherman Blvd. Suite 145
231-672-3882

Stronger Together
Providing Value -Creating Excellence

COPY

MERCY HEALTH PARTNERS

PRIORITY HEALTH

DEC - 2 2008

MEDICAL OPERATIONS EXECUTIVE

November 24, 2008

Kim Suarez
Senior Network Manager
Priority Health
MS 975 1231 E. Beltline NE
Grand Rapids, MI 49505

Dear Kim:

Phase II of the integration of Hackley Health System with Mercy General Health Partners (MGHP) is to incorporate all the Muskegon entities under the Mercy Heath Partners Corporate umbrella. In Phase II, the legacy Mercy General Health Partners organization (including, for example, Mercy Hospital and Muskegon General Hospital) will be transferred to and become an operating division of Mercy Health Partners rather than as an operating division of Trinity-Health, Michigan.

You (or your organization) presently is a party to a contract with MGHP directly or through our PHO, Lakeshore Health Network, that either requires notice or consent to the assignment of the contract from MGHP to Mercy Health Partners, or is silent on the matter. This letter is to inform you that Phase II of the transaction will take effect on January 1, 2009, and to let you know of our intent to assign your contract to Mercy Health Partners as of that date. Since Mercy Health Partners is owned by Trinity Health-Michigan, your contractual relationship will still be within the Trinity Health Family.

Please sign below to document your acknowledgement and/or consent to this assignment and return this letter to Linda Bailey at Lakeshore Health Network.
A self-addressed envelope is enclosed for your convenience.

Sincerely,

Linda J. Bailey

Linda J. Bailey
Managed Care Director

cc: David Livingston

Please sign and Print your Name and Date:

Signed By: _____

Contact Title: Director, Network Strategy & Provider Performance

Date: 12/4/08

CONFIDENTIAL

HLH001701

MERCY HEALTH PARTNERS

April 9, 2008

COPY

Kim Suarez
Senior Network Manager
Priority Health
1231 E. Beltline MS 975
Grand Rapids, MI 49505

Dear Kim:

We are pleased to announce the merger of Mercy General Health Partners and Hackley Health System was completed effective April 1, 2008. The new merged entity will be known as **Mercy Health Partners.**

We are most anxious to meet with you and discuss the future structure of our relationship with Priority Health as our ongoing relationship has been a strong and positive one. Please be patient with us in scheduling this time together. Until the merger was completed on 4/1/08, we were not able to review the respective managed care contracts that existed for Hackley Health System and Mercy General Health Partners (WHN). We are now in a period of analysis attempting to determine the similarities/differences in our managed care arrangements. Once this analysis is complete, we will be in contact with you and will schedule time for discussion about the future.

Thank you for your ongoing support of our ministry here in West Michigan. We are very excited about the coming together of our two organizations and the opportunity Mercy Health Partners will have to positively impact the health of the residents in West Michigan. We look forward to working with you in that endeavor.

Mission Statement

We serve together in Trinity Health,
In the spirit of the Gospel
To heal body, mind and spirit,
To improve the health of the communities we serve, and
To steward the resources entrusted to us.

Mercy Health Partners Vision Statement

Mercy Health Partners will distinguish itself as a nationally recognized healthcare destination with an unrelenting commitment to innovation, quality, diversity, compassion and access.

Sincerely,

Linda J. Bailey, RN
Executive Director
Westshore Health Network – Sherman Campus

Paul Peppin
Director, Contracting & Business Development
Hackley Campus

EMAILS RE: PRIORITY HEALTH NEGOTIATIONS

Working on a Sunday night? I got this last night and shook my head. But thanks and I would echo your sentiments. We're going to put our heads together to come up with implementation steps for your consideration. It may take a few days. We appreciate your patience and collaboration on this contract. Am looking forward to working with you in the coming year. Steve

-----Original Message-----
From: Linda Bailey [mailto:baileylj@trinity-health.org]
Sent: Sunday, December 07, 2008 7:26 PM
To: Steve Williams
Cc: Mark Gross; Mike Wallis; Jill McCarthy; Gary Allore
Subject: Re: 2008-2009 Contract

Steve I have discussed this with Gary Allore and Mark Gross. We appreciate your conisderation and believe that you have offered us a fair contract with the changes below. I believe we can move forward with finalization. Three items we need further clarification on:

1. You asked for a 2 year contract for the hospital with a clause to adjust the hospital payment by CPI. Gary has agreed with this.

2. We noted early in our discussions that we want the ability to adjust the Lakeshore Hospital rates to 90% of charges making that from the other facilities rates. Jerry and David has indicated that we could do that once we had final agreement. I will have Mike Wallis send you an adjusted DRG rate that will accomadate that request.

3. I am willing to discuss point two. Having said that we have been unsuccessful before in those discussions. I wouldn't take it off the table but I do believe the probability is fairly low.

Steve I know these are difficult time. I want you to know that we appreciate the efforts you have made to make this contract more doable for our heatlh system. We look forward to a continued partnership with you in the future.

Linda J Bailey
Executive Director
Westshore Health Network
1560 E. Sherman Blvd. Suite 145
231-672-3882

>>> <Steve.Williams@priorityhealth.com> 12/03/08 1:56 PM >>>

Linda:

I apologize for the delay in responding to your e-mail of 11-21. We have met on multiple occasions to discuss this and other facility and PHO agreements currently under negotiation. We are in the midst of a number of similar negotiations with other facilities are attempting to balance our overall facility payments throughout West Michigan. In this economic environment, this has proven to be particularly difficult in looking ahead to 2009 and 2010.

With that in mind, we would offer the following as our final offer for the contract year of 2009:

1. Given Priority's current financial performance and projections for 2009, it is impossible to go much beyond our current outpatient fee increase offer, however, we will agree to implement the DRG adjustment January 1, 2009, (6 months early) that you propose below ($6250) and, rather than make the agreement retroactive, propose a small additional increase in the current outpatient fee schedule offer of 0.50%, bringing this to 1.5% overall for the combined entity.

2. While we cannot agree to any additional improvement in incentives as they are currently constituted, we would be prepared to discuss an incentive based on your assistance with hospital-based physician contracts that create a competitive disadvantage for us compared to the dominant state carrier. These would include emergency room physicians and anesthesiologists. In the former case, we have no current contract and in the latter case, we pay significantly higher than the dominant carrier. Both of these constrain our efforts to do more with LHN. If you could assist us in bringing these costs into line, we could share some of the savings in those contracts with you. We can discuss this further and are open to your thoughts on this topic.

3. Finally, we received endorsement at the Priority Health board meeting November 12 for our general outline for primary care funding, which will include a capitation increase of 30 cents pmpm and the removal of alternative visit codes from capitation. An afterhours fee will also be paid for care delivered outside of the 8-5 period in a primary care setting. We are also considering a second year grant program, but this is subject to review based on results from the initial

grant performance. We will share complete details with you as we develop our communications plan and invite feedback as we move forward.
Linda, I won't belabor the point on our financials except to say our October results did not improve our financial situation, and in fact, were worse than we expected given the portfolio losses in our reserves. This adds pressure to these negotiations. I would also say that as we look ahead to 2010, it is apparent to us that the economic and other pressures we face are going to raise the stakes for our negotiations and are forcing us to reexamine our system negotiating strategy globally, including with our parent. We must find ways to fund our primary care strategy and at least some of this funding must come from reductions in hospital and specialty costs, as well as emergency room and urgent care use.
These are, indeed, trying times for health care and health administration. I hope that while our bonds are strained that our history will help us maintain perspective and our relationship.
Steve

From: Linda Bailey [mailto:BaileyLJ@trinity-health.org]
Sent: Friday, November 21, 2008 8:39 AM
To: Steve Williams
Cc: Allore, Gary; Gross, Mark; Wallis, Mike
Subject: Re: 2008-2009 Contract

Sorry for the delay Steve. I needed to discuss this with Gary our Board and Finance Committee. Although we understand your well stated situation below and are thankful for the dollars you have put on the table we too are facing many of the same dilemmas.

1. Medical cost inflation: Your proposal does not address the inflation we are seeing on the Mercy or General Campus. It only has a 1% increase for those two facilities on the out patient side, thus resulting in far less that a cola to meet our ongoing needs for those facilities, just to keep even.

2. Cost shifting to patients/members and membership losses: This is a large growing concern in our facilites. We continue to see a major shift to this model and that has resulted in more bad debt for our facilities as more and more people have less resources to go around and health care seems to be one of the last bills to get paid, if they ever get paid.

3. Michigan's economy: We are very aware of the economy impact as our charity care has risen to the highest levels we have ever seen and continues to

grow. This is having a further impact on our ability to keep pace with the growing community needs.

4. Priority Health funding of infrastructure and PCMH initiatives: We do understand the need to support the PCMH and are one of its largest promoters, but having said that we also need a solid infrastructure for our facilities.

5. Priority Health's current financial position: Again our reason for asking for some additional consideration is our own financial position. We too have frozen capitol and positions to try to position ourselves so that more drastic measures are not needed.

6. Although I know we have discussed this before, would you consider making these changes retroactive till October 1, 2008, with a mid year adjustment to our DRG to $6250 in July of 2009.

7. Another thought would be to increase our Incentive to 4% for the Hackley and Mercy Facilities.

8. Steve I know this is a difficult year. Our team is open to further discussions on how to resolve this gap. Thanks for your consideration Linda

Linda J Bailey
Executive Director
Lakeshore Health Network
1560 E. Sherman Blvd. Suite 145
231-672-3882
Stronger Together
Providing Value -Creating
Excellence

>>> <Steve.Williams@priorityhealth.com> 11/7/2008 3:51 PM >>>
Linda:

We received your message and appreciate your prompt and thoughtful response. I wanted to take a few moments to share our current thinking on provider reimbursement overall and to propose a second year rate request.
Five issues inform our reimbursement approach to providers today.

9. Medical cost inflation

10. Cost shifting to patients/members and membership losses

11. Michigan's economy

12. Priority Health funding of infrastructure and PCMH initiatives

13. Priority Health's current financial position

Let me discuss each briefly.

1. Over the past several years, medical trends have been running in the 7-10% range. As you are aware, increases to health plans and thus employer groups, are driven by two elements-contractual cost increases and utilization rates. New technology, new procedures and new drugs also contribute to increases in total costs. All of these are passed along to employer groups in the way of premium increases. While we appreciate the perspective of hospitals, it is important to understand that health plans must pass along cost increases for all provider types and pharmaceuticals. If we pay hospitals 5% more per year in contractual increases and use increases 4%, the overall increase is 9% as these are additive. With hospital inpatient and outpatient costs accounting for 40% of overall premium costs, this adds nearly 4% to premium. New technology, physician utilization increases and new drugs typically add another 7-10 percent to cost and at 60% of premium, another 4-6% to premium. Thus, our medical trends have been running at 7-10%, 2-3 times the rate of inflation. I hope you can appreciate how much each percentage point impacts our premium trends

2. Even if we were prepared to pass along these kinds of premium trends, employers are no longer prepared to accept them. Thus, as you are aware, they are shifting additional cost to employees or moving to other plans to reduce their premium costs. Priority has lost a significant number of employer accounts in the past two years and while we have stabilized in recent months, we are faced with a number of large group losses on January 1, 2009. Many of these groups are being lost to Blue Cross. Each time a group moves from Priority to the Blues, it forces payment down to many physicians and further consolidates their enormous market share advantage. (We assume that hospital rates are near parity.) But even when we maintain a group, it is often with higher deductibles and out of pockets for members. As you are well aware, cost shifting has a negative impact on your collection rates, thus raising your costs even more. And

reduced benefits are having an impact on use rates, thus negatively affecting facilities with high fixed expenses. For employers and plans, this reduction is positive. For facilities and physicians, it is causing increasing concern. This vicious cycle is one we are all caught up in, but we would respectfully submit that simply raising your rates is increasingly having diminishing returns with all of the cost shifting.

3. You are well aware of the impact the economy is having on all of our businesses. The impact this is having to the plan is two-fold: More and more employers are closing or dropping health benefits, thus reducing the insured pool. This has the impact of increasing the ranks of the uninsured and those on Medicaid-neither of which is good for you or us. In recognition of the need to tighten our belts, we are being forced to hold our administrative budget absolutely flat. The only increases we will pass along to employers in 2009 is for medical expense.

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Lakeshore Health Network and Priority Health have a long and enduring relationship that has been good for both parties. We have supported your efforts in many ways over the years and we support the merger of the two facilities Our willingness to bring Hackley rates up to those at Mercy, we believe, is a demonstration of that support. But it also limits the amount we can pay the

Exhibit WWW

UNITED STATES OF AMERICA, ET AL v. BLUE CROSS BLUE SHIELD OF MICHIGAN

LAURA EORY

November 12, 2012

Prepared for you by

BIENENSTOCK
NATIONWIDE COURT REPORTING & VIDEO

Bingham Farms/Southfield • Grand Rapids
Ann Arbor • Detroit • Flint • Jackson • Lansing • Mt. Clemens • Saginaw

LAURA EORY
November 12, 2012

Page 1

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
LAURA EORY,
Taken at 1901 St. Antoine, 6th Floor at Ford Field,
Detroit, Michigan,
Commencing at 9:00 a.m.,
Monday, November 12, 2012,
Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

Page 2

APPEARANCES:

MICHAEL T. KOENIG
RICHARD LIEBESKIND
U.S. Department of Justice
Antitrust Division
450 5th Street, NW
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Washington, DC 20001
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Appearing on behalf of Plaintiff
United States of America.

MATTHEW P. ALLEN
Miller, Canfield, Paddock and Stone, PLC
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allen@millercanfield.com
Appearing on behalf of Plaintiff Aetna, Inc.

Page 3

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Page 4

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Appearing on behalf of Health Alliance Plan of
Michigan and the witness.

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Health Alliance Plan of Michigan
2850 West Grand Boulevard
Detroit, Michigan 48202
313.664.8379
amacderm@hap.org
Appearing on behalf of Health Alliance Plan of
Michigan and the witness.

ALSO PRESENT:
Travis Jewell - Video Technician

Page 177

Q. Did Beaumont ever tell you that an MFN contract with Blue Cross was limiting their ability to, to work with other health plans to make them stronger competitors?
A. No.
Q. Did the University of Michigan ever tell you that?
A. No.
Q. Did Oakwood ever tell you that?
A. No.
Q. Did DMC?
A. No.
Q. Has anyone ever told you that?
A. No.
Q. And you talked about St. John being a must-have in the southeast, in Southeast Michigan?
A. Yes.
Q. Are there any services that DMC offers that are substitutable for services that St. John offers?
A. Yes.
Q. Okay. Beaumont is also in your view a must-have hospital; is that accurate?
A. Yes.
Q. Are there services they offer that are substitutes -- I'm sorry -- are there any services DMC offers that are substitutes for Beaumont services?
A. Yes.

Page 178

Q. And are there members that could conveniently go to DMC to substitute DMC's services for corresponding Beaumont services?
A. Yes.
Q. And are there members that could conveniently go to DMC to substitute DMC's services for St. John's services?
A. Yes.
MR. MARTIN: Thank you. That's all the questions I have.
MR. LIEBESKIND: Go ahead if you want.
MR. KOENIG: No, no. I do have some questions but I'd rather consolidate them all.
VIDEO TECHNICIAN: Want to go off the record?
Going off the record. The time is 2:49 p.m.
(Recess taken at 2:50 p.m.)
(Back on the record at 2:51 p.m.)
VIDEO TECHNICIAN: Back on the record. The time is 2:51 p.m.
RE-EXAMINATION
BY MR. KOENIG:
Q. It turns out I have just a couple more questions. The last line of questioning by Mr. Martin regarding DMC,

Page 179

I think was the example he used, does that change your view as to whether Beaumont or St. John remain must-haves in the Detroit area?
A. I believe his question was that could they go someplace else. They could but there are issues with transportation. There are issues with members crossing what is perceived as an Eight Mile line of where they want to receive care. So from a HAP perspective, we consider Beaumont and St. John as must-haves in our network.
Q. Okay.
A. We believe that those members would not travel to the DMC as an option.
Q. One other thing. Way back early this morning the term "MFN" and "Most Favored Nations" was thrown around, and I just want to make sure I understand what you understand the Most Favored Nations to be.
A. My impression is that it's an agreement with someone or other so that they have the best rates available or the best discount available, or there's some level of difference or discrepancy between the rate that that hospital can contract with another payer at.
Q. So if you were to describe, say, an MFN between, you know, Blue Cross and some hospital, what would that MFN under how you just described it, what would that

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MFN allow or prevent the hospital from doing?
A. As I understand it, the MFN -- the MFN would prohibit the hospital from either contracting a certain rate or within a certain percentage with another payer as they already have contracted under the MFN.
Q. Okay. And from HAP's perspective, if Blue Cross has MFNs with hospitals, is that beneficial to HAP?
A. No.
MR. MARTIN: Object to the form.
BY MR. KOENIG:
Q. Why not?
A. Because as we go in and try to negotiate reductions, it may be that there is an MFN out there or some other reason prohibiting the hospital from being able to contract at a lower rate. So all the years we asked for reductions and were unable to get them could be that there's an MFN prohibiting that situation, and obviously we can't be as competitive on the premium side when we go out there in the marketplace without lower hospital rates.
Q. So my question was framed in terms of is it beneficial to HAP. Based on your answer, is it fair to say that MFNs are harmful to HAP's ability to be competitive in the marketplace?
MR. MARTIN: Object to the form.

A. Yes.

MR. KOENIG: That's all I have.

RE-EXAMINATION

BY MR. MARTIN:

Q. You don't have any example where any hospital has told you that a given rate negotiation was affected by a Blue Cross MFN contract, do you?

A. No.

MR. KOENIG: Asked and answered.

MR. MARTIN: Well, you have the last word.

MR. KOENIG: I'm done.

MR. WILSON: One request. We'd like to review the transcript before it's finalized.

MR. ALLEN: Another housekeeping matter, I'd like to just confirm that an objection for one party during this depo was an objection for all on the plaintiffs' side.

MR. KOENIG: That's fine with me, and I'd also add to that that there were times when Lindsey beat me to the punch, Mr. Wilson beat me to the punch objecting, and just to prevent, you know, further disruption, since he's not a plaintiff, HAP's not a plaintiff, I would like to adopt those objections for the United States in any event.

MR. ALLEN: As would Aetna.

MR. KOENIG: Okay.

MR. ALLEN: Okay.

VIDEO TECHNICIAN: This concludes today's deposition. The time is 2:55 p.m.

(Deposition concluded at 2:55 p.m.
Signature of the witness was requested.)

UNITED STATES OF AMERICA, et al,
Plaintiffs,
vs. Case No. 2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD
OF MICHIGAN,
Defendant.

VERIFICATION OF DEPONENT

I, having read the foregoing deposition consisting of my testimony at the aforementioned time and place, do hereby attest to the correctness and truthfulness of the transcript.

_____
LAURA EORY
Dated:

ERRATA SHEET

PAGE	LINE	READS	PAGE	LINE	SHOULD READ

LAURA EORY
Dated:

Exhibit XXX

UNITED STATES OF AMERICA, ET AL v. BLUE CROSS BLUE SHIELD OF MICHIGAN

TIMOTHY MICHAEL JODWAY

September 7, 2012

Prepared for you by

BIENENSTOCK
NATIONWIDE COURT REPORTING & VIDEO

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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 TIMOTHY MICHAEL JODWAY,

Taken at 660 Woodward Avenue, Suite 2290,

Detroit, Michigan,

Commencing at 9:01 a.m.,

Friday, September 7, 2012,

Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

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A. Yes.
Q. And who was that person?
A. That was our Vice President of Human Resources.
Q. And who was the Vice President of Human Resources?
A. Steve Solomon.
Q. Thank you. Sir, could you look at the exhibit that was marked earlier today as Blue Cross 667?
A. Yes.
Q. Do you have that in front of you?
A. Yes.
Q. What is the -- what is the list here 1 through 10; what are those organizations?
A. Some are commercial insurers and some are Medicaid HMO, PPO products.
Q. And during your time at Garden City Hospital, have you negotiated reimbursement arrangements on behalf of the hospital with any of the firms listed on Blue Cross 667?
A. Yes.
Q. And which ones, please?
A. HAP I think is the only one.
Q. Okay, and can you tell me the approximate timeframe of your reimbursement dealings with HAP?
A. Probably about two years ago.
Q. So close to when you first started at Garden City; is

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that correct?
A. Yes.
Q. And did you ultimately arrive at an agreement with HAP?
A. Yes.
Q. Who, who at HAP were you dealing with in your reimbursement negotiations?
A. I don't recall.
Q. Do you know whether it was Laura Eory?
A. That doesn't sound familiar.
Q. Okay, and can you describe generally what, what sort of reimbursement rate agreement you were able to arrive with HAP on?
A. It was a fee schedule based contract.
Q. Can you tell me roughly speaking how the rates in the HAP fee schedule you negotiated compare -- compared to the rates that you were receiving from Blue Cross Blue Shield of Michigan at the time you negotiated the HAP agreement?
A. I believe they were lower.
Q. You believe HAP's rates were lower than Blue Cross's rates?
A. Yes.
Q. And when you say that HAP's rates were lower than Blue Cross's rates, just so I understand and we're on the

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same page, was, was Blue Cross's reimbursement rates a smaller amount than the HAP reimbursement rates; is that right?
A. No. HAP's rates were a lower reimbursement amount than Blue Cross's.
Q. Okay. So you were getting more money from Blue Cross than from HAP?
A. Yes.
Q. Okay, and can you tell me roughly speaking how much volume Blue Cross was accounting for at Garden City Hospital at the time you negotiated the HAP agreement compared to HAP?
A. Well, Blue Cross, again, was about a quarter of our business. HAP was -- is probably in the low single digits.
Q. Okay. Given that HAP has less volume at Garden City than Blue Cross, why were you willing to accept less money from, from HAP than, than you do from Blue Cross?
A. Because they were at the time steering business away from us, so in order to grow our business, we needed to accept the rate that was lower.
Q. In what way was, was HAP steering business away from Garden City Hospital at the time you were negotiating the agreement?

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A. I think with the insurance, with their insurance network, they were -- there was some favorable reasons for patients to be sent to Henry Ford Hospital rather than to us.
Q. What do you understand the relationship to be, if any, between HAP and Henry Ford?
A. I believe HAP is owned by Henry Ford.
Q. And, and Henry Ford is a health system; is that right?
A. Yes.
Q. And included in the Henry Ford Health System are hospitals?
A. Yes.
Q. And I think one of the hospitals in the Henry Ford system that you mentioned earlier today is West Bloomfield; is that right?
A. Yes.
Q. And since arriving at the agreement that you did with HAP, have you noticed that HAP has decreased the amount of business that it was steering away from Garden City Hospital?
A. Yes.
Q. Do you know roughly how much of a decrease in steerage Garden City has experienced since the HAP agreement?
A. No.
Q. Can you roughly tell me the level of significance in

Exhibit CCCC

FIRST AMENDMENT TO HOSPITAL AGREEMENT

THIS FIRST AMENDMENT TO HOSPITAL AGREEMENT is attached to that certain Hospital Agreement dated June 1, 2006, by and between PPOM, L.L.C., a Delaware limited liability company d/b/a Cofinity (hereinafter referred to as "PPOM") and Lakeview Community Hospital, a duly licensed hospital in the State of Michigan (hereinafter referred to as "Hospital").

The parties hereto agree that the Agreement is hereby amended, effective 1/1/2008 as follows:

1. Lakeview Community Hospital Family Care and Specialty Practices became a member of the Bronson Healthcare Group. The providers will bill under the legal name of Bronson LakeView Hospital.

2. Effective 1/1/2008, claims for all professional services will be billed with the Bronson LakeView Hospital tax ID and paid according to the Bronson Agreement rates, Cofinity Master Payment Schedule (G23).

3. Effective 1/1/2008 LakeView Community Hospital became a member of the Bronson Healthcare Group. The new legal name is Bronson LakeView Hospital. All services are to be paid under the current in-patient/out-patient rates of the Bronson Methodist Hospital Agreement, as shown on Exhibit A attached hereto.

4. For Bronson LakeView Hospital facility claims, workers compensation policies and auto insurance policies shall be specifically excluded under this Agreement.

Except as stated herein to the contrary, the Hospital Agreement is not amended or modified in any manner whatsoever.

Exhibit A

For all Hospital Services, both inpatient and outpatient, excluding the physician component, Hospital's usual and customary charges for such services reduced by fifteen percent (15%).

In witness whereof, the parties hereto have executed this First Amendment to said Hospital Agreement to be executed by their respective officers duly authorized to do so.

WITNESSES:

"COFINITY"

PPOM, L.L.C., a Delaware Limited liability Company

by: _____

Its: _____

"Bronson LakeView Hospital"

by: _____

Its: _____

Exhibit EEEE

UNITED STATES DEPARTMENT OF JUSTICE

EASTERN DISTRICT OF MICHIGAN

United States and State of Michigan,	:	
Plaintiffs,	:	
vs	:	Civil Action No. 2:10-cv-14155-DPH-MKM
Blue Cross Blue Shield of Michigan,	:	
Defendant.	:	

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.

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A. Those are estimated -- 2008 would be what we had projected as the estimated reimbursement rates, and then going forward was basically what we thought we could get the other payors up to over the transition period.

Q. Focusing on Cofinity for a moment, at this point in time did you attempt to increase rates with Cofinity?

A. Well, I --

MR. HESSEN: For clarification, are you talking about the date of the email?

MR. JOYCE: Yes.

THE WITNESS: I would say that -- I probably should clarify something. Obviously from a hospital -- from our standpoint, if you go back to 2007, 2008, we started to see some financial issues, so I want to clarify that renegotiating with these payors is not solely a result of what Blue Cross is doing but it is basically -- we try to do tbis periodically, so I will say that in this case obviously the Blue Cross agreement accelerate that process, so at this point these numbers

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basically represent what we predicted we could get in future years from those payors.

VIDEO TECHNICIAN: Mr. Joyce, I am still picking up a slight something in close proximity to your mike. I am not sure.

MR. JOYCE: Are you sure it's mine?

VIDEO TECHNICIAN: Yes, I am isolating it.

MR. JOYCE: I don't have anything on me that's electronic.

BY MR. JOYCE:

Q. Focusing on the Cofinity column, if you look at the row across, where it says "2010" on the left, it looks like the number there for Cofinity is 75 percent?

A. That's correct.

Q. Now, what does that 75 percent number represent?

A. 75 percent of billed charges.

Q. Why did you write down, "Cofinity, 75 percent, 2010"?

A. The -- at this point in time I didn't

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have any illusions that I would be able to get any of these payors up to Blue Cross levels in the first year, so it was my way of predicting in increments how we could get there. Then at that point in time we really didn't know what was going to happen, so that's what it was. At that point in time -- those were the two largest commercial payors that were below Blue Cross levels.

Q. So around the time of February 20, 2008, was it your goal at that time to increase Cofinity's rate up to 75 percent by the year 2010?

MR. STENERSON: Object to the form.

THE WITNESS: It was my projection, yes.

BY MR. JOYCE:

Q. How did you -- how do you select 75 percent as your target for 2010?

A. It wasn't a lot of scientific analysis, just kind of a quick and dirty projection, essentially that's what it was.

Q. How did you project that would compare to your Blue Cross rate in 2010?

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A. That's -- it would exceed Blue Cross.

Q. I'm sorry?

A. As it shows there, it wonld exceed Blue Cross --

MR. STENERSON: Object.

THE WITNESS: I mean, comparable to Blue Cross in 2010 basically.

THE WITNESS: I don't recall -- at that point in time I don't even recall if we had begun discussing any of this with the payors.

MR. STENERSON: Move to strike his misstating the record.

BY MR. JOYCE:

Q. So was your projection of 75 percent for Cofinity by 2010 related to the Most Favored Nation provision we had discussed previously today?

MR. STENERSON: Object to the form.

THE WITNESS: Yes.

BY MR. JOYCE:

Q. How is that 75 percent figure related to the Blue Cross MFN?

MR. STENERSON: Object to the form,

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vague and ambiguous.
THE WITNESS: How is it related? Essentially it is related in that that 75 percent puts us at or near Blue Cross levels.
BY MR. JOYCE:
Q. So, around the time of February 20, 2008, was it your goal to get Cofinity to Blue Cross's -- to Blue Cross's reimbursement rate levels by 2010?
A. It was my goal then that I put a plan in place that by the end of 2010 we are assured of getting the maximum reimbursement rate from Blue Cross.
Q. Is that because of the MFN provision we discussed earlier?
MR. STENERSON: Object to the form.
THE WITNESS: It is related, yes.
BY MR. JOYCE:
Q. I think you mentioned earlier that you discussed negotiations with other payors and you mentioned in that context that the Blue Cross contract accelerated that process; do you recall

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saying that?
A. Yes.
Q. What did you mean by describing it as accelerating the process?
A. Well, I would say that obviously with some of these payors you get annual contracts and you may wait until three months to the end of the term to start negotiations, this caused us, the negotiations, to start early basically, yes.
Q. The same questions for the column labeled "UHC," is that United?
A. Yes.
Q. So you wrote here "76 percent" under the UHC column for 2010?
A. Yes.
Q. What does that figure represent, the 76 percent?
A. The percent of reimbursement of billed charges.
Q. In February 20, 2008, were you projecting to get your reimbursement rate with United up to 7[illegible] percent of billed charges?

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A. Yes.
Q. Why did you project 76 percent as the number?
A. Well, obviously the relevance of the 76 percent is that, once again, it is near the -- or at Blue Cross levels at the end of 2010.
Q. Was your MFN agreement with Blue Cross factor in your selecting 76 percent as your projection for United for 2010?
A. Yes.
Q. Was it a substantial factor?
MR. STENERSON: Object to the form.
THE WITNESS: A partial factor.
BY MR. JOYCE:
Q. What do you mean by that?
A. Part of -- I would say that we historically always tried to get United Healthcare up. It's probably been our most difficult payor to contract with. So, once again, I would say the Blue Cross Letter of Agreement accelerated the negotiation process.

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(Deposition Exhibit No. 9 was marked for identification.)
MR. JOYCE: Mr. Andrews, I am handing you what's marked as Exhibit 9.
MR. HESSEN: 9?
MR. JOYCE: It is 9. It is a multipage document, with a Bates number on the first page, TRH-DOJ-000006. It appears the title of the document -- the top line of the document states, "Payor reimbursement percent - 2007 through 2010." I believe this is a printout of a cell sheet you provided to us in response to a Civil Investigative Demand we had issued to Three Rivers
MR. STENERSON: Yes, I would just ask, Barry, that you lay a little more foundation to describe what this is for the record because I don't think that this is a document created in the regular course of business by this hospital, so I would object to the lack of foundation.
BY MR. JOYCE:
Q. What is this document, Mr. Andrews?
A. It is basically some projections I did on

Exhibit FFFF

Three Rivers Health

701 S. Health Parkway
Three Rivers, MI 49093-9342
269.278.4145 Phone
269.273.9611 Fax
www.threerivershealth.org

December 3, 2008

David Brown
Cofinity
801 Broadway Avenue N.W.
Suite 201
Grand Rapids MI 49504

Dear Dave:

Thanks for taking the time to discuss our current contract with Cofinity. As I have mentioned before, Three Rivers Health is experiencing significant financial difficulties, and presently we are projecting losses in excess of $2,300,000 for 2008. Because of these difficulties, we are in violation of certain bond covenants. Our largest concern is one of liquidity, and presently our days cash on hand are 14. We presently are looking at all areas for opportunities to decrease costs, and increase revenues. As of November we have presently eliminated over 30 jobs during this fiscal year, and will most certainly eliminate other jobs if we cannot increase revenues. We are presently looking at our contracts with our payors to identify potential increases in rates. As I have mentioned in earlier discussions, our Blue Cross contract is presenting challenges regarding the most favored nation clause. In addition, it has become challenging for me to justify giving larger discounts to payors that generate less business than Blue Cross. It is because of these reasons that we need to get all of our payors near or at BlueCross levels by the end of 2009. While we do not expect the increased rates to solve all of our financial issues, it certainly will help.

I appreciate your willingness Dave to discuss our issues, and to consider increasing our rates to necessary levels. If we cannot get to levels that are needed, we will have to eliminate programs that are critical to the health of our community. The current programs being targeted are cardiac rehab, diabetic education, pulmonary rehab, and closing our wellness center, and possibly Home Care and Hospice. These are all areas that are offered to the community, even though they generate no profit. In addition, this hospital serves a large population of Medicaid patients, so you can see that the Board's mission is to serve the community, but we all know no margin, no mission. Another service that is also being considered is the Hospitals OB program. This serves a large Medicaid population, so eliminating this service will have far reaching ramifications.

Thanks again Dave for listening to our issues, and hopefully we can finalize our discussions this month.

Sincerely,

Steven T. Andrews
V.P. of Finance

DEPOSITION EXHIBIT
Pl. Andrews 11
PENGAD 800-631-6989

Exhibit GGGG

SECOND AMENDMENT TO HOSPITAL AGREEMENT

THIS SECOND AMENDMENT TO HOSPITAL AGREEMENT is attached to that certain Hospital Agreement dated February 15th, 2001, and its Second Amendment dated September 1 2006, by and between PPOM, L.L.C., a Delaware limited liability company, now d/b/a Cofinity (hereinafter referred to as "COFINITY"), and Three Rivers Health, a duly licensed hospital in the State of Michigan ("Hospital").

The parties hereto agree that the Agreement is hereby amended effective January 1, 2009 as follows:

1. Sec 1G "Master Payment Schedule" shall be deleted and replaced with the following:

   G. "MASTER PAYMENT SCHEDULES" shall mean those schedules referred to as Exhibits "A" and "B" (which are hereby incorporated by reference herein) which set forth the maximum payment which Hospital hereby agrees to accept as reimbursement in full for Hospital Services. Exhibit "A" refers to inpatient and outpatient reimbursement rates and same are special and specific to Hospital facility only, and may be amended only by mutual written agreement. Exhibit "B" refers to reimbursement rates by CPT code (where applicable) and same apply to all HCPs; will be reviewed by Cofinity upon written request from Hospital; and may be amended by Cofinity from time to time as it deems reasonably necessary and proper in the exercise of its reasonable discretion.

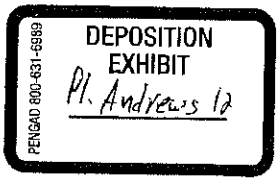
2. Exhibit A Master Payment Schedule (DRG rates) shall be deleted and replaced with the Exhibit A attached hereto.

3. Exhibit B Master Payment Schedule shall be deleted and replaced with the Exhibit B attached hereto.

4. Sec 11.A.shall be amended as follows:

   A. Hospital shall submit to Cofinity all claims for Hospital Services within a reasonable time after the provision of such Hospital Services. Hospital shall submit same on its customary billing form and shall set forth therein its usual and customary charges for the Hospital Services rendered. However, except as set forth in subparagraph C hereinbelow, Hospital hereby agrees to accept as payment in full for all Hospital Services rendered, those amounts as shown on Exhibits A and B.

   Hospital shall be entitled to recover from the applicable Insurer, for Hospital Services which are Medically Necessary and covered under a Patient's Health Plan, the amount determined hereinabove less any co-insurance or deductible specified in such Patient's Health Plan (which amounts Hospital may recover from the Patient) and/or less any coordination of benefit reimbursement for which another payor is prior obligated (which amounts Hospital may recover from any other obligated third party payor). Upon agreement of Patient, Hospital shall be entitled to collect any co-insurance or deductible from any Patient at the time of service. However, any funds collected by Hospital in error shall be promptly refunded to the Patient. In the event the applicable Insurer fails to pay Hospital for Hospital Services which are Medically Necessary and covered under a Patient's Health Plan, after obtaining Cofinity's written consent, Hospital may pursue the Patient (and any person legally responsible for the Patient) for payment. Except as specifically provided in the preceding sentence, Hospital hereby agrees that the only Hospital Services for which a Patient (and any person legally responsible for the Patient) may be liable, and be billed by Hospital, are as follows:



Master Payment Schedule

EXHIBIT A

Hospital Agreement with: Three Rivers Health

Hospital facility

1. Group Health and Workers Compensation

For all hospital facility Covered Services (inpatient and outpatient), excluding the Physician Component provided by hospital's employed physicians/professionals, hospital to be reimbursed the agreed upon rates as follows:

Year 1: 1/1/2009 to 12/31/2009: 65% of billed charges (35% reduction)

Year 2: 1/1/2010 to 12/31/2010: 75% of billed charges (25% reduction)

Year 3: 1/1/2011 to 12/31/2011: 80% of billed charges (20% reduction)

Note: Special rules exist by Michigan statute that control reimbursement to health care providers for Workers Compensation. Cofinity reimbursement cannot exceed, by law, the state mandated fee schedule. Accordingly, reimbursement through Cofinity is the lower of either the state mandated fee schedule or the Cofinity Master Payment Schedule.

2. Auto Insurers

For all hospital facility Covered Services (inpatient and outpatient), excluding the Physician Component provided by hospital's employed physicians/professionals, hospital to be reimbursed the agreed upon 82% of billed charges (18% reduction).

EXHIBIT B

Physician / Professional Component of all Hospital Services (both inpatient and outpatient):

Group Health/Auto:

1. For the Physician/Professional Component of all Covered Services (both inpatient and outpatient), excluding workers compensation, the lesser of:
   a) Hospital's usual and customary charges for such services; or
   b) the amount determined in accordance with the Cofinity Master Payment Schedule
2. For the Physician/Professional Component of all covered services for Workers Compensation, the lesser of:
   a) Hospital's usual and customary charges for such services; or
   b) the amount determined in accordance with the Cofinity Master Payment Schedule, or
   c) the amount as determined by the State of Michigan workers compensation fee schedule

(i) Hospital Services for which prospective review is not required under the terms of the Patient's Health Plan, which are not covered by such Health Plan (e.g. elective plastic surgery), and for which the Patient (or any person legally responsible for the Patient) has agreed, in writing, to pay Hospital prior to Hospital providing such services; and

(ii) Hospital Services for which prospective review is required under the terms of the Patient's Health Plan, which are determined by the Insurer or its agent to not be Medically Necessary, and for which Hospital has satisfied the terms of subparagraph 11.D.3. hereinbelow; and

(iii) Co-payments, coinsurance, and deductible amounts required by the Patient's Health Plan

Except as stated herein to the contrary, the Hospital Agreement is not amended or modified in any manner whatsoever.

In witness whereof, the parties hereto have executed this Second Amendment to Hospital Agreement to be executed by their respective officers duly authorized to do so.

WITNESSES:

_____

_____

_____

_____

"Cofinity"

By: _____

Its: _____

"Hospital"

By: : _____

Its: 1/28/09

2nd Amendment 2009

TRH-HC-0003779

Confidential

Exhibit IIII

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

UNITED STATES OF AMERICA and the STATE OF MICHIGAN,	
Plaintiffs,	Civil Action no.: 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. 2:11-cv-15346-DPH-MKM
v.	
BLUE CROSS BLUE SHIELD OF MICHIGAN,	
Defendant.	

Troy, Michigan

Monday, October 8, 2012

Confidential Video Deposition of:

FREDERICK SCHAAL,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 201 West Big Beaver Road, Suite 500, Troy, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:10 a.m., when were present on behalf of the respective parties:

Q -- Model Reimbursement Methodology?
So I just want to understand this a little better. For Peer Group 5 hospitals, the MRM sets out a reimbursement rate that Blue Cross will pay the hospital; is that right?
A Yes.
Q And does that apply to the traditional and the TRUST product?
A Yes.
Q Does it also apply to BCN?
A Yes.
Q Is it the same rate for all three?
A Yes.
Q And is that rate -- does that rate differ for inpatient or outpatient?
A No.
Q So the model sets out one reimbursement rate for traditional, TRUST, and BCN at a Peer Group 5 hospital?
A Yes.
Q Do you have any authority to go above the model?
A Yes.
Q Do you have the authority to go below the model?

A No.
Q Have you ever tried to go below the model for any Peer Group 5 hospital?
MR. GILMAN: Objectiou, form.
You ean answer.
THE WITNESS: No.
BY MS. BHAT:
Q Have you ever agreed to pay a Peer Group 5 hospital more than the model sets out?
A Yes.
Q When?
A When I've negotiated their agreement.
Q Can you think of any Peer Group 5 hospitals that today receive more than the model sets out?
A Yes.
Q Which hospitals?
A Hills & Dales.
Q Are there any other hospitals?
A Not that I remember.
Q Why did you agree to pay Hills & Dales more than the model set out?
A I believe for Hills & Dales, they are having some financial issues that were not accounted for in the model.
Q Do you remember what those financial issues

were?
A No.
Q Do you remember how much more than the model you agreed to reimbursement Hills & Dales?
A No.
Q Are you familiar with the term "Peer Group 4 hospital"?
A Yes.
Q I'm sorry, I should have asked you this.
Do you remember who you negotiated with at Hills & Dales?
A Mike Flatko.
Q And what position does he hold?
A I believe he's the CFO.
Q Do you remember when you negotiated with them to go above the model?
A It would have been within the last couple years.
Q So since 2010?
A Yes.
Q Okay. So what does the term "Peer Group 4" apply to?
A A size of the hospital.
Q And what type of hospital would qualify for Peer Group 4?

A They would be bigger than 100 beds.
Q Do they -- is there any requirement that they be rural or urban or...?
A No.
Q Would Peer Group 4 hospitals typically be bigger than Peer Group 5 hospitals?
A Yes.
Q What are the requirements for Peer Group 5 hospitals? Do you remember?
A What are the requirements for Peer Group 5?
Q Yes.
MR. GILMAN: Objectiou, form.
THE WITNESS: 100 beds or less, and designated as rural.
BY MS. BHAT:
Q Who designates the hospital as rural?
A I believe Michigan does.
Q So the hospital has to be located somewhere that's designated as rural by the government?
A Yes.
Q Okay. How is the reimbursement rate for Peer Group 4 hospitals determined?
A Through a model.
Q Is it the same model as the one that's used for Peer Group 5 hospitals?

Exhibit JJJ

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.	
BLUE CROSS BLUE SHIELD OF MICHIGAN,	2:11-cv-15346-DPH-MKM
Defendant.	

Troy, Michigan

Monday, October 8, 2012

Confidential Video Deposition of:

FREDERICK SCHAAL,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 201 West Big Beaver Road, Suite 500, Troy, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:10 a.m., when were present on behalf of the respective parties:

compliance with the most favored discount?

A They send in an annual attestation. 10:35:33

Q So if a PG 5 hospital sends in an attestation to compliance with the most favored discount, that could have some effect on its reimbursement rate?

A Yes.

Q Okay. And then the last sentence says, 10:35:48 "Percent of Charge reimbursement." Do you see that?

A Yes.

Q What does that refer to?

A How they're -- Peer Group 5 hospitals are reimbursed. 10:35:59

Q Are Peer Group 5 hospitals reimbursed on a percent of charges basis?

A Yes.

Q Does that apply to both inpatient and outpatient? 10:36:06

A Yes.

Q Does the Model Reimbursement Methodology take into account the previous Blue Cross reimbursement rate at that PG 5 hospital?

A No. 10:36:25

Q Does the Model Reimbursement Methodology take into account the reimbursement rate that other payers are paying at that hospital?

Exhibit KKKK

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

Volume 1

Detroit, Michigan

Tuesday, October 16, 2012

Confidential Video Deposition of:

KIM SORGET,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:05 a.m., when were present on behalf of the respective parties:

discount advantage?
MR. GILMAN: Objection, form, foundation.
THE WITNESS: Restate?
BY MR. KRAMER:
Q Was the verifiable favored status in reimbursement levels that was part of the model proposal designed to enable Blue Cross to maintain its discount advantage?
MR. GILMAN: Same objections.
THE WITNESS: That would have been a desire, but it wasn't accepted.
BY MR. KRAMER:
Q And when you say "it wasn't accepted," would you explain what you mean?
A We didn't put it in the contract as it relates to the Peer Group 1 through 4s.
Q And why was that the case?
A Feedback from the industry was that they didn't feel they could support that.
Q And did they explain why they did not feel they could support verifiable favored status in reimbursement levels?
A I think that was -- my recollection is they didn't know if it was something that their members would sign.

Q Was there any consideration of the legality of such a policy or provision?
A That may have been, but I think that would be better come from them, in terms of what their understanding was.
(Sorget Exhibit 3 was marked.)
BY MR. KRAMER:
Q Mr. Sorget, please familiarize yourself with the document marked as Exhibit 3, which is Bates BLUECROSSMI-99-01007796 through '799. It appears to be a draft dated 7-21-05 of the minutes of the Blue Cross Contingent of the Participating Hospital Agreement Advisory Committee Meeting on June 22nd of 2005.
My questioning will focus on the portions that start with Section b, on page 3 onto page 4, including c on page 4, just to focus you in on where to focus your attention.
A (Reviewing Sorget Exhibit 3.) Okay.
Q Are you familiar with Exhibit 3, sir?
A It's seven years ago, but vaguely.
Q Okay. It indicates you attended the meeting on June 22nd, 2005 of the PHAAC; is that right?
A I believe so.
Q Okay. And what is the PHAAC, please?
A Well --

Q The Blue Cross contingent, that is.
A Right. The Participating Hospital Agreement, or PHA, has provisions for what they call a contract administration process, of which there is a structure of groups that -- that input. And this meeting represented only the Blue Cross contingent of that group.
Q Okay. And would that include Blue Cross executives and Blue Cross board members?
A It would include the board members that were identified here as being on the phone or in person.
Q And who were the board members present?
A That would be William Black, John Hamilton, Jon Barfield, Kathleen Shapiro, and Charles Gayney.
Q Did any of them have hospital affiliations?
A Not to my knowledge.
Q Let me ask you, please, to turn to the third page of Exhibit 3, where under heading b, "BCBSM's Response to the Cohen Report," it starts with, "Management provided an overview of an environmental assessment that included," and among other things included would be, "...a competitor analysis for hospital charge discounts."
Do you see that, sir?
A I see that.
Q And what was the purpose of providing that as

part of the environmental assessment?
A I can't recall at this time.
Q But would that be the type of analysis that would give rise to the belief that Blue Cross had a hospital discount advantage over its competitors?
A It may have.
Q Okay. There's next mention in these minutes, Exhibit 3, that, "The committee also reviewed two proposed models for hospital reimbursement: 1) a collaborative approach; and 2) an individual contracting approach."
Could you contrast those two approaches briefly, please, sir.
A Well, a collaborative approach would be consistent with the social missions of hospitals being not-for-profit and Blue Cross being not-for-profit, to deliver high quality, low cost, accessible care to members. We had had that relationship for many years with the hospital industry, and would it be our goal to be able to continue that relationship, as the collaborative approach.
The individual contracting approach would have been a direction of saying -- abandoning the collaboration and working together to try and solve problems for the healthcare delivery in the state and

Exhibit LLLL

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.	:	
BLUE CROSS BLUE SHIELD OF MICHIGAN,	:	2:11-cv-15346-DPH-MKM
Defendant.	:	Volume II

Detroit, Michigan

Wednesday, October 17, 2012

Confidential Video Deposition of:

KIM SORGET,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman, 1901 St. Antoine Street, 6th Floor at Ford Field, Detroit, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:05 a.m., when were present on behalf of the respective parties:

small in terms of overall payout, but they're important to our access requirements that were expected by the state labeling, is that we provide broad access, and we did not want to take the risk of these hospitals financially failing because we didn't pay what we felt was a fair and adequate reinbursement, and we believe that methodology did.

Q But my question was, would it have been a disadvantage to Blue Cross if hospitals were giving deeper discounts to Blue Cross competitors, sir?

MR. GILMAN: Objection, form.

THE WITNESS: As I stated, our objective was to get the equal to or better discount for the volume we provided. If we weren't getting that, to that extent, we wouldn't be receiving the discount value that we think we should have been.

BY MR. KRAMER:

Q I understand that, but my question, once again, is, would it bave been a disadvantage to Blue Cross if hospitals were giving deeper discounts to Blue Cross competitors?

A It would have --

MR. GILMAN: Objection, form.

THE WITNESS: It would have been a disadvantage to our customers, through Blue Cross, if we

weren't getting the best deal. They're the ones that paid the bill.

BY MR. KRAMER:

Q And why would it have been a disadvantage to your customers if Blue Cross were not getting the best deal?

A Well, they weren't acbieving the volume discounts that we should get based upon the volume of services we provide to them.

Q And is it the case, then, that the level of discount that a commercial health insurer obtains ultimately redounds to the benefit of its customers?

A What the commercial benefits from? Other commercial, is what you're saying?

Q Any commercial health insurer.

A I can't speak to what benefits them.

Q Okay. Is it the case that the level of disconnt that Blue Cross obtains ultimately redounds to the benefit of its customers?

A Could you define "redounds"? It's a term unfamiliar to --

Q Ultimately runs to the benefit of its customers?

A I would think any reimbursement rate that we could get that is -- recognizes our volume would be a

value to our customers.

Q And why is that?

A They are looking to pay the lowest cost they can for their healthcare, and we're required by our enabling legislation to provide quality, cost, and access. And to the extent we get the deepest discounts, would affect -- could affect the cost factor to what customers have to pay.

Q And I take it the level of discounts generally affect the cost factor that customers have to pay?

A It's a factor.

Q Okay. If Blue Cross did not get the deepest discounts, would there be a concern that its customers might switch to another commercial health insurer, given the concern about getting the lowest cost?

A It may or may not.

Q But it may?

A It may.

Q Okay. Why is that?

A When I say "may," I don't believe it would -- it would only be may because I don't believe competitors, if they are looking to gain market share, are going to do it with rural hospitals. That's not where the volume occurs. We need the rural access hospitals for access, and we also need the rural

hospitals to support our statewide customers. And if a commercial payer was to think they're going to establish a network of rural hospitals, I would think it probably wouldn't be their best investment of time, in my opinion.

Q But if it may benefit them, why do you think that would be the case?

A I question whether it would benefit them at all.

Q Then why was Blue Cross concerned about obtaining the deepest discounts with the PG 5 hospitals, sir?

A We wanted the deepest discounts to be recognizing the volume of services that we're providing to them. We were their largest payer.

Q Okay.

A And we didn't want to be cross-funding our competition, who these hospitals may have been giving better discounts to.

As frail hospitals, we stepped up to the table by our methodology that was supported by the industry to provide their reimbursement that we felt that our expectation was that we should achieve the deepest discount. And that was, I believe, some of the principles that was inserted into those Technical