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

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

SECOND NOTICE OF FILING PUBLIC VERSION OF BLUE CROSS BLUE SHIELD OF MICHIGAN'S MOTION TO EXCLUDE THE EXPERT TESTIMONY OF DR. JEFFREY LEITZINGER [DKT. 140]

Pursuant to the April 20, 2018 Notice of Supplementing the Public Record Consistent with the Court's April 17, 2018 Order [Dkt. 322], Defendant Blue Cross Blue Shield of Michigan (BCBSM) now files full versions of briefs previously filed under seal, making public material disclosed in previously-sealed filings that the Parties and Third Parties agree may be unsealed, materials that Third Parties did not move to seal, and materials that the April 17, 2018 Order has ordered unsealed or redacted as listed in Exhibit 1 to the April 20, 2018 Notice of Supplementing the Public Record Consistent With the Court's April 17, 2018 Order. Attached hereto as Exhibit 1 is Blue Cross Blue Shield of Michigan's

Motion and Brief to Exclude the Expert Testimony of Dr. Jeffrey Leitzinger [Dkt. 140] and corresponding exhibits.

This 20th day of April.

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CERTIFICATE OF SERVICE

I hereby certify that on April 20, 2018, I electronically filed the foregoing paper with the Clerk of the Court using the ECF system, which will send notification of such filing to all parties of record. I further certify that I have caused the foregoing document to be sent by email or U.S. Mail to all individuals or entities who filed objections to the previous Settlement Agreement or, for those individuals or entities represented by counsel, their counsel.

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April 20, 2018

Attorney for Defendant

EXHIBIT

1

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

THE SHANE GROUP, INC. et al.	)	
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v.	)	Judge Denise Page Hood
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BLUE CROSS BLUE SHIELD OF MICHIGAN,	)	
	)	
Defendant.	)	

DEFENDANT'S MOTION TO EXCLUDE THE
EXPERT TESTIMONY OF DR. JEFFREY LEITZINGER

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Defendant Blue Cross Blue Shield of Michigan ("BCBSM"), by its undersigned counsel, submits this Motion to Exclude the Expert Testimony of Dr. Jeffrey Leitzinger. BCBSM relies upon the authorities and arguments set forth in the incorporated brief, as well as all attachments.

As required by Local Rule 7.1(a)(2)(A), BCBSM's counsel conferred with attorneys for Plaintiffs entitled to be heard on this Motion. BCBSM explained the nature and legal basis of the motion and requested, but did not obtain, concurrence in the relief sought.

Respectfully submitted,

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February 3, 2014

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

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

DEFENDANT'S BRIEF IN SUPPORT OF MOTION TO EXCLUDE THE EXPERT TESTIMONY OF DR. JEFFREY LEITZINGER

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STATEMENT OF ISSUES PRESENTED

I. Should the opinions of Plaintiffs' proposed expert, Dr. Jeffrey Leitzinger, be excluded under *Daubert* and Federal Rule of Evidence 702 where his opinions are neither the product of reliable principles and methods nor relevant to the issues raised by Plaintiffs' motion for class certification?

BCBSM's Answer: Yes.

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INTRODUCTION

Instead of analyzing the impact of Blue Cross Blue Shield of Michigan's ("BCBSM") most favored nations clauses ("MFNs") at hospitals throughout Michigan, Dr. Jeffrey Leitzinger applies a statistical regression "model" to a very limited number of hospitals, and a very limited number of payor contracts, which were pre-selected for his analysis by Plaintiffs' counsel. Leitzinger claims that his economic model shows that a common methodology can be used to prove injury to the class. But it cannot because, among other things, Leitzinger admits that he never undertook any independent factual analysis of the record, and that his model does not account for the actual rate negotiations between any hospital and BCBSM, or between any hospital and any other payor. Plaintiffs' class expert's opinions are therefore unreliable and irrelevant and should be excluded.

Recognizing what Leitzinger did and, more importantly, what he did not even attempt to do, leads to the inevitable conclusion that Leitzinger's expert opinions must be excluded as unreliable. Leitzinger's methodology is unreliable because it shows similar effects even when applied to hospitals without MFNs, is not based on a valid benchmark, and produces statistically insignificant results. The model's shortcomings aside, Leitzinger blindly attributes any and all differences in rates to the MFNs, ignoring the fact that hospitals uniformly testified that the MFNs had no effect on reimbursement rates. Leitzinger does not take into

account, nor does he test for the effect of, the many other factors that affect reimbursement rates. Such an approach has been appropriately described by one Court of Appeals as "worthless."[1]

Even if the model were reliable, Leitzinger's opinions still must be excluded as irrelevant because they are unconnected to Plaintiffs' theory of antitrust injury. The Complaint alleges that BCBSM entered into contracts that contained MFN clauses as a means to raise rivals' rates in order to enhance BCBSM's market share and power. Leitzinger did not analyze these questions. Rather, he analyzed only whether a few commercial payors' rates were raised at 13 of 144 hospitals. But although he claims the increase in reimbursement rates for these few commercial payors at these few hospitals was attributable to MFNs, his model does nothing to link the claimed increase to BCBSM's allegedly enhanced market share and power, as required by the Supreme Court. *Comcast Corp v. Behrend*, 133 S. Ct. 1426, 1433 (2013) ("[A]t the class certification stage (as at trial), any model supporting a plaintiff's damages cause must be consistent with its liability case, particularly with respect to the alleged anticompetitive effect of the violation.").

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[1] *See Blue Cross and Blue Shield of Wisc. v. Marshfield Clinic*, 152 F.3d 588, 593 (7th Cir. 1998).

STATEMENT OF FACTS

A. Plaintiffs' Theory of Liability.

Plaintiffs allege that BCBSM contracted for MFNs in its hospital contracts in order to raise rival insurance sellers' costs, limit their ability to compete, and enhance BCBSM's market power as a seller of health insurance in Michigan.[2]

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

At the conclusion of discovery, and admitting that "it may not be possible to prove damages at all the MFN hospitals," Plaintiffs removed all but one of their class representatives and now seek to certify a significantly narrower class.[4] Plaintiffs' narrowed class includes only MFN agreements at 13 "affected hospitals" in Michigan and only those who paid these hospitals pursuant to a select

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[2] *See* Leitzinger Report ¶ 77 (App. 1).

[3] Consolidated Amended Complaint [Doc. 78] ("Compl.) ¶ 26 (emphasis added).

[4] *See* Pls. Mot. for Class Certification [Doc. 133] at 5 n.2.

group of "affected provider agreements."[5] The "affected" payors only include three commercial payors: Aetna, Priority and HAP, and Plaintiffs do not even assert that these three payors were impacted at all 13 "affected hospitals." According to Plaintiffs' expert, there are 23 "affected combinations" composed of an "affected hospital" and one of four "affected" payors (HAP, Priority, Aetna or BCBSM).

B. Leitzinger's Report.

Plaintiffs retained Dr. Jeffrey Leitzinger to offer an opinion on Plaintiffs' alleged antitrust impact and damages in relation to class issues. Leitzinger Report ¶ 9 (App. 1). Leitzinger conducted a "difference-in-differences" ("DID") regression analysis for each of the 23 "affected combinations." *Id.* ¶ 51. Leitzinger admitted that he did no analysis to select the "affected combinations," but was simply provided these combinations by Plaintiffs' counsel. Leitzinger Dep. at 22 (App. 2) (testifying that "counsel said, here are the combinations we're going to use for purposes of defining the class").

Leitzinger's DID regression analysis compared the supposed average reimbursement rate each affected payor paid an affected hospital before and after the implementation of the MFN to reimbursement rates at a control group of

[5] *Id.* at 4.

hospitals without MFNs. Leitzinger Report ¶ 51 (App. 1). Leitzinger utilized BCBSM's internal Peer Group system[6] to create his "control" or "benchmark" group. *Id.* ¶ 53. Specifically, Leitzinger's control groups consist of the "affected" payor's agreements for the same product and network at non-MFN hospitals in the same BCBSM-designated Peer Group as the "affected hospital." For example, if an affected combination was comprised of a PG 1 hospital (the affected hospital) and HAP PPO (the affected payor), Leitzinger's proposed control group consists of non-MFN PG 1 hospitals operating under HAP PPO agreements. *Id.* ¶ 53. Leitzinger uses PG 4 hospitals without MFNs as the control group when analyzing PG 5 hospitals (because there are no non-MFN PG 5 hospitals). *Id.* ¶ 54.

According to Leitzinger, the model showed that reimbursement levels for each of the 23 affected combinations were "higher than the level one would have expected based upon the experience of the control group and the other variables included in the model." *Id.* ¶ 57. From this, Leitzinger concluded that "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." *Id.* Leitzinger reached this conclusion without any

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[6] For internal purposes, BCBSM categorizes hospitals as belonging to Peer Groups. The Peer Group 5 hospitals ("PG 5" hospitals) are rural hospitals with 100 or fewer licensed beds. The larger hospitals are designated PG 1-4.

consideration of individual factors that may have contributed to the detected increase in hospital reimbursement rates.[7]

***DAUBERT* STANDARD OF REVIEW**

Where an expert's report is "critical to class certification" the district court must "perform a full *Daubert* analysis before certifying the class." *American Honda Motor Co., Inc. v. Allen*, 600 F.3d 813, 815-16 (7th Cir. 2010). *See also Comcast Corp. v. Behrend*, 133 S. Ct. at 1426, 1432-33 (2013) (lower courts "ran afoul of our precedents" by "refusing to entertain arguments against respondents' damages model that bore on the propriety of class certification"). Federal Rule of Evidence 702 obliges the Court to perform its "gatekeeper" role with regard to proffered expert testimony with "heightened care."[8] An expert's opinion must meet three requirements, including (1) that the expert is qualified; (2) the expert's testimony "must be relevant," meaning that it is helpful in determining a fact in issue; and (3) it must be reliable, meaning that it is the "product of reliable principles and methods." *In re Scrap Metal Antitrust Litig.*, 527 F.3d 517, 528-29

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[7] Leitzinger Dep. at 78-79 ("Q: So your opinion does not include a review, analysis, and conclusion based on the totality of the record evidence at any given affected combination; is that correct? A: Insofar as the totality of the evidence as you're using it in that phrase would include negotiating documents, yes, that's correct, it does not.") (App. 2).

[8] *Surles ex. rel. Johnson v. Greyhound Lines, Inc.*, 474 F.3d 288, 295 (6th Cir. 2007).

(6th Cir. 2008).

Rule 702 requires that expert testimony "rely on 'sufficient facts or data,' *and* be 'the product of reliable principles and methods.'"[9] Although use of regression analysis is a "generally accepted method[]" in antitrust cases, *Conwood Co., L.P. v. U.S. Tobacco Co.*, 290 F.3d 768, 793 (6th Cir. 2002), "when inappropriately used, regression analysis can confuse important issues while having little, if any, probative value."[10]

When the record establishes that a premise or data upon which an expert relies is flawed, the defective opinion is not sufficiently reliable to be admitted. Such a flaw in the foundation of an opinion is not a matter of the weight to be given that opinion, but of its admissibility: "When an expert opinion is not supported by sufficient facts to validate it in the eyes of the law, or when indisputable record facts contradict or otherwise render the opinion unreasonable, it cannot support a [judgment]."[11] If any step in an expert's analysis is determined

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[9] *Walbridge Aldinger Co. v. Aon Risk Servs., Inc. of Penn.*, No. 06-CV-11161-DT, 2007 WL 1219036, at *3 (E.D. Mich. Apr. 25, 2007) (emphasis in original).

[10] Daniel L. Rubinfeld, *Reference Guide on Multiple Regression*, in Reference Manual on Scientific Evidence, Fed. Judicial Cntr., 3d ed. 2011, at 308 (App. 3).

[11] *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 242 (1993); *see also Wallace v. Bank of Bartlett*, 55 F.3d 1166, 1170 (6th Cir. 1995).

to be unreliable, the entire opinion is unreliable and thus inadmissible.[12]

ARGUMENT

I. LEITZINGER'S OPINION IS NOT BASED ON RELIABLE PRINCIPLES AND METHODS.

Leitzinger opines that his DID regression analyses show that putative class members suffered antitrust injury as a result of MFNs. Leitzinger Report ¶ 11 (App. 1). Leitzinger further opines that proof of such injury is susceptible to classwide proof. Id. These opinions are inherently unreliable for four reasons. First, Leitzinger's regression model detects "MFN effects" at hospitals that do not even have MFNs. Second, Leitzinger's control groups do not provide a reliable benchmark for comparing rates at MFN hospitals. Third, Leitzinger's regressions produce statistically insignificant results for several of his hospital payor combinations such that no causal inference can be drawn. Fourth, Leitzinger blindly attributes all price differences with the control group hospitals solely to the MFNs.

A. Leitzinger's Methodology Produces MFN Effects in Hospitals Without MFNs.

When Leitzinger's DID regression methodology is applied to some hospitals *without* MFNs, it shows positive and statistically significant evidence of the same

[12] *In re Scrap Metal Antitrust Litig.*, 527 F.3d at 530.

type of "antitrust injury" he claims exists for the affected combinations where none could possibly exist. "It is not enough to submit a questionable model whose unsubstantiated claims cannot be refuted through *a priori* analysis. Otherwise, 'at the class-certification stage *any* method of measurement is acceptable so long as it can be applied classwide, no matter how arbitrary the measurements may be.'" *In re Rail Freight Fuel Surcharge Antitrust Litig.*, 725 F.3d 244, 254 (D.C. Cir. 2013) (quoting *Comcast,* 133 S. Ct. at 1433).

Here, Leitzinger utilizes a DID regression analysis to show the impact MFNs had on the reimbursement rates at the affected combinations. Leitzinger Report ¶ 57 (App. 1). Leitzinger's analysis allegedly shows that, following the effective date of the MFN, the reimbursement at each affected combination was higher than the control group. *Id.* From this, Leitzinger concludes that "***MFN clauses produced increased rates of reimbursement*** . . . ." *Id.* (emphasis added). If Leitzinger's methodology is truly reliable, then it must be true that the methodology not only shows impact from MFNs at the affected combinations but also that it shows the absence of an impact where there is no MFN at all.[13] But that

[13] Leitzinger's control group is composed of hospitals that were "unaffected by the event," *i.e.*, the reimbursement levels experienced at these hospitals represent reimbursement "levels that would otherwise have prevailed" in the absence of MFNs. Leitzinger Report ¶¶ 51 & 57 (App. 1). Thus, if Leitzinger's own DID analysis measures an impact at the control hospitals, the model is fundamentally

is not the case here.

Professor Sibley, BCBSM's class expert, applied Leitzinger's methodology to the 12 non-MFN hospitals that were used by Leitzinger as the control group for the affected combination of Beaumont Hospital – Royal Oak/HAP HMO. Sibley Report ¶ 123 (App. 4). Using Leitzinger's methodology, Sibley compared the average reimbursement rate under a HAP HMO provider contract at a non-MFN hospital in the control group during the same period as used by Leitzinger to reimbursement rates at the 11 other hospitals without MFNs in the control group. *Id.* Sibley found "several statistically significant 'MFN effects' (both rate increasing and rate reducing)" in these examples. *Id.*

Notably, Leitzinger did not explore the possibility that his methodology could find effects where none existed. Instead, he intentionally limited his analysis to the combinations provided to him by counsel. Leitzinger Dep. at 84 (App. 2). But to validate his methodology, Leitzinger needed to demonstrate that his methodology produces the result he claims, which is injury allegedly caused by the MFNs at the affected combinations. *In re Rail Freight Surcharge Antitrust Litig.*, 725 F.3d at 252-53 (where "the same methodology also detects injury where none exists" that methodology cannot be a "reliable means of proving classwide injury

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flawed because we know in advance that the measured for event – impact of MFNs – is nonexistent at these hospitals.

in fact"). Because he has not done that, his methodology is unreliable.

B. Leitzinger Does Nothing to Validate his Control Group.

Leitzinger's DID regression analysis compares the supposed average reimbursement rate each affected payor paid an affected hospital before and after the implementation of the MFN to reimbursement rates at a control group of hospitals without MFNs. Leitzinger Report ¶ 51 (App. 1). The result of this analysis purportedly shows the impact of MFNs on reimbursement rates on the affected combinations. *Id.* ¶ 57. Thus, the reliability of Leitzinger's analysis is based, in large part, on whether he selected "'sufficiently comparable'" control groups. *See Cason-Merenda v. Detroit Med. Ctr.*, No. 06-15601, 2013 WL 1721651, at *6 (E.D. Mich. Apr. 22, 2013) (*quoting In re Nw. Airlines Corp. Antitrust Litig.*, 197 F. Supp. 2d 908, 922 (E.D. Mich. 2002)). Here, the chosen control groups are woefully insufficient.

For purposes of crafting a control group, Leitzinger employed BCBSM's internal Peer Group system. Leitzinger Report ¶ 53 (App. 1). Thus, for example, if an affected hospital was a PG 1 hospital, Leitzinger's control group consisted of every non-MFN PG 1 hospital that also contracted with the affected payor. Id. at Ex. 7.[14] Leitzinger's selection of a control group was done without any analysis as

[14] For PG 5 hospitals, Leitzinger used non-MFN PG 4 hospitals. This undermines

to whether the hospitals comprising the control group were sufficiently comparable to the affected hospital. Leitzinger Dep. at 180:11-18 (App. 2). Rather, Leitzinger simply assumes that because BCBSM groups these particular hospitals together, ipso facto, he can group them together for purposes of an economic analysis of alleged antitrust injury. By simply assuming that the factors affecting prices among his control group hospitals and the MFN hospitals are the same, Leitzinger thus assumes his conclusion, i.e., that the non-MFN hospitals of the same Peer Group are sufficiently comparable.

Leitzinger fails to recognize, let alone account for, substantial variation among the hospitals. For example, perceived bargaining power differs even among hospitals of the same Peer Group. This perceived bargaining power may translate into more aggressive negotiation tactics and lead to higher reimbursement rates paid by commercial payors. This perceived bargaining power does not follow directly from hospital size.[15] Sparrow Health System was willing to threaten termination in its negotiations with commercial payors because it believed commercial payors have more to lose than the hospital.[16] In contrast, Beaumont, a

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his supposed determination that BCBSM's Peer Group system is a valid methodology for selecting control groups. Sibley Report ¶ 104 (App. 4).

[15] Sibley Report ¶ 44 (App. 4).

[16] *Id.* ¶ 42 (*quoting* Reichle Dep. at 203 (App. 5)).

hospital comparable to Sparrow in terms of size, was unwilling to consider termination of its agreement with BCBSM during negotiations.[17] Leitzinger makes no attempt to account for varying levels of bargaining power between an "affected hospital" and its "control groups."

Hospitals' economic conditions are also unique and individualized. Furthermore, the outcome of individual negotiations between hospitals and providers depend on a variety of other factors, including: whether a hospital belongs to a system of hospitals; whether a hospital owns a competing insurance plan; the hospital's geographic location and proximity to other hospitals; and a hospital's financial condition, strategic goals, a payor's need for access for its members at a particular hospital, and relationship with a specific payor. A hospital's quality, size, reputation, range of special services, and affiliations with universities and physicians also can influence negotiations. See Sibley Report ¶ 82 (collecting testimony on all these issues) (App. 4). Simply put, hospital prices are the product of numerous factors that differ from hospital to hospital and from payor to payor. These factors are not captured in BCBSM's Peer Groups (because they are not intended to be, as BCBSM utilizes Peer Groups for wholly different

[17] *Id.* ¶ 44 (*quoting* Johnson Dep. at 107 (App. 6)). Varying levels of bargaining power is not a factor that is unique to large hospitals. *See id.*

purposes than does Leitzinger). Leitzinger's failure to account for these factors renders his report and proposed testimony entirely useless and unreliable.

Further demonstrating the unreliability of Leitzinger's control groups is the fact that in some cases dropping a single hospital from the control group completely reverses Leitzinger's conclusions. Professor Sibley re-estimated DID regressions for the affected combinations of HAP's PHP plans at Beaumont Hospital – Troy and Beaumont Hospital – Grosse Pointe after dropping a single hospital from the control group (based on the distance from the respective Beaumont hospitals). Sibley Report ¶ 122 (App. 4). Once the single hospital was dropped from the control group, Sibley found that the "magnitude of his alleged 'MFN effects' dropped markedly and, in all cases, the effects were no longer statistically significant, even at the 10 percent level." Id. Sibley concluded that Leitzinger's "results are very sensitive to adding or dropping a single more distant hospital from his control group." Id. The conclusion is entirely logical and identifies another fundamental flaw in Leitzinger's methodology. If the hospitals in the control group were actually subject to similar market forces affecting prices to make them sufficiently comparable to serve as a reliable control group, the results should be the same, not completely different, with one less geographically distant control group hospital in the mix.

C. Leitzinger's Analysis Produces Statistically Insignificant Results.

Rule 702 allows a qualified expert to testify in the form of an opinion or otherwise if the "expert's scientific, technical, or other specialized knowledge will *help* the trier of fact to understand the evidence or to determine a fact in issue." FRE 702 (emphasis added). Some of Leitzinger's DID regressions produce results that are not considered to be statistically significant under widely accepted guidelines. "Statistical significance" is the probability that an effect (here, the increase in reimbursement rates due to MFN clauses) is not likely due to chance alone.[18]

Leitzinger claims that the results of his DID regressions show the impact of MFN clauses on reimbursement rates for each affected combination. Leitzinger Report ¶ 57 (App. 1). Even assuming that Leitzinger's DID regression methodology was suitable for determining the impact MFN clauses had on reimbursement rates, the results from at least two of his DID regressions are incapable of demonstrating impact based on MFN clauses because they are not statistically significant. Under widely accepted guidelines, a result is statistically significant and not likely to have occurred by chance alone if its significance level

[18] David H. Kaye and David A. Friedman, *Reference Guide on Statistics*, in Reference Manual on Scientific Evidence, Fed. Judicial Cntr., 3d ed. 2011, at 249-251 (App. 7).

is greater than 1%, 5% or 10%.[19] Leitzinger's DID regression results supposedly show "MFN effects" for BCBSM's PPO products at Beaumont Hospital – Royal Oak and Beaumont Hospital – Troy.[20] Using Leitzinger's supporting documentation, however, Professor Sibley analyzed these results and determined that the results "are not statistically different from zero at levels of statistical significance commonly applied and generally accepted by the economics community" even if the 10% percent level is applied.[21]

Leitzinger's *chosen* DID regression analysis produces statistically insignificant results for some of the "affected combinations." But, aside from these hospitals, when alternative regression analyses are performed using more appropriate statistical techniques, even more doubt is cast upon Leitzinger's results. For example, by performing an alternative DID regression analysis that aggregates quarterly data into averages within the pre-MFN and post-MFN periods, Professor Sibley concluded that "only five of the twenty-three DID estimates are statistically different from zero, even at the 10 percent level." Sibley

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[19] Daniel L. Rubinfeld, *Reference Guide on Multiple Regression*, in Reference Manual on Scientific Evidence, Fed. Judicial Cntr., 3d ed. 2011, at 320 (App. 3). *See also* Sibley Report ¶ 111 (noting that the level of statistical significance "commonly applied and generally accepted by the economics community is" is 10%, 5% or 1%) (App. 4).

[20] Leitzinger Report Exhibit 9 Column 5 (App. 1).

[21] Sibley Report ¶ 111 (App. 4).

Report ¶ 118 (App. 4). Further, by performing a similar analysis and examining the 2-year period before and after the start of Leitzinger's post-period, "many of the DID effects are smaller in magnitude and . . . most are not statistically different from zero at professionally-accepted levels." *Id.* ¶ 119.

Because these results are not statistically significant at any reasonable level, they are incapable of helping the jury determine whether an MFN at these hospitals affected reimbursement rates. *See Conwood Co., L.P. v. U.S. Tobacco Co.*, 290 F.3d 768, 793 (6th Cir. 2002) ("statistically significant" regression results "ruled out the possibility that the statistical relationship was caused by factors other than [defendant's] conduct"). Indeed, Leitzinger does not even express an opinion as to whether his DID regressions are statistically significant.[22] Therefore, his opinions should be excluded.

D. Leitzinger Attributes Any Increase in Reimbursement Rates Solely to MFNs Without Accounting For Other Factors.

Based on his DID regression methodology, Leitzinger concludes that "MFN clauses produced increased rates of reimbursement" at the affected combinations. Leitzinger Report ¶ 57 (App. 1). The conclusion is devoid of logical reasoning and

[22] Leitzinger Dep. at 137-138 ("Q. Without applying a statistical significance screen or threshold to those results, how can you conclude whether or not any of the results on Exhibit 9 are statistically significant? A. I couldn't. But I'm not giving opinions about whether each of the results in column 5 achieve a certain level of statistical significance.") (App. 2).

amounts to nothing more than an untested hypothesis unsuitable for consideration by a court.

First and foremost, Leitzinger did not do any independent analysis or assessment of the impact of all MFNs at hospitals throughout Michigan, or on all payor contract rates at those hospitals. Instead, Leitzinger applied his DID regression methodology to a very limited number of hospitals, and a very limited number of payor contracts, each of which were identified and selected by class counsel (based on an unknown analysis performed by someone other than Leitzinger) as having been affected by an MFN.[23] As BCBSM's expert explains, there will likely be a few hospitals with MFNs where the reimbursement rate increased for at least one payor by more than the average increase at a group of other hospitals, for reasons that have nothing to do with the MFNs.[24] Implementation of Leitzinger's test is therefore entirely circular as it only serves to confirm an effect at the limited number of combinations for which an effect was

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[23] Leitzinger Dep. at 22 ("Q: How did you determine what the affected combinations were to be for your analysis? A: That was provided to me by counsel. Q: How did that work? A: Well, essentially, as the report was taking shape, counsel said, here are the combinations we're going to use for purposes of defining the class. And in light of the assignment that I was given in the report, that was then – those were then the combinations that I focused on.") (App. 2).

[24] *See* Sibley Report ¶ 107 (App. 4).

already determined by class counsel.[25]

Second, aside from the fact that Leitzinger did no independent analysis or assessment of MFNs, his methodology and conclusions are fundamentally unreliable because they fail to take into consideration individual characteristics of the affected hospitals that may account for any identified increase in reimbursement rates over the period of time analyzed. "Statistical studies that fail to correct for salient factors, not attributable to the defendant's misconduct, that may have caused the harm of which the plaintiff is complaining do not provide a rational basis for a judgment."[26] Here, discovery revealed that hospitals sought increased reimbursement rates from providers for many reasons including, among others, financial needs attributable to the hospital's economic conditions,[27]

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[25] Indeed, as Professor Sibley shows, Leitzinger's analysis would, in many instances, get causation entirely backward. Sibley Report ¶ 144 (App. 4).

[26] *See Blue Cross and Blue Shield of Wisc. V. Marshfield Clinic,* 152 F.3d 588, 593 (7th Cir. 1998) (expert's "attribut[ion of] the entire difference between the prices of the Marshfield Clinic and the prices of other Wisconsin providers of medical services" to defendant's alleged conduct with "no correction for any other factor" is "worthless").

[27] *See, e.g.*, ARMC00068-0068.001 (App. 8) (Alpena finances so bad it only had ten days cash on hand); Felbinger (Ascension) Dep. at 214-17 (App. 9); Matzick (Beaumont) Dep. at 58-61 (App. 10); Marcellino (Botsford) Dep. at 150 (App. 11); Gronda (Covenant) Dep. at 138, 153-54 (App. 12) & BC Ex. 1301 (App. 13) (citing government shortfalls and financial troubles brought on by the recession); BLUECROSSMI-E-0043304 (App. 14) & BLUECROSSMI-08-021004 (App. 15) (citing Dickinson financial difficulties); Worden (Marquette) Dep. at 152-53 (App.

reductions in reimbursement levels from government programs,[28] or changes to a provider's volume of business.[29] Notwithstanding, Leitzinger admitted that his analysis did not "account for hospitals' desire to attain higher reimbursement." Leitzinger Dep. at 167 (App. 2). This is especially problematic given the undisputed testimony from many hospitals that MFNs did not affect the reimbursement rates of other providers.[30]

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16); BLUECROSSMI-08-010215 (App. 17) (hospital financially distressed and about to default on bond covenants); Susterich (Metro Health) Dep. at 48-53 (App. 18); BLUECROSSMI-99-02238941 (App. 19) (hospital in "serious financial trouble"); Gov't Ex. 19 (Rodgers) (App. 20) (MidMichigan seeking to carry out new construction); Leach (Munson) Dep. at 183 (App. 21); BLUECROSSMI-10-008253 (App. 22) (citing Sparrow financial difficulties).

[28] *See, e.g.*, Fifer (Spectrum Health) Dep. at 187-92 (App. 23) (stating that Spectrum Health's Medicare and Medicaid shortfalls totaled $80 million in 2012); Nelson (Memorial Medical Center) Dep. at 43 (App. 24) (stating that Medicare and Medicaid shortfalls "actually reduces our operating income"); Longbrake (Huron Medical Center) Dep. at 48-50 (App. 25) (stating that Medicare reimburses the hospital "[a]bout 48 cents on the dollar" and Medicaid reimburses the hospital "between 20 and 30 cents on the dollar"); Susterich (Metro Health Hospital) Dep. at 26-27 (App. 18) (stating that government reimbursement shortfalls is "a burden that we have to bear").

[29] Gross Dep. at 39:4-16 (App. 33).

[30] *See, e.g.*, Hughes Dep. at 304 (Bronson Lakeview executive testified that she did not believe that renegotiation of the Aetna/PPOM contract was initiated because of the MFN or that the MFN clause affected the contractual rate of reimbursement) (App. 26); Andrews Dep. at 269:5-14 (testifying that Three Rivers Hospital would have sought increases from other commercial payors separate and apart from the MFN because of the hospital's financial condition) (App. 27); Vitale Dep. at 65:21-66:1 (App. 28) and Matzick Dep. at 141:11-21 (testifying that Beaumont never adjusted a commercial payor's reimbursement rate to comply with the MFN)

Third, and similarly, Leitzinger fails to take into consideration that, at certain of his affected hospitals, the calculated average reimbursement rate after the MFNs was significantly more than the MFN required.[31] Leitzinger's DID regressions show that rates were anywhere from 2 to 26 percentage points higher than required by an MFN at several hospitals.[32] Because these rates were above and beyond what the MFN required, there must be some other factor that caused the increase. Consider, for example, if an MFN required a hospital to provide an 80% reimbursement rate to a payor, but the hospital negotiated for an 85% reimbursement rate with that payor. The additional 5% over and above the MFN requirement cannot be causally attributed to the MFN, yet that is what Leitzinger does. For the foregoing reasons, Leitzinger's opinions are unreliable and should be

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(App. 10); McGuire Dep. at 186:21-187:14 (testifying that no commercial payor at Ascension Hospitals paid a higher reimbursement rate because of an MFN) (App. 29); Harning Dep. at 176:11-178:8, 230:11-231:10 (testifying that Allegan General Hospital would have sought reimbursement rate increases from commercial payors who had rates below BCBSM's rate regardless of the MFN) (App. 30); Jackson Dep. at 193:10-24 (testifying that Charlevoix Area Hospital would have sought increases from other commercial payors separate and apart from any MFN) (App. 31); Leach Dep. at 63:3-23 (testifying that reimbursement rate increases from Priority Health at Paul Oliver and Kalkaska were sought prior to MFNs being in place) (App. 21); Roeser Dep. at 51:7-52:6 (testifying that Sparrow Ionia's decision to raise Priority Health's reimbursement rate was not related to BCBSM's contract) (App. 32).

[31] Sibley Report ¶ 99 (App. 4).

[32] *Id.*

excluded. *The Iams Co. v. Nutro Products, Inc.*, No. 3:00-CV-566, 2004 WL 5496244, at *2-*5 (S.D. Ohio June 30, 2004) (recognizing that regression "as a technique . . . meets the *Daubert* standards" but nevertheless granting motion to exclude expert's "fatally flawed" regression analysis because it failed to test for "a number of very significant or likely to be significant" factors influencing sales).

II. LEITZINGER'S OPINION IS NOT RELEVANT BECAUSE HIS MODEL OF IMPACT IS DIVORCED FROM PLAINTIFFS' THEORY OF LIABILITY.

Leitzinger's opinion also should be excluded because it is not relevant to the Rule 23 inquiry as to whether the class can show common antitrust impact causally connected to the alleged theory of liability. Thus, Leitzinger's opinion also fails *Daubert's* second prong. It is insufficient to submit a model that shows some impact, even if common to the class, if that impact is unconnected to the alleged theory of liability, which is precisely what Leitzinger has done here.

It is axiomatic that "at the class-certification stage (as at trial), any model supporting a plaintiff's damages case must be consistent with its liability case, particularly with respect to the alleged anticompetitive effect of the violation." *Comcast Corp.*, 133 S.Ct. at 1433 (omitting internal quotation and citation); *see also Jacob v. Duane Reade, Inc.*, 293 F.R.D. 578, 592 (S.D.N.Y. 2013) ("*Comcast* demands that a class's theory of liability track its theory of damages or injury."). As Leitzinger acknowledges, Plaintiffs' theory of liability is that "BCBSM

contracted for MFNs in its hospital contracts as a means for raising 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." Leitzinger Report ¶ 77 (emphasis added) (App. 1).

Despite this acknowledgement, Leitzinger's model is patently inconsistent with Plaintiffs' theory of liability. First, Leitzinger only superficially analyzes whether rivals' rates were raised because of MFNs. Plaintiffs' Complaint alleged BCBSM entered into contracts containing MFN clauses with at least 70 Michigan hospitals. But, instead of analyzing the effect of MFNs at all 70 hospitals on the rates of all other rivals, Leitzinger only analyzed whether 13 hospitals charged higher rates to just three rivals. And he concludes that at 11 of those hospitals the rates of only a single BCBSM rival was increased.[33] At two others (Providence Park and St. John), Leitzinger completely ignores the "raising rivals rates" theory, claiming that his DID analysis shows only that BCBSM's rates were higher, but that no rivals' rates were affected. Thus, Leitzinger's model does not support

[33] According to Leitzinger's Table 1 (App. 1), at Bronson Lake View Hospital and Three Rivers Health only Aetna's rates were higher (the only two hospitals where Aetna's rates were increased). Similarly at the three Beaumont hospitals only rates for HAP (and BCBSM) were higher, while at six other hospitals (Allegan, Charlevoix, Kalkaska, Mercy Health Partners Lakeshore, Paul Oliver and Sparrow Ionia) only rates for Priority were higher.

Plaintiffs' liability theory that rivals' rates were higher because of an MFN.

Second, Leitzinger's model does not account for how Plaintiffs were damaged by reason of any enhancement in BCBSM's market power, or harm to competition.[34] Leitzinger admitted this at his deposition:

> Q: Does the regression that you've performed in this case, any of the 23, tell you anything about whether Blue Cross increased its market power in the market for commercial insurance?
>
> A. No.[35]

The disconnect between Leitzinger's model and the theory of liability can be demonstrated by a simple example. Plaintiffs allege that BCBSM agreed to pay higher rates to various hospitals in exchange for MFNs, but that BCBSM nevertheless benefitted because the MFNs raised the rates paid by its rivals "even more." Compl. ¶ 4. Leitzinger's DID analysis is incapable of demonstrating

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[34] Leitzinger even conceded that his model would show harm if the only MFN effect statewide was a small increase in just one payor's rate at just one hospital – a situation where there could be no harm to competition. Leitzinger Dep. at 44-45.

[35] Leitzinger Dep. at 45 (App. 2). *See also id.* at 56 ("Q: You mentioned earlier one of the anticompetitive effects is the potential change in relative position of competitors. I want to know if you've done any analysis of that. A: I haven't done any analysis of how that changed following the institution of the MFN scheme, no. Q: So did you do any analysis as to the relative change in position if any between Priority and Blue Cross in the state of Michigan? A: No. Q: Have you done any analysis if any as to the relative change in competitive position between Blue Cross and Aetna in the state of Michigan? A: No. Q: Have you done any analysis as to the effect if any on the change in relative position between HAP and Blue Cross in Michigan? A: No.").

whether that is true for most of his 23 affected combinations. That is because the DID analysis looks at, for example, Priority's rate at Charlevoix Area Hospital as compared to Priority's rate at a control group of non-MFN hospitals to determine whether the MFN at Charlevoix raised Priority's prices. Leitzinger's regression does not even consider whether Priority's rates at Charlevoix increased relative to BCBSM's rates at Charlevoix. Thus Leitzinger's analysis cannot show whether Priority was worse off (because its rates increased "even more" than BCBSM's rates) or whether it was better off (for example if the rate gap between BCBSM and Priority narrowed because Priority's rates increased but by less than the amount of BCBSM's increase).

Because Leitzinger's model does not measure the impact on class members resulting from the class's theory of anticompetitive effects, the model cannot assist the Court in making the necessary determination that the class can prove, with common evidence, that all or virtually all members of the class suffered the alleged antitrust injury. See *Comcast*, 133 S. Ct. at 1435 (expert's model must be capable of "bridg[ing] the differences between supra-competitive prices in general and supra-competitive prices attributable to" the particular theory of anticompetitive injury sought to be proved by the class). Because it cannot assist the Court in making this determination, Leitzinger's opinion is not relevant and should be excluded.

CONCLUSION

For the foregoing reasons, BCBSM respectfully requests that the Court exclude the report and testimony of Dr. Jeffrey Leitzinger.

Respectfully submitted,

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February 3, 2014

CERTIFICATE OF SERVICE

I hereby certify that on February 3, 2014, I caused the foregoing **DEFENDANT'S MOTION TO EXCLUDE THE EXPERT TESTIMNONY OF DR. JEFFREY LEITZINGER** be served via electronic mail upon:

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

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

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DEFENDANT'S MOTION TO EXCLUDE THE
EXPERT TESTIMONY OF DR. JEFFREY LEITZINGER

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APPENDIX 1

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). *See also* Deposition of Don Whitford, November 21, 2012 ("Whitford Deposition") at 125:1-7 ("Clients who want to assume more of the risk of their health insurance are willing to go to a self-funded approach, because, basically, we're paying the claims, and they're paying us for the administrative fee, and they're assuming the risk of their claims expense, and the larger the client, the more the risk tolerance increases.")

[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**

28. Priority Health ("Priority") is the second largest health plan in Michigan. Founded in 1986, Priority is a Michigan-based nonprofit company which is owned mostly by Spectrum Health and Munson Healthcare, two healthcare provider systems.[46] Priority predominantly sells fully-funded HMO health benefit plans to Michigan-based employers in 65 Michigan Counties in the Lower Peninsula.[47] Priority also sells fully- and share-funded[48] PPO, EPO, and POS plans, self-funded PPO, EPO, and POS plans, and Individual plans. Priority offers administrative services contracts for self-insured organizations ("ASCs") which use its provider network. Only 5 percent of Priority Health's member employers are self-insured, but they represent about 25 percent of all employees (subscribers) covered by Priority.[49]

29. Priority earned $1.6 billion in premiums from fully-insured plans in 2011,[50] with 99 percent of premiums earned from commercial group plans and the remaining $19 million from individuals.[51] In 2012, Priority represented 7% of commercial health coverage in Michigan, with 12 percent of fully insured and 2 percent of self-insured. Priority covered 20 percent of the HMO market and 2 percent of the PPO market.

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https://www.yourlifesecure.com/.

[46] Spectrum Health is a 95 percent shareholder. State of Michigan Office of Financial and Insurance Regulation ("OFIR"), *Priority Health Annual Statement for 2011*, Statement of Revenue and Expenses ("Priority Health 2011 Annual Statement") at 25.

[47] See, Priority Health Michigan service area, at PriorityHealth.com, available at http://www.priorityhealth.com/about-us/profile/service-area, and http://www.priorityhealth.com/about-us/profile/~/media/Images/05_240w_content/Pages/05-priority-health-service-area-map.jpg.

[48] Share funding is a type of self-insured policy where an employer pays a premium to a health insurance payor, but retains any unspent claim funds. http://www.asrhealthbenefits.com/content/public/default.aspx?id=509

[49] Crofoot Deposition at 51:1-13. About six percent of Priority's members were covered by self-insured plans in 2009 and about 12 percent in 2012.

[50] Excludes government-sponsored plans and workers compensation.

[51] 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.

From 2003-2011, Priority's share of lives covered in the fully insured market ranged from 10 to 16 percent (Exhibit 4).

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. *See also* Deposition of Joseph Fifer, August 23, 2012 at 103:16-23. ("Q. And are they desired in rural communities because people don't like to travel far for primarily and secondary

> 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:

- "[A] network is a key factor in determining the health insurance coverage [employers] select […] in all market segments." [72]
- "[N]etwork is a key component that clients evaluate when they purchase health insurance."[73]
- "[T]he depth or the breadth of [a] network, the largeness of it, gives [the insurer] greater opportunity to sell business and retain business."[74]
- In an internal 2011 strategy document, Priority Health noted, "Research indicates Priority Health's network limitations vs. our

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services? […] A. If they can get those services provided close to home, sure. And there's a high demand for those services. (In response to Fifer's description of the types of primary and secondary healthcare services available at his hospital, Spectrum Health Reed City). *See also* Whitford Deposition at 117:1-8 ("It's really where the employer's located. So the employer -- if the hospitals close to them are in the network, it helps you sell in that particular market, because a lot of times the employer's employees live in closer proximity. Now, there's a wide distribution of them, but a lot of it is around the strength of your overall network and how strong your network is across the entire state of Michigan.")

[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.").

[72] Whitford Deposition at 86:6-11.

[73] Whitford Deposition at 118:7-10.

[74] Whitford Deposition at 119:23-120:1.

competitors, limit our ability to sell to a significant segment of the SE market […] Estimates indicate 1.3M of the 2.7M lives in SE Michigan are not accessible to Priority Health due to the network gap.[75]

- The absence of certain SE hospital systems "is a competitive disadvantage for [Priority Health] in the SE market and with statewide employer groups."[76]
- Adding the three SE hospital systems would lead to "Opening the market of commercial members currently closed to [Priority Health] due to employer preferences. "[77]
- "[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

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[75] Whitford Deposition, Exhibit 1587 at PH-DOJ-0005193.

[76] Whitford Deposition, Exhibit 1587 at PH-DOJ-0005202.

[77] Whitford Deposition, Exhibit 1587 at PH-DOJ-0005204.

[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. In some instances, MFN provisions kept hospitals entirely out of the networks offered by other insurers.[86] 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,

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[85] *See* Health Terms.

[86] *See* Horn Deposition at 63, 71 (Priority CEO testified that hospitals told Priority "that they had an MFN clause with Blue Cross which … restricted them in their ability to negotiate or offer rates … that put parameters around what they could do with other payors" and Priority doesn't have a contract with one hospital because "the payment rates required under that would not be – we couldn't offer coverage" due to the MFN); Andreshak Dep. 160:12–161:4 (10/29/12) (Aetna would not even approach PG5 hospitals to negotiate better discounts due to effects of MFN).

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] As stated in the Second Amended PHA, the reimbursement rates provided therein "…will only be allowed if the hospital is in compliance with the Most Favored Discount provision of this Section."[92] 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.

[92] AGH 04 - 00049 at AGH 04 -000071.

[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).

2. *Priority Health reimbursement at Allegan General Hospital under its HMO network*

49. BCBSM had an MFN clause in its contract with Allegan General Hospital that was effective on January 1, 2010.[109] As I understand that clause, Allegan General Hospital was required to negotiate a reimbursement rate from Priority that was greater than or equal to its reimbursement rate from BCBSM. During the period following the implementation of the MFN, BCBSM's reimbursement rate at the hospital averaged 70 percent. In the years leading up to that new contract, Priority's reimbursement rate to Allegan General Hospital under its HMO network ranged from 51 percent -56 percent, averaging 53 percent. On January 1, 2009, Priority entered into a new contract with the hospital.[110] In the years following the effective

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[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.

[109] AGH04-000049.

[110] PH-DOJ-0001440. In some cases, the contract (or amendment) for the non-BCBSM insurers is dated

date of Priority's contract, its reimbursement rate at the hospital averaged 77 percent. (Exhibit 6).

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. For example, I understand that Priority Health PPO and HMO agreements were signed with Allegan General Hospital after the BCBSM Second Amended PHA (or its related LOU) was signed but before July 1, 2009 when compliance with the MFN was mandated. This is true also for a Priority Health PPO agreement with Charlevoix Area Hospital; Priority Health PPO and HMO agreements with Mercy Health Partners, Lakeshore Campus; and a Priority Health HMO agreement with Sparrow Ionia Hospital.

[111] PH-DOJ-0001440.

[112] AETNA-00072525.

[113] For a discussion of DID regression analysis, S*ee*, James H. Stock and Mark W. Watson, *Introduction to Econometrics* at p. 480-483. For examples of DID used by economists, S*ee*, 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, Micropolitian 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.

2. ***Priority Health***

66. In the case of Priority Health, all of its contracts during the Class period in question at the Affected MFN Hospitals provided for reimbursement as to each claim based upon fixed percentages of the billable charge ("percentage-of-charge reimbursement").[132] In other words, this is a discount off of the billed charge listed in the charge master. For example, suppose an appendectomy is listed on the charge master with a cost of $10,000 and the reimbursement rate contracted between the insurer and the hospital is 85 percent. The amount due to be reimbursed for this claim is $10,000*0.85 percent = $8,500.

67. Hence, if that rate was inflated in the aggregate (i.e., at the overall contracted rate), it was also inflated as to every charge. Accordingly, the DID regression results (showing that overall Priority reimbursement rates at each Affected MFN Hospital were inflated), taken in combination with the structure of reimbursement under

[132] See PH-DOJ-0001440, PH-DOJ-0001443, PH-DOJ-0001650, PH-DOJ-0001902, PH-DOJ-0003526, PH-DOJ-0002047, PH-DOJ-0002204, PH-DOJ-0002207, SHS001191.

Priority's contracts, leads to the conclusion that all (or virtually all) Class members were impacted.

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

[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] Mr. Whitford of Priority Health testified similarly.[169] 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.

[169] Whitford Deposition at 125:12-19. ("Q. Are there -- is there some, you know, group of customers that tends to consider both the self-funded and the fully-insured option? A. Yes. Usually that happens in up to, it could be a hundred to 300, they'll evaluate both and make a decision as to what's the best for their given situation. And even in the 100 to 300, there's a large percentage that has self-funding.")

[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. For its part Priority's service area covers 44 counties, almost all of the lower peninsula.[177] 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

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[177] See Koziara Deposition, Exhibit 1564.

[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] BCBSM's share of fully-insured commercial health membership in the State far exceeds that of its largest rivals. Between 2005 and 2011, Priority Health and HAP averaged 13 percent and 11 percent respectively[182] (Exhibit 4). 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.

[182] In terms of member months.

[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).

Priority Health the second largest insurance company in Michigan and gave it access to Detroit.

> Priority long had eyed venturing into the Detroit market, but President and CEO Kim Horn said that would not have occurred for a long time without the acquisition of a company already established in that region. [188]

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. Even as the second largest payor in Michigan, Priority Health has not been able to expand its reach into the Upper Peninsula. Apparently, BCBSM's MFN clause with Marquette impeded Priority's ability to negotiate a competitive contract.[190]

> In the instance of Marquette, we were in negotiations, and during those negotiations, where we thought at one point we were close to having an agreement on terms, Marquette came back and said, "Oops, we didn't take into consideration our Blue Cross contract, and we need more than what we had thought we needed beforehand.""[191]

Priority Health was told that, because of its BCBSM MFN agreement, Priority would have to pay at least 18 percent more for Marquette.[192]

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[188] See C. Beeke, "Deals of the Year: Care Choices acquires Priority Health, " available at http://blog.mlive.com/wmbr/2007/10/carechoices_acquisition_makes.html (last visited October 2013) .

[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.

[190] *See, e.g.,* Crofoot Deposition, Exhibit 1069. ("When we ran into the MFD issue with Marquette Hospital in the middle of 2010, we stopped our efforts.").

[191] Koziara Deposition at 223:2-8.

[192] "Priority Health initiated a network expansion in the Upper Peninsula of Michigan [in 2009], which has extremely limited health care choices. Our discussion with a consortium of hospitals was lengthy and complex, eventually breaking down when we were advised we would have to pay at least 18 percent more for

110. When asked what Priority would need in order to expand in the UP, it's CFO testified:

> It requires provider agreements at competitive rates. […] To provide access to care across the UP, you would need all the hospitals, but without Marquette General, you would -- if you had all the other hospitals, you still wouldn't have a viable network, because of their major services that they provide.[193]

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.

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the primary quaternary facility in the UP" (BLUECROSSMI-99-04862772 at BLUECROSSMI-99-04862778). (Note: quaternary is used sometimes as an extension of the term tertiary.)

[193] Koziara at 219:4-24.

[194] Reed Abelson, *Antitrust Suit in Michigan Tests Health Law*, N.Y TIMES, Dec. 20 2010 at 3.

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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.

REGULATORY SUBMISSIONS (cont'd.)

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
1053365924
1083666812
1205078920
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1497706964
1538195409
1568739423
1578501367
1639186521
1750694790

PH-DOJ prefix

0001423
0001440
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0001447
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

Publicly Available Materials

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.
Bell, Jacqueline, "Blue Cross Michigan Calls DOJ Antitrust Suit Flawed, Law 360, www.law360.com, December 17, 2010.
Borenstein, Severin, Airline Mergers, Airport Dominance, and Market Power, The American Economic Review, May 1990.
Burns, James M., "Most Favored Nation Clauses and Health Insurers," Law 360, www.law360.com, April 23, 2010.
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
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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.
Edlin, Aaron S., Rubinfeld, Daniel L., Exclusion or Efficient Pricing? The "Big Deal" Bundling of Academic Journals, 2004.
Gaynor, Martin, Haas-Wilson, Deborah, "Change, Consolidation, and Competition in Health Care Markets," Journal of Economic Perspectives, Winter 1999.
Glazer, Kenneth and Larose, Catherine "No Longer Waiting: The Antitrust Division Comes to Life with the Amex and Blue Cross Cases," Antitrust, Spring 2011.
Graybeal, John, "Most Favored Nations Clauses: Has a Tortured Past Produced a Settled Future?" www.antitrustandtraderegulationlaw.ncbar.org, August 22, 2011.
Ho, Katherine, The Welfore Effects of Restricted Hospital Choice in the US Medical Care Market, Journal of Applied Econometrics, 2006.
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.
Kongstvedt, Peter R., Wagner, Eric R., Types of Health insurers, Managed Health Care Organizations, and Integrated Health Care Delivery Systems, Essentials of Managed Health Care, Sixth Edition.
Kongstvedt, Peter R., Managed Care What It Is and How It Works, Third Edition, 2009.
Krattenmaker, Thomas G., Salop, Steven, "Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price, December 1986
Larner, Robert, Nelson, Caterina, Market Definition in Cases Involving Branded and Generic Pharmaceuticals, Economics Committee Newsletter Fall 2007.
Martin, Joseph A., "Antitrust Analysis of "Most Favored Nation" Clauses in Health Care Contracts," Private Antitrust Litigation News, Fall 2000.
Michigan Office of Financial and Insurance Regulation, Health Entities […] Forms & Instructions for Required Filings in Michigan, 2012.
Michigan Office of Financial and Insurance Regulation, Michigan Health Insurance Enrollment, Premiums & Losses Form, 2010.
Morrisey, Michael A. "Health Insurance" AUPHA Press, Health Administration Press, Chicago, 2008.
Nieberding, James F. and Cantor, Robin A., "Price Dispersion and Class Certification in Antitrust Cases: An Economic Analysis, September 2007, www.SSRN.com.
Milyo, Jeffrey, Waldfogel, Joel, The Effect of Price Advertising on Prices: Evidence in the Wake of 44 Liquormart, The American Economic Review December 1999.
Morrisey, Michael A. "Health Insurance" AUPHA Press, Health Administration Press, Chicago, 2008.
Reinhardt, Uwe E., The Pricing of U.S. Hospital Services: Chaos Behind A Veil of Secrecy, Health Affairs, May 7, 2012, www.healthaffairs.org.
Ringel, Jeanne S., et al., "The Elasticity of Demand for Health Care A Review of the Literature and It's Application to the Military Health Systems," RAND Health.
Rubenstein, Abigail, "Blue Cross Michigan Can't Dodge DOJ Antitrust Suit," Law 360, www.law360.com, June 07, 2011.
Salop, Steven C., Scheffman, David T. Recent Advances in the Theory of Industrial Structure, Rising Rivals Costs, The American Economic Review May 1983.
Schmalensee, Richard, Inter-Industry Studies or Structure and Performance, Studies of Structure and Performance.
Starc, Amanda, Insurer Pricing and Consumer Welfare: Evidence from Medigap, November 9, 2010.
Stenger, Susan E., Most Favored Nation Clauses and Monopsonistic Power: An Unhealthy Mix? American Journal of Law & Medicine, 1989.
Stock, James H., Watson Mark W., Introduction to Econometrics, Second Edition, 2007.
The Great Seat of Ohio Department of Justice, "House Bill 125 Joint Legislative Commission on Most Favored Nation Clauses in Health Care Contractors Reports," March 2010.
The Kaiser Family Foundation and Health Research & Educational Trust, 2010 Annual Survey, Antitrust Health Care Handbook.
Wright, Beth Ann, How MFN Clauses Used in the Health Care Industry Unreasonably Restrain Trade Under the Sherman Act, Journal of Law and Health, 2003-2004.

2012 LARA, Workers Compensation Agency, Health Care Services Manual revised 2013.
Department of Insurance and Financial Services, Self-Funded Health Care Plans, www.michigan.gov.
DIFS - Blue Cross Blue Shield of Michigan (BCBSM), www.michigan.gov.
Employer Health Benefits, Annual Survey, 2010.
Glossary of Health Care Terms, Michigan Health & Hospital Association, www.mha.org.
Health Care Costs a Primer, Key Information on Health Care Costs and Their Impact, May 2012.
Health Quarterly Statement, Blue Cross Blue Shield of Michigan as of March 31. 2011.
Justice Department Files Motion to Dismiss Antitrust Lawsuit Against BSBCM After Michigan Passes Law to Prohibit Health Insurers from Using Most Favored Nation Clauses in Provider Contracts, March 25, 2013.
Medicare Hospital Prospective Payment System How DRG Rates Are Calculated and Updated, August 2001
Michigan Office of Financial and Insurance Regulation, Health Entities […] Forms & Instructions for Required Filings in Michigan, 2012.
Michigan Office of Financial and Insurance Regulation, Michigan Health Insurance Enrollment, Premiums & Losses Form, 2010.
Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas, Executive Office of the President Office of Management and Budget, February 28, 2013.
Role of Blue Cross in Michigan's Health Insurance Market, Commissioned by: Anderson Economic Group, November 28, 2007.
State Statistics - 2011 Michigan Outcomes for All Discharges, http://hcupnet.ahrq.gov
The Blue Cross and Blue Shield Association Supporting the 37 Independent, Locally Operated Blue Cross and Blue Shield Companies BCBS, www.bcbs.com
Why Define Markets, Antitrust Law Journal, 2007.

Financial Statements
Aetna Annual Report, Financial Report to Shareholder 2012.
Aetna 10-K, Year End December 31, 2012.
Annual Statement Blue Cross Blue Shield of Michigan, Year End December 21, 2011.

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

Related Cases
Foundation for Interior Design Education Research v. Savannah College of Art & Design, No. 99-2122.
Messner v. Northshore Univ. HealthSystem, 669 F.3d 802, 815-16 (7th Cir. 2012)
United States v. E.I. DuPont de Nemours & Co., 351 U.S. 377, 404 76 Supreme Court Reporter. June 11, 1956.
Little Rock Cardiology Clinic PA, et al., Plaintiffs-Appellants, v. Baptist Health; Baptist Medical System HMO, Inc., Defendants-Appellees, Arkansas Blue Cross and Blue Shield; USAble Corporation; HMO Partners, Inc., Defendants. Nos. 08-3158, 09-1786. December 29, 2009.
White & White, Inc. v. Am. Hosp. Supply Corp., 723 F.2d 495, 500 (6th Cir. 1983)
Worldwide basketball & Sport Tours, Inc. v. Nat'l Collegiate Athletic Ass'n, 388 F.3d 955, 961, 6th Cir., 2004.

Press Releases
Aetna To Acquire HMS Healthcare, June, 24 2005, www.aetna.com.
Health Alliances Plan Announces CuraNet Acquisition and Geographic Expansion, CuraNet, August 15, 2006, www.curanet.org.

Websites
http://investing.businessweek.com
https://npiregistry.cms.hhs.gov
https://nppes.cms.hhs.gov
http://welcometounitedhealthcareonline.com
http://zipcodedownload.com
www.4everlife.com
www.aetna.com.
www.anthem.com
www.asrhealthbenefits.com.
www.beaumont.edu
www.borgess.com
www.bcbs.com
www.bcbsm.com
www.bronsonhealth.com
www.census.gov
www.cms.gov
www.covenanthealthcare.com
www.data.bls.gov.
www.guidestar.org
www.goldenrule.com
www.hap.org
www.hcsc.com
www.michigan-health-insurance.org
www.myallsavers.com
www.northstarhs.org
www.pacificlife.com
www.priorityhealth.com
www.stjohnprovidence.org

Exhibit 3: Michigan Acute Care Hospitals, 2011

	Hospital	System	Peer Group	MFN Type	City	City Population	Core Based Statistical Area (CBSA)[1]	CBSA Population	Beds[2]	Admissions[3]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1	Allegan General Hospital	QHR	5	Equal-to-MFN	Allegan	4,990	Holland, MI	111,591	25	879
2	Allegiance Health		2	Equal-to-MFN	Jackson	33,425	Jackson, MI	159,810	305	20,280
3	Alpena Regional Medical Center		3	MFN Plus	Alpena	10,410	Alpena, MI	29,352	125	4,902
4	Aspirus Grand View Hospital[4]		5	Equal-to-MFN	Ironwood	5,335				992
5	Aspirus Keweenaw Hospital	Aspirus, Inc.	5	Equal-to-MFN	Laurium	1,977	Houghton, MI	38,943	25	1,097
6	Aspirus Ontonagon Hospital	Aspirus, Inc.	5	Equal-to-MFN	Ontonagon	1,455			18	631
7	Baraga County Memorial Hospital		5	Equal-to-MFN	L'anse	1,998			15	558
8	Beaumont Hospital - Grosse Pointe	Beaumont Health System	2	MFN Plus	Grosse Pointe	5,365	Detroit-Warren-Dearborn, MI	4,287,966	250	10,301
9	Beaumont Hospital - Royal Oak	Beaumont Health System	1	MFN Plus	Royal Oak	57,607	Detroit-Warren-Dearborn, MI	4,287,966	1,070	55,689
10	Beaumont Hospital - Troy	Beaumont Health System	2	MFN Plus	Troy	81,508	Detroit-Warren-Dearborn, MI	4,287,966	394	28,966
11	Bell Hospital		5	Equal-to-MFN	Ishpeming	6,531	Marquette, MI	67,563	25	1,396
12	Borgess Medical Center	Ascension Health	1	MFN Plus	Kalamazoo	74,743	Kalamazoo-Portage, MI	328,353	387	19,607
13	Borgess-Lee Memorial Hospital	Ascension Health	5	Equal-to-MFN	Dowagiac	5,843	South Bend-Mishawaka, IN-MI	319,235	25	830
14	Botsford Hospital		1	MFN Plus	Farmington Hills	80,258	Detroit-Warren-Dearborn, MI	4,287,966	306	16,364
15	Bronson Battle Creek	Bronson Healthcare Group, Inc.	2		Battle Creek	52,093	Battle Creek, MI	135,529	218	10,361
16	Bronson LakeView Hospital	Bronson Healthcare Group, Inc.	5	Equal-to-MFN	Paw Paw	3,529	Kalamazoo-Portage, MI	328,353	35	1,007
17	Bronson Methodist Hospital	Bronson Healthcare Group, Inc.	1		Kalamazoo	74,743	Kalamazoo-Portage, MI	328,353	368	22,681
18	Caro Community Hospital		5	Equal-to-MFN	Caro	4,208			25	183
19	Carson City Hospital		4		Carson City	1,089	Grand Rapids-Wyoming, MI	996,454	62	1,874
20	Charlevoix Area Hospital		5	Equal-to-MFN	Charlevoix	2,518			25	1,018
21	Cheboygan Memorial Hospital[5]		4	Equal-to-MFN	Cheboygan	4,826			91	2,302
22	Chelsea Community Hospital	Trinity Health	4		Chelsea	4,991	Ann Arbor, MI	348,637	102	3,835
23	County		4	Equal-to-MFN	Coldwater	10,931	Coldwater, MI	43,902	96	3,508
24	Covenant Medical Center		1	MFN Plus	Saginaw	51,230	Saginaw, MI	198,990	533	27,634
25	Crittenton Hospital Medical Center		3		Rochester	12,793	Detroit-Warren-Dearborn, MI	4,287,966	254	12,921
26	Deckerville Community Hospital		5	Equal-to-MFN	Deckerville	820			15	198
27	Health Center	Vanguard Health System	1		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	268	12,977
28	Dickinson County Healthcare System		4	MFN Plus	Iron Mountain	7,630	Iron Mountain, MI-WI	30,596	96	3,397
29	Doctors' Hospital of Michigan		1		Pontiac	59,887	Detroit-Warren-Dearborn, MI	4,287,966	77	2,812
30	Eaton Rapids Medical Center		5	Equal-to-MFN	Eaton Rapids	5,229	Lansing-East Lansing, MI	465,614	20	368
31	Forest Health Medical Center		3		Ypsilanti	19,596	Ann Arbor, MI	348,637	24	1,463
32	Garden City Hospital		1		Garden City	27,408	Detroit-Warren-Dearborn, MI	4,287,966	220	9,480
33	Genesys Regional Medical Center	Ascension Health	1	MFN Plus	Grand Blanc	8,204	Flint, MI	422,053	410	22,057
34	Harbor Beach Community Hospital		5	Equal-to-MFN	Harbor Beach	1,681			54	137
35	Women's Hospital	Vanguard Health System	1		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	535	21,547
36	Hayes Green Beach Memorial Hospital	QHR	5	Equal-to-MFN	Charlotte	9,099	Lansing-East Lansing, MI	465,614	25	654
37	Helen Newberry Joy Hospital		5	Equal-to-MFN	Newberry	1,507			73	504
38	Henry Ford Cottage Hospital[6]		2		Farms	9,382	Detroit-Warren-Dearborn, MI	4,287,966	80	3,357
39	Henry Ford Hospital	Henry Ford Health System	1		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	759	41,056
40	Campus		2		Warren	134,243	Detroit-Warren-Dearborn, MI	4,287,966	122	6,045
41	Henry Ford Macomb Hospitals	Henry Ford Health System	2		township	96,931	Detroit-Warren-Dearborn, MI	4,287,966	421	23,651
42	Henry Ford West Bloomfield Hospital	Henry Ford Health System	3		charter township	65,110	Detroit-Warren-Dearborn, MI	4,287,966	191	12,553
43	Henry Ford Wyandotte Hospital	Henry Ford Health System	2		Wyandotte	25,618	Detroit-Warren-Dearborn, MI	4,287,966	348	19,648
44	Hills & Dales General Hospital		5	Equal-to-MFN	Cass City	2,415			25	503
45	Hillsdale Community Health Center		4		Hillsdale	8,278	Hillsdale, MI	46,565	84	3,564
46	Holland Hospital		3		Holland	33,270	Grand Rapids-Wyoming, MI	996,454	130	6,964
47	Hurley Medical Center		1		Flint	101,558	Flint, MI	422,053	418	17,988
48	Huron Medical Center		5	Equal-to-MFN	Bad Axe	3,090			37	1,592
49	Huron Valley-Sinai Hospital	Vanguard Health System	2		township	40,449	Detroit-Warren-Dearborn, MI	4,287,966	153	9,136

Exhibit 3: Michigan Acute Care Hospitals, 2011

	Hospital	System	Peer Group	MFN Type	City	City Population	Core Based Statistical Area (CBSA)[1]	CBSA Population	Beds[2]	Admissions[3]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
50	Kalkaska Memorial Health Center	Munson Healthcare	5	Equal-to-MFN	Kalkaska	2,022	Traverse City, MI	144,585	96	183
51	Watervliet	Lakeland Healthcare	5	Equal-to-MFN	Watervliet	1,736	Niles-Benton Harbor, MI	156,489	38	834
52	Joseph	Lakeland Healthcare	2		St. Joseph	8,372	Niles-Benton Harbor, MI	156,489	250	16,105
53	Mackinac Straits Health System		5	Equal-to-MFN	St. Ignace	2,435			63	320
54	Marlette Regional Hospital		5	Equal-to-MFN	Marlette	1,854			74	1,180
55	Marquette General Health System		2	MFN Plus	Marquette	21,524	Marquette, MI	67,563	276	10,535
56	McKenzie Health System		5	Equal-to-MFN	Sandusky	2,650			25	451
57	McLaren Bay Region	McLaren Health Care Corporation	2		Bay City	34,717	Bay City, MI	107,273	338	16,647
58	McLaren Central Michigan	McLaren Health Care Corporation	3		Mount Pleasant	26,111	Mount Pleasant, MI	70,636	78	3,813
59	McLaren Flint	McLaren Health Care Corporation	1		Flint	101,558	Flint, MI	422,053	336	21,520
60	McLaren Greater Lansing	McLaren Health Care Corporation	1		Lansing	114,605	Lansing-East Lansing, MI	465,614	318	15,927
61	McLaren Lapeer Region	McLaren Health Care Corporation	3		Lapeer	8,819	Detroit-Warren-Dearborn, MI	4,287,966	157	6,914
62	McLaren Macomb	McLaren Health Care Corporation	1		Mount Clemens	16,334	Detroit-Warren-Dearborn, MI	4,287,966	288	14,941
63	McLaren Northern Michigan	McLaren Health Care Corporation	3		Petoskey	5,696			178	8,803
64	McLaren Oakland	McLaren Health Care Corporation	1		Pontiac	59,887	Detroit-Warren-Dearborn, MI	4,287,966	288	6,160
65	Mecosta County Medical Center		4		Big Rapids	10,695	Big Rapids, MI	43,296	49	2,324
66	Memorial Healthcare		3		Owosso	15,024	Owosso, MI	69,934	134	4,039
67	Michigan		4	Equal-to-MFN	Ludington	8,069	Ludington, MI	28,642	80	2,379
68	Campus	Trinity Health	3		Muskegon	38,225	Muskegon, MI	170,021	213	8,902
69	Campus	Trinity Health	5	Equal-to-MFN	Shelby	2,060			24	488
70	Mercy Health Partners, Mercy Campus	Trinity Health	2		Muskegon	38,225	Muskegon, MI	170,021	188	10,170
71	Mercy Hospital Cadillac	Trinity Health	3		Cadillac	10,349	Cadillac, MI	47,622	65	4,044
72	Mercy Hospital Grayling	Trinity Health	4		Grayling	1,876			94	3,761
73	Mercy Memorial Hospital System		3		Monroe	20,672	Monroe, MI	151,609	169	9,605
74	Metro Health Hospital		2	MFN Plus	Wyoming	72,833	Grand Rapids-Wyoming, MI	996,454	208	10,147
75	MidMichigan Medical Center-Clare	MidMichigan Health	5	Equal-to-MFN	Clare	3,128			49	1,608
76	MidMichigan Medical Center-Gladwin	MidMichigan Health	5	Equal-to-MFN	Gladwin	2,950			25	592
77	MidMichigan Medical Center-Gratiot	MidMichigan Health	3	MFN Plus	Alma	9,312	Alma, MI	42,139	136	5,734
78	MidMichigan Medical Center-Midland	MidMichigan Health	2	MFN Plus	Midland	42,075	Midland, MI	84,015	250	11,133
79	Munising Memorial Hospital		5	Equal-to-MFN	Munising	2,329			25	193
80	Munson Medical Center	Munson Healthcare	2	MFN Plus	Traverse City	14,894	Traverse City, MI	144,585	391	23,392
81	NORTHSTAR Health System		5	Equal-to-MFN	Iron River	3,025			25	906
82	North Ottawa Community Hospital		4		Grand Haven	10,511	Grand Rapids-Wyoming, MI	996,454	39	1,615
83	OSF St. Francis Hospital	OSF Healthcare System	4		Escanaba	12,627	Escanaba, MI	36,955	48	2,042
84	Oakland Regional Hospital		3		Southfield	72,201	Detroit-Warren-Dearborn, MI	4,287,966	71	323
85	Oaklawn Hospital		4		Marshall	7,053	Battle Creek, MI	135,529	78	3,805
86	Oakwood Annapolis Hospital	Oakwood Healthcare, Inc.	2		Wayne	17,414	Detroit-Warren-Dearborn, MI	4,287,966	211	8,748
87	Oakwood Heritage Hospital	Oakwood Healthcare, Inc.	3		Taylor	62,489	Detroit-Warren-Dearborn, MI	4,287,966	183	8,029
88	Dearborn	Oakwood Healthcare, Inc.	1		Dearborn	97,144	Detroit-Warren-Dearborn, MI	4,287,966	553	31,762
89	Oakwood Southshore Medical Center	Oakwood Healthcare, Inc.	3		Trenton	18,662	Detroit-Warren-Dearborn, MI	4,287,966	144	8,334
90	Otsego Memorial Hospital		5	Equal-to-MFN	Gaylord	3,632			80	1,584
91	Paul Oliver Memorial Hospital	Munson Healthcare	5	Equal-to-MFN	Frankfort	1,280	Traverse City, MI	144,585	47	77
92	Pennock Hospital		4	Equal-to-MFN	Hastings	7,308	Grand Rapids-Wyoming, MI	996,454	58	2,673
93	Port Huron Hospital	Corporation	3		Port Huron	29,928	Detroit-Warren-Dearborn, MI	4,287,966	186	12,017
94	Portage Health		5	Equal-to-MFN	Hancock	4,635	Houghton, MI	38,943	96	1,730
95	ProMedica Bixby Hospital	ProMedica Health System	3		Adrian	21,045	Adrian, MI	99,340	66	4,217
96	ProMedica Herrick Hospital	ProMedica Health System	4	Equal-to-MFN	Tecumseh	8,481	Adrian, MI	99,340	60	1,640
97	Providence Hospital	Ascension Health	1	MFN Plus	Southfield	72,201	Detroit-Warren-Dearborn, MI	4,287,966	430	20,728
98	Providence Park Hospital		3	MFN Plus	Novi	55,583	Detroit-Warren-Dearborn, MI	4,287,966	222	12,771

Exhibit 3: Michigan Acute Care Hospitals, 2011

	Hospital	System	Peer Group	MFN Type	City	City Population	Core Based Statistical Area (CBSA)[1]	CBSA Population	Beds[2]	Admissions[3]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
99	Saint Mary's Health Care	Trinity Health	1		Grand Rapids	189,815	Grand Rapids-Wyoming, MI	996,454	344	19,919
100	Scheurer Hospital		5	Equal-to-MFN	Pigeon	1,193			44	555
101	Schoolcraft Memorial Hospital		5	Equal-to-MFN	Manistique	3,098			18	336
102	Sheridan Community Hospital		5	Equal-to-MFN	Sheridan	646	Grand Rapids-Wyoming, MI	996,454	22	276
103	Sinai-Grace Hospital	Vanguard Health System	1		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	337	18,414
104	South Haven Health System		5	Equal-to-MFN	South Haven	4,396	Kalamazoo-Portage, MI	328,353	33	1,135
105	Southeast Michigan Surgical Hospital	National Surgical Hospitals	3		Warren	134,243	Detroit-Warren-Dearborn, MI	4,287,966	20	106
106	Sparrow Clinton Hospital	Sparrow Health System	5	Equal-to-MFN	St. Johns	7,873	Lansing-East Lansing, MI	465,614	25	769
107	Sparrow Hospital	Sparrow Health System	1	MFN Plus	Lansing	114,605	Lansing-East Lansing, MI	465,614	638	32,611
108	Sparrow Ionia Hospital	Sparrow Health System	5	Equal-to-MFN	Ionia	11,402	Ionia, MI	63,898	25	501
109	Spectrum Health Butterworth Hospital	Spectrum Health	1		Grand Rapids	189,815	Grand Rapids-Wyoming, MI	996,454	1,066	57,057
110	Spectrum Health Gerber Memorial	Spectrum Health	4		Fremont	4,078			40	2,571
111	Spectrum Health Kelsey Hospital[7]	Spectrum Health	5	Equal-to-MFN	Lakeview	1,003	Grand Rapids-Wyoming, MI	996,454	29	321
112	Spectrum Health Reed City Hospital	Spectrum Health	5	Equal-to-MFN	Reed City	2,423			74	858
113	Hospital	Spectrum Health	4		Greenville	8,460	Grand Rapids-Wyoming, MI	996,454	88	2,748
114	Hospital		3		Zeeland	5,556	Grand Rapids-Wyoming, MI	996,454	57	1,590
115	St John Detroit Riverview Hosp[8]	Ascension Health	2		Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	285	11,432
116	St. John Hospital and Medical Center	Ascension Health	1	MFN Plus	Detroit	706,585	Detroit-Warren-Dearborn, MI	4,287,966	680	34,376
117	Macomb Center	Ascension Health	2	MFN Plus	Warren	134,243	Detroit-Warren-Dearborn, MI	4,287,966	336	20,029
118	Oakland Center[9]	Ascension Health	2		Madison Heights	29,887	Detroit-Warren-Dearborn, MI	4,287,966	157	7,425
119	St. John North Shores Hospital[6]	Ascension Health	3	MFN Plus	township	24,622	Detroit-Warren-Dearborn, MI	4,287,966	60	979
120	St. John River District Hospital	Ascension Health	3	MFN Plus	township	3,757	Detroit-Warren-Dearborn, MI	4,287,966	68	1,888
121	St. Joseph Health System	Ascension Health	4	MFN Plus	Tawas City	1,806			20	1,113
122	St. Joseph Mercy Hospital	Trinity Health	1		Ypsilanti	19,596	Ann Arbor, MI	348,637	530	31,956
123	St. Joseph Mercy Livingston Hospital	Trinity Health	4		Howell	9,527	Detroit-Warren-Dearborn, MI	4,287,966	55	3,481
124	St. Joseph Mercy Oakland	Trinity Health	1		Pontiac	59,887	Detroit-Warren-Dearborn, MI	4,287,966	409	19,385
125	St. Joseph Mercy Port Huron	Trinity Health	3		Port Huron	29,928	Detroit-Warren-Dearborn, MI	4,287,966	119	4,196
126	St. Joseph Mercy Saline Hospital[5]	Trinity Health	3		Saline	8,893	Ann Arbor, MI	348,637	24	883
127	St. Mary Mercy Hospital	Trinity Health	3		Livonia	95,958	Detroit-Warren-Dearborn, MI	4,287,966	289	16,877
128	St. Mary's of Michigan	Ascension Health	2	MFN Plus	Saginaw	51,230	Saginaw, MI	198,990	228	11,149
129	Hospital	Ascension Health	5	Equal-to-MFN	Standish	1,487			68	968
130	Straith Hospital for Special Surgery		3		Southfield	72,201	Detroit-Warren-Dearborn, MI	4,287,966	24	611
131	Sturgis Hospital	QHR	4		Sturgis	10,967	Sturgis, MI	61,016	49	1,625
132	Three Rivers Health	QHR	5	Equal-to-MFN	Three Rivers	7,791	Sturgis, MI	61,016	35	1,737
133	Health Centers		1		Ann Arbor	114,925	Ann Arbor, MI	348,637	919	45,137
134	War Memorial Hospital		4		Sault Ste. Marie	14,253	Sault Ste. Marie, MI	38,776	139	3,316
135	West Branch Regional Medical Center		4		West Branch	2,127			78	2,330
136	West Shore Medical Center		5	Equal-to-MFN	Manistee	6,220			34	1,666

Note:

[1] Core Based Statistical Area is a collective term for both metropolitan and micropolitan statistical areas. A metro area contains a core urban area of 50,000 or more population, and a micro area contains an urban core of at least 10,000 (but less than 50,000) population. See http://www.census.gov/population/metro/. Last accessed May 16, 2013.

[2] Total beds; HOSPBD in AHA Annual Survey Database.

[3] Total facility admissions; ADMTOT in AHA Annual Survey Database.

[4] AHA data have been adjusted to correct for partial year.

[5] Beds and Admissions data are from 2010.

[6] Beds and Admissions data are from 2009.

Exhibit 3: Michigan Acute Care Hospitals, 2011

Hospital	System	Peer Group	MFN Type	City	City Population	Core Based Statistical Area (CBSA)[1]	CBSA Population	Beds[2]	Admissions[3]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)

[7] Combined with Spectrum Health United Hospital in the AHA database. These hospitals have been separated here using the relative shares in Medicare data.
[8] Beds and Admissions data are from 2006.
[9] Merged with St. John Macomb-Oakland Hospital, Macomb Center, in 2007, per http://www.stjohnprovidence.org/Oakland/. Last accessed May 16, 2013.

Source:

Cols. (1), (2), (5), (9) & (10): AHA Annual Survey Database, 2011 unless otherwise noted.

Col. (3): BLUECROSSMI-99-02245412, BLUECROSSMI-99-01366299, BLUECROSSMI-99-439825, BLUECROSSMI-99-196148, BLUECROSSMI-99-658742, BCBSM EDW MED_BILL_PROV_HSTY Tables.
For Crittenton Hospital Medical Center, Lakeland Regional Medical Center-St. Joseph, MidMichigan Medical Center-Clare, Oakland Regional Hospital, St. Jospeh Mercy Saline Hospital, and St. Mary Mercy Hospital, peer groups were inferred from AHA Annual Survey Database and BLUECROSSMI-99-01010153.

Col. (4): MFN hospitals: DOJ v. BCBSM Defendant's Answers and Objections to Plaintiffs' Second Set of Interrogations, BLUECROSSMI-99-06171298; MFN Pluses: BLUECROSSMI-99-127218, BLUECROSSMI-99-135673, BLUECROSSMI-99-141212, BLUECROSSMI-99-142614, BLUECROSSMI-99-144371, BLUECROSSMI-99-169218, BLUECROSSMI-99-191636, BLUECROSSMI-99-193227, BLUECROSSMI-99-194458, BLUECROSSMI-99-388498, CIVLIT-BCBSM-00270479, MHC-EDMI-000930

Col. (6): U.S. Census Bureau Population Estimates, Incorporated Places and Minor Civil Divisions - Datasets, Michigan, at http://www.census.gov/popest/data/cities/totals/2011/SUB-EST2011-states.html. Last accessed May 16, 2013.

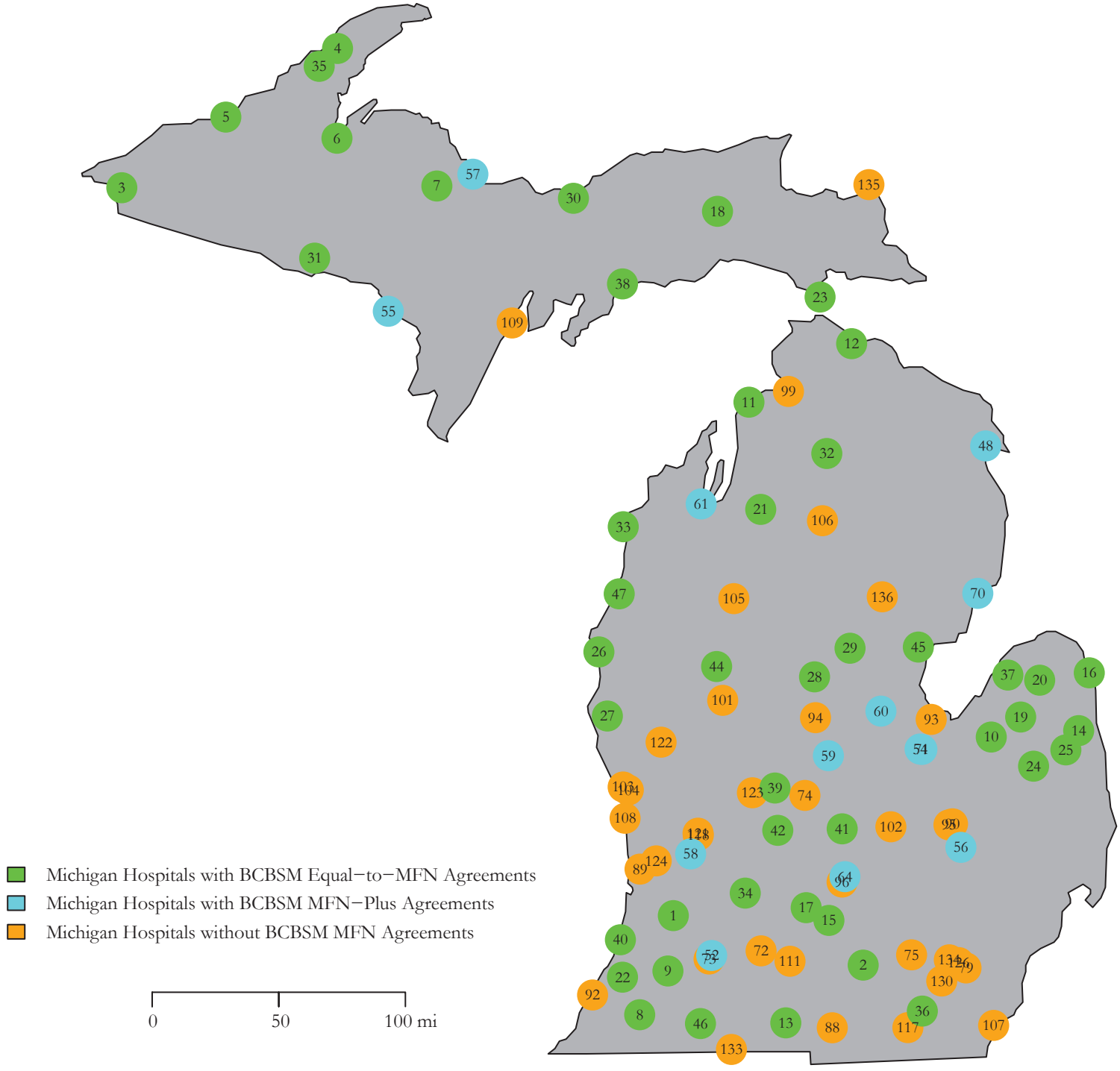
Cols. (7) & (8): U.S. Census Bureau Metropolitan and Micropolitan Delineation Files, Core based statistical areas (CBSAs) and combined statistical areas (CSAs), Feb. 2013, at http://www.census.gov/population/metro/data/def.html. Last accessed May 16, 2013.
U.S. Census Bureau Population Estimates, Metropolitan and Micropolitan Statistical Areas, Annual Estimates of the Population of Metropolitan and Micropolitan Statistical Areas: April 1, 2010 to July 1, 2012 (CBSA-EST2012-01), at http://www.census.gov/popest/data/metro/totals/2012/index.html. Last accessed May 16, 2013.

Exhibit 4: Fully-Insured Commercial Insurance: Share by Lives Covered

	2003	2004	2005	2006	2007	2008	2009	2010	2011
	(Percent)								
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
BCBSM	56 %	54 %	56 %	57 %	59 %	60 %	60 %	58 %	55 %
Priority Health	11	12	13	13	10	10	13	14	16
Health Alliance Plan	11	11	12	12	11	10	10	10	11
HealthPlus	2	2	2	2	2	3	2	3	3
UnitedHealth	2	2	2	3	2	3	2	3	3
Aetna	1	1	0	1	2	3	2	2	2
All others	18	18	14	13	13	11	11	10	9

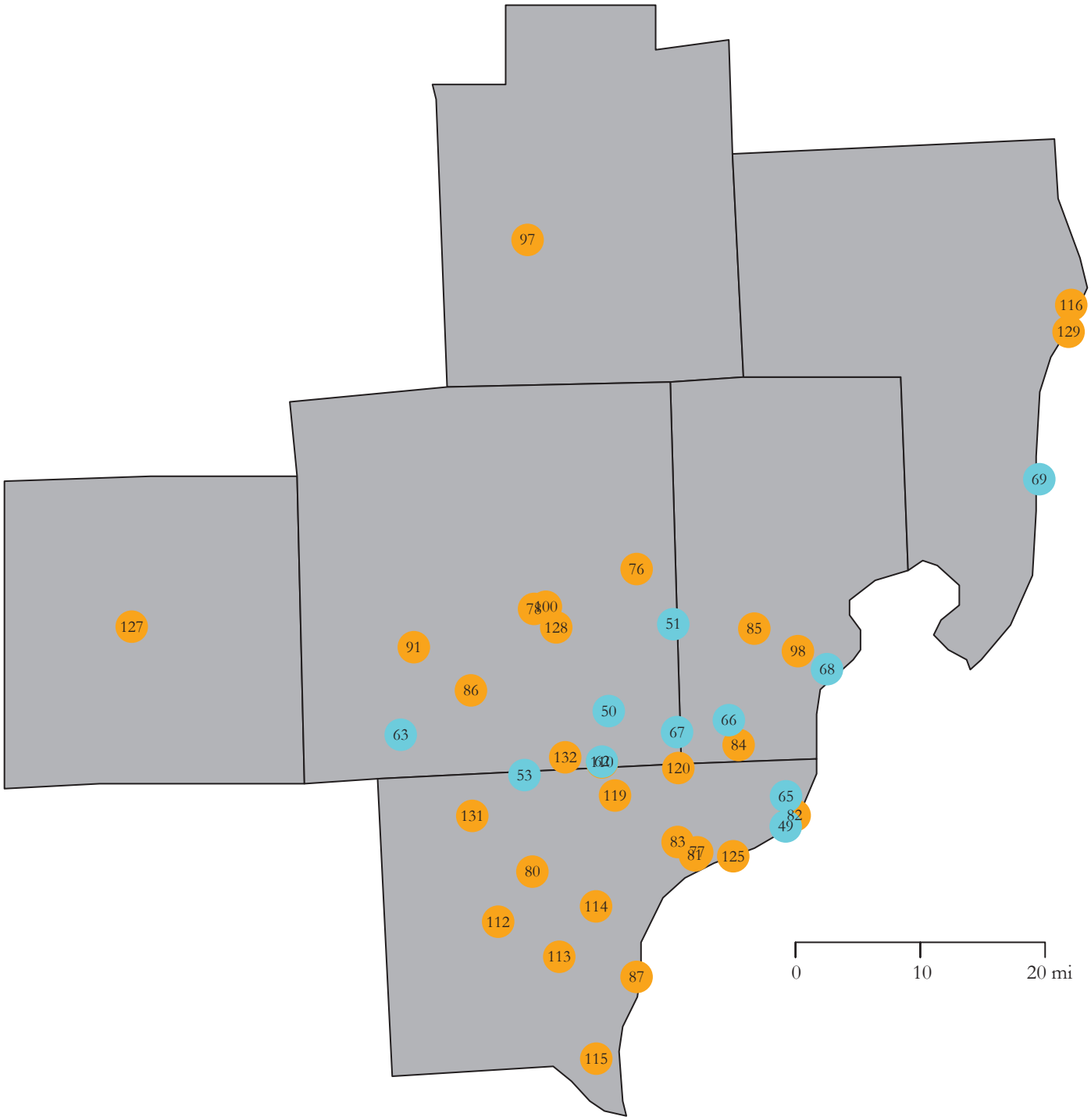
Source: Michigan Office of Financial and Insurance Regulation (OFIR).

Figure 1: Michigan Acute Care Hospital Locations Outside of the Detroit−Warren−Livonia Metropolitan Division



Source: AHA Annual Survey Data.

Figure 2: Acute Care Hospital Locations in the Detroit−Warren−Livonia Metropolitan Division



Michigan Hospitals with BCBSM Equal−to−MFN Agreements
Michigan Hospitals with BCBSM MFN−Plus Agreements
Michigan Hospitals without BCBSM MFN Agreements

Source: AHA Annual Survey Data.

Michigan Acute Care Hospital Locations
Extended Legend for Figures 1 & 2

Number on Map	Hospital Name	Agreement With BCBSM
1	Allegan General Hospital	Equal-to-MFN
2	Allegiance Health	Equal-to-MFN
3	Aspirus Grand View Hospital	Equal-to-MFN
4	Aspirus Keweenaw Hospital	Equal-to-MFN
5	Aspirus Ontonagon Hospital	Equal-to-MFN
6	Baraga County Memorial Hospital	Equal-to-MFN
7	Bell Hospital	Equal-to-MFN
8	Borgess-Lee Memorial Hospital	Equal-to-MFN
9	Bronson LakeView Hospital	Equal-to-MFN
10	Caro Community Hospital	Equal-to-MFN
11	Charlevoix Area Hospital	Equal-to-MFN
12	Cheboygan Memorial Hospital	Equal-to-MFN
13	Community Health Center of Branch County	Equal-to-MFN
14	Deckerville Community Hospital	Equal-to-MFN
15	Eaton Rapids Medical Center	Equal-to-MFN
16	Harbor Beach Community Hospital	Equal-to-MFN
17	Hayes Green Beach Memorial Hospital	Equal-to-MFN
18	Helen Newberry Joy Hospital	Equal-to-MFN
19	Hills & Dales General Hospital	Equal-to-MFN
20	Huron Medical Center	Equal-to-MFN
21	Kalkaska Memorial Health Center	Equal-to-MFN
22	Lakeland Community Hospital Watervliet	Equal-to-MFN
23	Mackinac Straits Health System	Equal-to-MFN
24	Marlette Regional Hospital	Equal-to-MFN
25	McKenzie Health System	Equal-to-MFN
26	Memorial Medical Center of West Michigan	Equal-to-MFN
27	Mercy Health Partners, Lakeshore Campus	Equal-to-MFN
28	MidMichigan Medical Center-Clare	Equal-to-MFN
29	MidMichigan Medical Center-Gladwin	Equal-to-MFN
30	Munising Memorial Hospital	Equal-to-MFN
31	NORTHSTAR Health System	Equal-to-MFN
32	Otsego Memorial Hospital	Equal-to-MFN
33	Paul Oliver Memorial Hospital	Equal-to-MFN
34	Pennock Hospital	Equal-to-MFN
35	Portage Health	Equal-to-MFN
36	ProMedica Herrick Hospital	Equal-to-MFN
37	Scheurer Hospital	Equal-to-MFN
38	Schoolcraft Memorial Hospital	Equal-to-MFN
39	Sheridan Community Hospital	Equal-to-MFN
40	South Haven Health System	Equal-to-MFN
41	Sparrow Clinton Hospital	Equal-to-MFN
42	Sparrow Ionia Hospital	Equal-to-MFN
43	Spectrum Health Kelsey Hospital	Equal-to-MFN

Michigan Acute Care Hospital Locations
Extended Legend for Figures 1 & 2

Number on Map	Hospital Name	Agreement With BCBSM
44	Spectrum Health Reed City Hospital	Equal-to-MFN
45	St. Mary's of Michigan Standish Hospital	Equal-to-MFN
46	Three Rivers Health	Equal-to-MFN
47	West Shore Medical Center	Equal-to-MFN
48	Alpena Regional Medical Center	MFN PLUS
49	Beaumont Hospital - Grosse Pointe	MFN PLUS
50	Beaumont Hospital - Royal Oak	MFN PLUS
51	Beaumont Hospital - Troy	MFN PLUS
52	Borgess Medical Center	MFN PLUS
53	Botsford Hospital	MFN PLUS
54	Covenant Medical Center	MFN PLUS
55	Dickinson County Healthcare System	MFN PLUS
56	Genesys Regional Medical Center	MFN PLUS
57	Marquette General Health System	MFN PLUS
58	Metro Health Hospital	MFN PLUS
59	MidMichigan Medical Center-Gratiot	MFN PLUS
60	MidMichigan Medical Center-Midland	MFN PLUS
61	Munson Medical Center	MFN PLUS
62	Providence Hospital	MFN PLUS
63	Providence Park Hospital	MFN PLUS
64	Sparrow Hospital	MFN PLUS
65	St. John Hospital and Medical Center	MFN PLUS
66	St. John Macomb-Oakland Hospital, Macomb Center	MFN PLUS
67	St. John Macomb-Oakland Hospital, Oakland Center	MFN PLUS
68	St. John North Shores Hospital	MFN PLUS
69	St. John River District Hospital	MFN PLUS
70	St. Joseph Health System	MFN PLUS
71	St. Mary's of Michigan	MFN PLUS
72	Bronson Battle Creek	NON MFN
73	Bronson Methodist Hospital	NON MFN
74	Carson City Hospital	NON MFN
75	Chelsea Community Hospital	NON MFN
76	Crittenton Hospital Medical Center	NON MFN
77	Detroit Receiving Hospital/University Health Center	NON MFN
78	Doctors' Hospital of Michigan	NON MFN
79	Forest Health Medical Center	NON MFN
80	Garden City Hospital	NON MFN
81	Harper University Hospital/Hutzel Women's Hospital	NON MFN
82	Henry Ford Cottage Hospital	NON MFN
83	Henry Ford Hospital	NON MFN
84	Henry Ford Macomb Hospital-Warren Campus	NON MFN
85	Henry Ford Macomb Hospitals	NON MFN
86	Henry Ford West Bloomfield Hospital	NON MFN

Michigan Acute Care Hospital Locations
Extended Legend for Figures 1 & 2

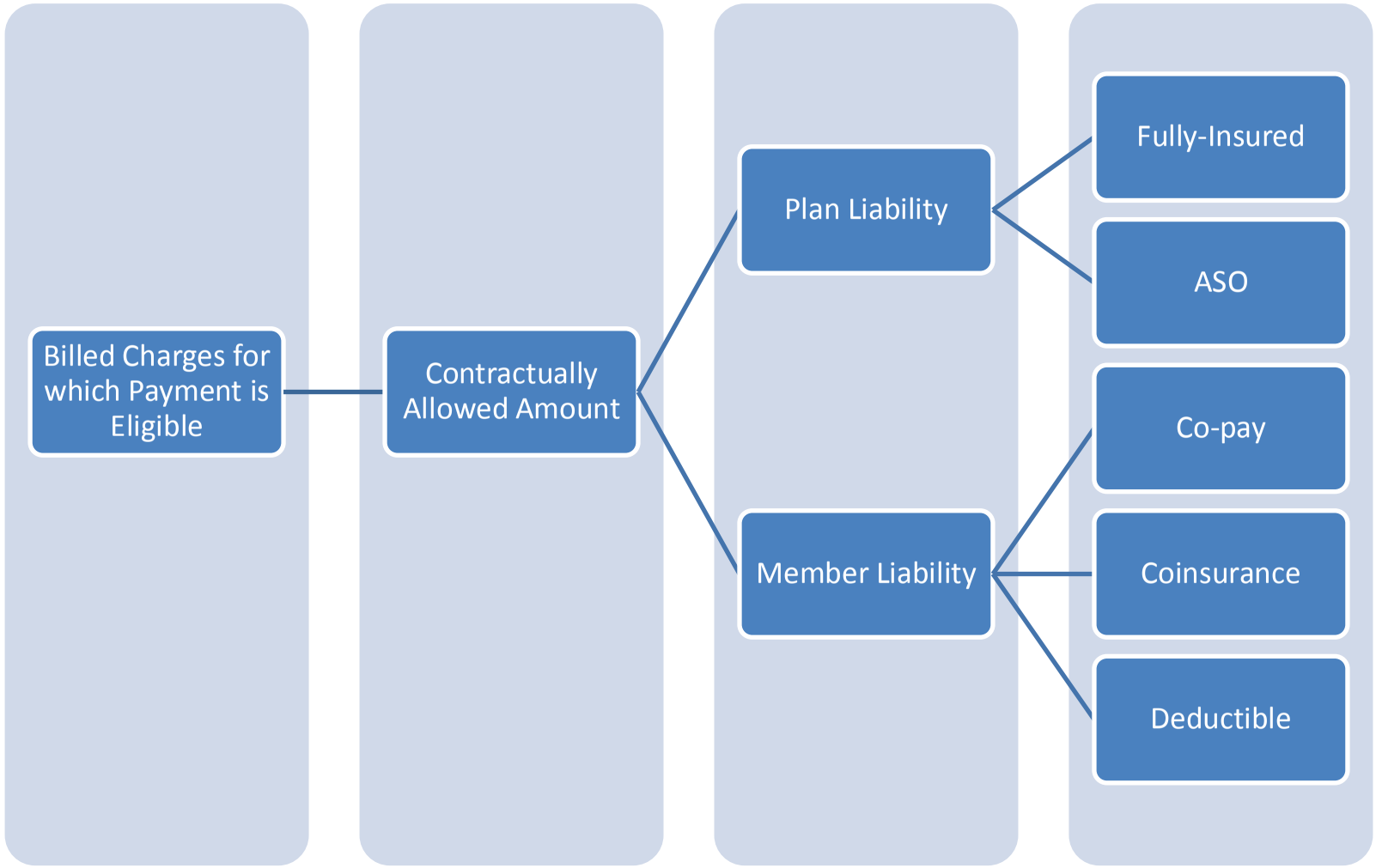
Number on Map	Hospital Name	Agreement With BCBSM
87	Henry Ford Wyandotte Hospital	NON MFN
88	Hillsdale Community Health Center	NON MFN
89	Holland Hospital	NON MFN
90	Hurley Medical Center	NON MFN
91	Huron Valley-Sinai Hospital	NON MFN
92	Lakeland Regional Medical Center-St. Joseph	NON MFN
93	McLaren Bay Region	NON MFN
94	McLaren Central Michigan	NON MFN
95	McLaren Flint	NON MFN
96	McLaren Greater Lansing	NON MFN
97	McLaren Lapeer Region	NON MFN
98	McLaren Macomb	NON MFN
99	McLaren Northern Michigan	NON MFN
100	McLaren Oakland	NON MFN
101	Mecosta County Medical Center	NON MFN
102	Memorial Healthcare	NON MFN
103	Mercy Health Partners, Hackley Campus	NON MFN
104	Mercy Health Partners, Mercy Campus	NON MFN
105	Mercy Hospital Cadillac	NON MFN
106	Mercy Hospital Grayling	NON MFN
107	Mercy Memorial Hospital System	NON MFN
108	North Ottawa Community Hospital	NON MFN
109	OSF St. Francis Hospital	NON MFN
110	Oakland Regional Hospital	NON MFN
111	Oaklawn Hospital	NON MFN
112	Oakwood Annapolis Hospital	NON MFN
113	Oakwood Heritage Hospital	NON MFN
114	Oakwood Hospital & Medical Center-Dearborn	NON MFN
115	Oakwood Southshore Medical Center	NON MFN
116	Port Huron Hospital	NON MFN
117	ProMedica Bixby Hospital	NON MFN
118	Saint Mary's Health Care	NON MFN
119	Sinai-Grace Hospital	NON MFN
120	Southeast Michigan Surgical Hospital	NON MFN
121	Spectrum Health Butterworth Hospital	NON MFN
122	Spectrum Health Gerber Memorial	NON MFN
123	Spectrum Health United Memorial Hospital	NON MFN
124	Spectrum Health Zeeland Community Hospital	NON MFN
125	St John Detroit Riverview Hosp	NON MFN
126	St. Joseph Mercy Hospital	NON MFN
127	St. Joseph Mercy Livingston Hospital	NON MFN
128	St. Joseph Mercy Oakland	NON MFN
129	St. Joseph Mercy Port Huron	NON MFN

Michigan Acute Care Hospital Locations
Extended Legend for Figures 1 & 2

Number on Map	Hospital Name	Agreement With BCBSM
130	St. Joseph Mercy Saline Hospital	NON MFN
131	St. Mary Mercy Hospital	NON MFN
132	Straith Hospital for Special Surgery	NON MFN
133	Sturgis Hospital	NON MFN
134	University of Michigan Hospitals and Health Centers	NON MFN
135	War Memorial Hospital	NON MFN
136	West Branch Regional Medical Center	NON MFN

Source: AHA Annual Survey Data

Figure 3: Path of a Claim



CORRECTED 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)
1	26	19.1 %	12,487	51.3 %
2	21	15.4	5,409	22.2
3	27	19.9	3,387	13.9
4	21	15.4	1,506	6.2
5	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.

CORRECTED 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	20.8
Beaumont Hospital - Grosse Pointe	MFN Plus	HAP	PHP	2	2	8.0
Beaumont Hospital - Royal Oak	MFN Plus	HAP	AHL	1	1	10.3
Beaumont Hospital - Royal Oak	MFN Plus	HAP	HMO	1	1	11.5
Beaumont Hospital - Royal Oak	MFN Plus	HAP	PHP	1	1	8.6
Beaumont Hospital - Troy	MFN Plus	HAP	AHL	2	2	10.2
Beaumont Hospital - Troy	MFN Plus	HAP	PHP	2	2	9.0
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.

CORRECTED 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	20.8	52.9	2,948,051	39.3	1,158,977
Beaumont Hospital - Grosse Pointe	MFN Plus	HAP	PHP	8.0	47.4	5,356,706	17.0	907,994
Beaumont Hospital - Royal Oak	MFN Plus	HAP	AHL	10.3	53.0	31,380,835	19.4	6,078,438
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	8.6	62.8	97,088,896	13.6	13,217,302
Beaumont Hospital - Troy	MFN Plus	HAP	AHL	10.2	53.9	18,866,282	18.9	3,574,952
Beaumont Hospital - Troy	MFN Plus	HAP	PHP	9.0	63.1	49,433,558	14.3	7,053,896
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**		**$ 118,587,576**

Source: Insurers' claims data, Affected Hospital Contracts.xlsx.

Exhibit 10: Fully-Insured Commercial Insurance: Share of Administrative Services by Lives Covered

	2011 (Percent)
BCBSM	83 %
Cigna	6
HAP	6
Aetna	5
All other ASO plans*	0.2

* This category includes only one other company: Principal Life Insurance Company.

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

APPENDIX 2

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN

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

THE SHANE GROUP, et al., :

Plaintiffs, onbehalf :

of themselves and all : Case No.

others similarly : 2:10-cv-14360-DPH

situated, : -MKM

v. :

BLUE CROSS BLUE SHIELD OF :

MICHIGAN, :

Defendant. :

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

CONFIDENTIAL

Videotaped Deposition of JEFFREY J. LEITZINGER, Ph.D.

Washington, DC

Tuesday, December 10, 2013

9:08 a.m.

Pages: 1 - 224

Reported By: Lee Bursten, RMR, CRR

Aetna, and the -- on the one hand, and then the hospitals that were involved with the MFNs.

Q You mentioned 23 what you termed "affected combinations." Do you recall that?

A Yes.

Q How did you determine what the affected combinations were to be for your analysis?

A That was provided to me by counsel.

Q How did that work?

A Well, essentially, as the report was taking shape, counsel said, here are the combinations we're going to use for purposes of defining the class. And in light of the assignment that I was given in the report, that was then -- those were then the combinations that I focused on.

Q Did you start writing your report before you were provided the affected combinations?

A Probably to some extent, although since much of the report relates to the affected combinations, there wasn't a whole lot I could do in that regard. But there was probably some -- I think there was some work in advance of getting the list, certainly a final list.

Q What methodology -- strike that. What methodology, Dr. Leitzinger, did you use in

otherwise would have.

And as a result, in a but-for world, they would have been bigger players in the state. Their reimbursement rates would have been lower. That would have put pressure on reimbursement rates statewide, including at Blue Cross hospitals, where there were no MFNs.

Q Am I correct, however, Doctor, that you did not do any analysis of such an argument in your report?

A That's correct.

Q I'll shift back to some product market questions. Is the effect of the MFNs on the market for commercial health insurance, if any, important to your regression?

A No.

Q Is the effect if any of the Blue Cross's MFNs with Michigan hospitals important to your -- strike that. Is the effect if any of Blue Cross's MFNs with Michigan hospitals in the market for commercial health insurance important to your analysis?

A No.

Q Hypothetical. Assume for me, Doctor, that there's only a single MFN with a single hospital

between Blue Cross and a hospital in Michigan, okay?

A All right.

Q And there are no MFNs at any other hospital in the state. If hypothetically, Doctor, that hospital raised a Blue Cross competitor's rate after the MFN became effective, would your analysis show any impact?

MR. SMALL: Objection to the form.

A Assuming that that rate increase was not typical of the rate increase that that same payer gave to other hospitals where there were no MFNs, yes, I think that would reveal impact in my analysis.

BY MR. STENERSON:

Q Impact on what?

A On reimbursement.

Q Why -- well, strike that. Does the regression that you've performed in this case, any of the 23, tell you anything about whether Blue Cross increased its market power in the market for commercial insurance?

A No.

Q Does your regression in any way show whether or not any class member was impacted from harm resulting from any anticompetitive effects in the market for commercial health insurance?

Have you done any analysis on the relative position of Blue Cross and any of its competitors in Michigan?

MR. SMALL: You mean market share? Is that what you're talking about?

MR. STENERSON: No.

BY MR. STENERSON:

Q You mentioned earlier one of the anticompetitive effects is the potential change in relative position of competitors. I want to know if you've done any analysis of that.

A I haven't done any analysis of how that changed following the institution of the MFN scheme, no.

Q So did you do any analysis as to the relative change in position if any between Priority and Blue Cross in the state of Michigan?

A No.

Q Have you done any analysis if any as to the relative change in competitive position between Blue Cross and Aetna in the state of Michigan?

A No.

Q Have you done any analysis as to the effect if any on the change in relative position between HAP and Blue Cross in Michigan?

A No.

Q Would it be important to your analysis to know whether or not any documentary or testimonial evidence is inconsistent with your conclusion that, say, Priority was affected at Paul Oliver?

A No, my analysis and conclusions don't depend in a -- in any specific or direct way on what the negotiating documents might show. I'll leave it at that.

Q Why not?

MR. SMALL: Objection to the form.

A Well, the nature of the analysis is to look to see whether in terms of the actual market outcomes, the kinds of economic data that an economist would customarily use and review, whether or not from that evidence -- whether or not from that information there is evidence of impact.

BY MR. STENERSON:

Q So if I understand you correctly, your opinion is solely related to whether or not you believe there's economic evidence of impact; is that correct?

A My opinion is about economic evidence of impact, that's correct.

Q So your opinion does not include a review, analysis, and conclusion based on the totality of the

record evidence at any given affected combination; is that correct?

A Insofar as the totality of the evidence as you're using it in that phrase would include negotiating documents, yes, that's correct, it does not -- my analysis does not rest upon that or incorporate that kind of review.

Q Do you have an opinion as to whether or not the individual negotiation between a hospital and a payer is relevant to the conclusion whether an MFN had an effect?

MR. SMALL: Objection to the form. And in particular, I object to the extent that it calls for a legal conclusion.

BY MR. STENERSON:

Q I'm only asking for economic opinions here today, Doctor.

MR. SMALL: Well, then you should ask questions that call for that.

BY MR. STENERSON:

Q Let me rephrase. As an economist, do the individual negotiations between Priority and the hospitals with MFNs matter to a conclusion about the effect if any of the Blue Cross MFN?

A I don't think the negotiating documents

combination?

MR. SMALL: Objection to the form.

BY MR. STENERSON:

Q You can answer.

A I would agree with it if you take -- it's more than potential impact. The nature of my analysis is there is economic evidence of impact at the affected combinations.

Q But limited to the affected combination, correct?

A Yes.

Q In fact, you intentionally limited your analysis to the affected combinations, right?

MR. SMALL: Objection to the form.

A That was my assignment, that's correct.

BY MR. STENERSON:

Q Based on instruction from counsel, you limited your analysis to the affected combinations in your report, right?

MR. SMALL: Objection, asked and answered several times.

A Based upon the class definition that is advanced by plaintiffs, that is what I measured, yes.

BY MR. STENERSON:

Q So back to my two hospital examples, for

reimbursement that the model revealed for that particular combination as compared with the control group in the post-MFN period.

Q Are all of those numbers in column 5 statistically significant?

A It depends on what significance level one uses in answering that question.

Q What significance level did you use?

A I don't particularly employ a certain threshold in that regard.

Q Do you have an opinion that each and every number in column 5 is in fact a statistically significant result?

A It depends on the threshold one uses for purposes of defining what constitutes statistical significance.

Q In issuing your report in this case at the class stage, are you employing a level of statistical significance to apply to the results in column 5?

A No, I am not applying a statistical significance screen or threshold of some sort to those results.

Q Without applying a statistical significance screen or threshold to those results, how can you conclude whether or not any of the results on Exhibit

9 are statistically significant?

A I couldn't. But I'm not giving opinions about whether each of the results in column 5 achieve a certain level of statistical significance.

Q What is a typical level of statistical significance that an economist of your ilk would apply in analysis of this type?

MR. SMALL: Objection to the form.

A I don't know that there is such a thing.

BY MR. STENERSON:

Q Would you disagree if a Ph.D. economist concluded that the regression results that you reflect in column 5 for Beaumont Royal Oak were statistically insignificant?

MR. SMALL: Objection to the form.

A It would -- it would depend on what threshold that Ph.D. economist was employing to come to that conclusion.

BY MR. STENERSON:

Q Would you disagree if an economist concluded that the regression results that you reflect in column 5 for the Beaumont Royal Oak HAP -- strike that -- for the Beaumont Royal Oak Blue Cross regression was not statistically different than zero?

MR. SMALL: Objection to the form. Asked

possibility that hospitals that ended up with MFNs were in general more likely to be seeking higher reimbursements than hospitals that did not have MFNs?

MR. SMALL: Objection to the form.

A I think you asked me about that earlier this afternoon, and as I said then, I didn't introduce a variable into the analysis to somehow account for hospitals' desire to attain higher reimbursement.

BY MR. STENERSON:

Q What was your control group for the peer group 5 hospitals in the affected combinations?

A It was peer group 4 hospitals where there was no MFN, and that involved the same insurance company and product as the affected combination.

Q What do you know if anything about the difference in reimbursement methodology that Blue Cross used for peer group 5 versus peer group 4 hospitals?

A I know that there were differences in the reimbursement methodology. I understand that the peer group 5 methodology was more favorable than the peer group 4 methodology. I understand that that went hand in hand with the agreement to an MFN.

Q What's the basis of the understanding you

group selection process, I asked you a question about anything you did to determine whether or not reimbursement rates moved in a similar fashion between the affected hospitals and the control group hospitals. Do you remember that?

A Yes.

Q I want to specifically ask, and I think -- I think your answer was it was in the regression.

A Yes.

Q It's kind of like Ragu. It's in there. Let me ask you specifically. Separate and apart from your DID analysis, for the period of time before the MFN, did you do any analysis as to if and how reimbursement rates at the control group hospitals for any affected combination moved in a similar fashion to that of the affected hospital?

MR. SMALL: Objection to the form.

A I did not.

BY MR. STENERSON:

Q So do you have your report in front of you? I'll have you turn to page 3, paragraph 8. It said, "Excluded from the class are, one, BCBSM, its officers and directors, and its present and former parents, predecessors, subsidiaries and affiliates."

Do you see that?

APPENDIX 3

Reference Manual on Scientific Evidence

Third Edition

Committee on the Development of the Third Edition of the
Reference Manual on Scientific Evidence

Committee on Science, Technology, and Law
Policy and Global Affairs

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Reference Guide on Multiple Regression

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CONTENTS

Multiple regression analysis can be a source of valuable scientific testimony in litigation. However, when inappropriately used, regression analysis can confuse important issues while having little, if any, probative value. In *EEOC v. Sears, Roebuck & Co.*,[13] in which Sears was charged with discrimination against women in hiring practices, the Seventh Circuit acknowledged that "[m]ultiple regression analyses, designed to determine the effect of several independent variables on a dependent variable, which in this case is hiring, are an accepted and common method of proving disparate treatment claims."[14] However, the court affirmed the district court's findings that the "E.E.O.C.'s regression analyses did not 'accurately reflect Sears' complex, nondiscriminatory decision-making processes'" and that the "'E.E.O.C.'s statistical analyses [were] so flawed that they lack[ed] any persuasive value.'"[15] Serious questions also have been raised about the use of multiple regression analysis in census undercount cases and in death penalty cases.[16]

The Supreme Court's rulings in *Daubert* and *Kumho Tire* have encouraged parties to raise questions about the admissibility of multiple regression analyses.[17] Because multiple regression is a well-accepted scientific methodology, courts have frequently admitted testimony based on multiple regression studies, in some cases over the strong objection of one of the parties.[18] However, on some occasions courts have excluded expert testimony because of a failure to utilize a multiple regression methodology.[19] On other occasions, courts have rejected regression

76-1634-MA, 1991 WL 4087 (D. Mass. Jan. 11, 1991); Estate of Vane v. The Fair, Inc., 849 F.2d 186, 188 (5th Cir. 1988) (lost profits were the result of copyright infringement), *cert. denied,* 488 U.S. 1008 (1989); Louis Vuitton Malletier v. Dooney & Bourke, Inc., 525 F. Supp. 2d 576, 664 (S.D.N.Y. 2007) (trademark infringement and unfair competition suit). The use of multiple regression analysis to estimate damages has been contemplated in a wide variety of contexts. *See, e.g.,* David Baldus et al., *Improving Judicial Oversight of Jury Damages Assessments: A Proposal for the Comparative Additur/Remittitur Review of Awards for Nonpecuniary Harms and Punitive Damages,* 80 Iowa L. Rev. 1109 (1995); Talcott J. Franklin, *Calculating Damages for Loss of Parental Nurture Through Multiple Regression Analysis,* 52 Wash. & Lee L. Rev. 271 (1997); Roger D. Blair & Amanda Kay Esquibel, *Yardstick Damages in Lost Profit Cases: An Econometric Approach,* 72 Denv. U. L. Rev. 113 (1994). Daniel Rubinfeld, *Quantitative Methods in Antitrust, in* 1 Issues in Competition Law and Policy 723 (2008).

13. 839 F.2d 302 (7th Cir. 1988).

14. *Id.* at 324 n.22.

15. *Id.* at 348, 351 (quoting EEOC v. Sears, Roebuck & Co., 628 F. Supp. 1264, 1342, 1352 (N.D. Ill. 1986)). The district court commented specifically on the "severe limits of regression analysis in evaluating complex decision-making processes." 628 F. Supp. at 1350.

16. *See* David H. Kaye & David A. Freedman, Reference Guide on Statistics, Sections II.A.3, B.1, in this manual.

17. Daubert v. Merrill Dow Pharms., Inc. 509 U.S. 579 (1993); Kumho Tire Co. v. Carmichael, 526 U.S. 137, 147 (1999) (expanding the *Daubert's* application to nonscientific expert testimony).

18. *See* Newport Ltd. v. Sears, Roebuck & Co., 1995 U.S. Dist. LEXIS 7652 (E.D. La. May 26, 1995). *See also* Petruzzi's IGA Supermarkets, *supra* note 6, 998 F.2d at 1240, 1247 (finding that the district court abused its discretion in excluding multiple regression-based testimony and reversing the grant of summary judgment to two defendants).

19. *See, e.g., In re* Executive Telecard Ltd. Sec. Litig., 979 F. Supp. 1021 (S.D.N.Y. 1997).

ticular form.[44] Alternatively, in an antitrust damages proceeding, the expert may want to test a null hypothesis of no legal impact against the alternative hypothesis that there was an impact. In either type of case, it is important to realize that rejection of the null hypothesis does not in itself prove legal liability. It is possible to reject the null hypothesis and believe that an alternative explanation other than one involving legal liability accounts for the results.[45]

Often, the null hypothesis is stated in terms of a particular regression coefficient being equal to 0. For example, in a wage discrimination case, the null hypothesis would be that there is no wage difference between sexes. If a negative difference is observed (meaning that women are found to earn less than men, after the expert has controlled statistically for legitimate alternative explanations), the difference is evaluated as to its statistical significance using the *t*-test.[46] The *t*-test uses the *t*-statistic to evaluate the hypothesis that a model parameter takes on a particular value, usually 0.

2. What is the appropriate level of statistical significance?

In most scientific work, the level of statistical significance required to reject the null hypothesis (i.e., to obtain a statistically significant result) is set conventionally at 0.05, or 5%.[47] The significance level measures the probability that the null hypothesis will be rejected incorrectly. In general, the lower the percentage required for statistical significance, the more difficult it is to reject the null hypothesis; therefore, the lower the probability that one will err in doing so. Although the 5% criterion is typical, reporting of more stringent 1% significance tests or less stringent 10% tests can also provide useful information.

In doing a statistical test, it is useful to compute an observed significance level, or *p*-value. The *p*-value associated with the null hypothesis that a regression coefficient is 0 is the probability that a coefficient of this magnitude or larger could have occurred by chance if the null hypothesis were true. If the *p*-value were less than or equal to 5%, the expert would reject the null hypothesis in favor of the

44. Tests are also appropriate when comparing the outcomes of a set of employer decisions with those that would have been obtained had the employer chosen differently from among the available options.

45. *See* David H. Kaye & David A. Freedman, Reference Guide on Statistics, Section IV.C.5, in this manual.

46. The *t*-test is strictly valid only if a number of important assumptions hold. However, for many regression models, the test is approximately valid if the sample size is sufficiently large. See Appendix, *infra,* for a more complete discussion of the assumptions underlying multiple regression..

47. *See, e.g.*, Palmer v. Shultz, 815 F.2d 84, 92 (D.C. Cir. 1987) ("'the .05 level of significance . . . [is] certainly sufficient to support an inference of discrimination'" (quoting Segar v. Smith, 738 F.2d 1249, 1283 (D.C. Cir. 1984), *cert. denied,* 471 U.S. 1115 (1985))); United States v. Delaware, 2004 U.S. Dist. LEXIS 4560 (D. Del. Mar. 22, 2004) (stating that .05 is the normal standard chosen).

APPENDIX 4

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

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

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

EXPERT REPORT OF PROFESSOR DAVID S. SIBLEY

February 3, 2014

I. INTRODUCTION

A. Qualifications

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

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

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

B. Assignment

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

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

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

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

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

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

C. Summary of conclusions

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

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

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

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

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

1. Class-wide versus individual issues

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

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

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

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

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

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

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

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

2. Antitrust injury

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Dr. Leitzinger's methodology is not reliable

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

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

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

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

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

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

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

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

II. REVIEW OF ALLEGED CONDUCT

A. Proposed class

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

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

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

[14] CAC at ¶ 10.

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

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

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

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

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

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

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

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

[19] Plaintiffs' Motion at 5.

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

B. Alleged anticompetitive conduct

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

C. Summary of Dr. Leitzinger's economic analysis

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

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

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

[23] Plaintiffs' Motion at 4.

[24] Leitzinger Report at ¶ 51.

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

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

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

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

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

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

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

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

III. INDUSTRY BACKGROUND

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

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

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

[28] Leitzinger Report at ¶ 59.

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

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

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

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

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

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

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

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

of Medicare and Medicaid patients. The total margin in the PHA for Peer Group 5 hospitals was 28 percent, in anticipation of [redacted].[35]

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

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

1. Hospitals vary in their bargaining power

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

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

[36] See Leitzinger Report, Exhibit 3.

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

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

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

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

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

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

[41] Deposition of Mark Johnson (BCBSM), 10/30/2012, at 36 (stating that Beaumont is one of the largest hospitals in the country), at 37 (stating that its significant size in the market makes it a preferred hospital), and at 38 (stating that a plan without Beaumont would not be able to market insurance products in Detroit); Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 69:1-4, 70:23-25 (stating that St. John is a hospital that BCBSM needs to carry to be competitive).

bargaining power. Sparrow Ionia Hospital also considers itself an important hospital to payers, though due to its geographic remoteness rather than its size.[42] Conversely, Allegan General Hospital ("Allegan") did not regard itself as having significant bargaining power over BCBSM.[43]

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

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

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

[43] Deposition of Richard Harning (Allegan), 11/7/2011, at 103 ("A. We weren't in a position of power. Q. As it relates to Blue Cross? A. Right.").

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

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

43. Although Ascension-Michigan was willing to terminate or threaten to terminate agreements, other hospitals like Allegan and Three Rivers Health ("Three Rivers") felt much less empowered to make such threats to BCBSM, although they may have felt differently about other insurers.[46] Allegan described the potential loss of BCBSM as "catastrophic."[47]

44. Bargaining strategies do not follow directly from hospital size. For example, Beaumont, despite having both size and a system of hospitals, did not avail itself of "the lever of threatening a termination" in its 2008 negotiations with BCBSM.[48] On the other hand, while some small, financially-distressed hospitals may feel they have little leverage over BCBSM, others may derive bargaining power from their financial situation. After all, without higher rates from payers, hospital cutbacks would lead to a deterioration of access and service for the payers' customers. Further, many of these small hospitals are the only hospitals in their communities.[49] For both of these reasons, insurers may agree to pay more. These factors can empower even small, financially-distressed hospitals to seek higher prices.[50]

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

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

[47] Deposition of Richard Harning (Allegan), 11/7/2011, at 85.

[48] Deposition of Mark Johnson (BCBSM), 10/30/2012, at 142 and at 74 ("So we talked about termination proceedings, as yet another example of a point of leverage, also targeted against what I believed would be a risk to Blue Cross that if Beaumont were to terminate, there would be a loss of membership") and at 107 (noting that executives at Beaumont were unwilling to terminate the agreement with BCBSM).

[49] CAC at ¶ 58.

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

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

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

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

2. The complex and multifaceted nature of contracting

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

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

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

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

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[52] BLUECROSSMI-99-848322: Participating Hospital Agreement Workshop 1 at 95. BCBSM considers "hospital importance to BCBSM provider network" in terms of providing "access for existing customers" as of "critical" importance and recognizes that this serves as a leverage point for hospitals in negotiations with BCBSM.

[53] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 184 (a shift in the payer mix toward Medicaid caused concern over financial condition) and at 185 ("even a 2 percent shift has significant ramifications, if you go from commercial to Medicaid.").

[54] Not-for-profit hospitals often have concerns beyond profit-maximization, including the devotion of financial resources to increasing quality of care and access to care. See, for example, Daniel Deneffe and Robert T. Mason (2002), "What Do Not-for-profit Hospitals Maximize?" *International Journal of Industrial Organization* 20, 461-492, at 486 ("Our results … are consistent with [not-for-profit hospitals having] an objective function that places positive utility weight upon both social welfare and profits."). Also see Martin Gaynor and William B. Vogt, "Antitrust and Competition in Health Care Markets" (April 30, 1999), Chapter prepared for the *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), Amsterdam: North-Holland. BCBSM, unlike some rival insurers, shares these goals and is concerned with hospital viability. See Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 278 (noting that a hospital simply losing money won't get payers like Cofinity and United Healthcare to raise reimbursement rates). BCBSM's support of hospitals' missions and its local presence can provide it a special place in negotiations. For example, William Beaumont (hospital)'s CFO, Dennis Herrick, expressed concern about BCBSM's competitors' motives: "we are equally concerned about the long-term consequences of assisting new market entrants and their dedication to the principles of non-profit care." Deposition of Douglas Darland Government Exhibit 4, BLUECROSSMI-08-004240 at BLUECROSSMI-08-004244 and Deposition of Karmon Bjella (Alpena), December 13, 2011, at 41 (calling Blue Cross "the most dependable business-like insurer").

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

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

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

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

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

A. Dr. Leitzinger's approach to common proof

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

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

[redacted] BLUECROSSMI-E-0008311-8315.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[63] Leitzinger Report at ¶ 111.

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

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

2. The BCBSM explanation for MFNs

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

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

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

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

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

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

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

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

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

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

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

negotiator stated that MFNs generally were raised in negotiations only after he obtained "the absolute best bargain that [he] could."[72] Similarly, the Chief Executive Officer ("CEO") of Alpena Regional Medical Center ("Alpena") stated that he believed Alpena would have received the same rate increase from BCBSM even in the absence of an MFN.[73] The Chief Financial Officer ("CFO") of Ascension-Michigan stated that "the MFN was relatively ineffective" because it reflected (rather than caused) prices that were in their "best business interest" anyway[74] and that no rates for any competing insurers were raised because of an MFN.[75] Evidence such as this suggests that high reimbursement rates may have "caused" the MFNs, rather than the reverse, as assumed by Dr. Leitzinger. Similarly, a representative from Sparrow testified that its rates were not altered as a result of the MFN.[76] Three Rivers aimed to bring Priority's rates in line with BCBSM rates in its 2006 negotiations, but an MFN was not a factor in this goal.[77] Three Rivers' CFO stated that the MFN did not lead to higher payments from BCBSM.[78]

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

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

[73] Deposition of Karmon Bjella (Alpena), December 13, 2011 at 264.

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

[75] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 186-189.

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

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

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

61. At Beaumont, there was little regard for including the MFN provision because "I found little value to it, either on what it gave to Blue Cross or what it gave to myself, I attached no value to it, so the answer is, yes [I would not object to the MFN]. It wasn't meaningful to me to include it."[79] Other hospitals also acknowledged that the MFN was irrelevant to the hospital but was seen as very important to BCBSM for bureaucratic reasons.[80]

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

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

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

[79] Deposition of Mark Johnson (BCBSM), 10/30/2012, at 139; also at 158 ("As I've testified earlier, these MFN provisions meant nothing to me, so the fact that they were changed periodically, still had no effect on me or my behavior at Beaumont.").

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

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

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

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

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

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

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

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

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

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

66. A hospital in financial distress is likely to need and thus insist on higher prices from everyone. However, a hospital that wants only higher prices from BCBSM may still *claim* that it needs more money from everyone. An MFN can serve an informational role by revealing the veracity of a hospital's claim. Far from tying hospitals' hands, an MFN resolves this uncertainty on the part of BCBSM and places absolutely no burden on a hospital intent on raising everyone's prices anyway. With the uncertainty resolved, agreements to fund service quality improvements or rescue hospitals from financial ruin are much more likely. Without such promises, BCBSM may be unsure as to the hospital's true intent, and thus unwilling to enter into an agreement.[85] At the very least, this uncertainty may involve costly delays as true motives are discovered.

[85] With these assurances and the reduction in risk and uncertainty, "the buyer is more willing to enter into a mutually beneficial long-term contract with the seller." William J. Lynk (2000), "Some basics about most favored nation contracts in health care markets," *Antitrust Bulletin* 45 at 519. This also appears consistent with the experience of Priority at Scheurer Hospital. Prior to Scheurer's adoption of an MFN agreement with BCBSM, Priority regularly offered but failed to obtain a contract with Scheurer. "[Priority] had never offered us enough money or enough of percentage to where it was worthwhile." Deposition of Terry Joe Lutz (Scheurer), 1/12/2012, at 124:11-12. Also at 229:21-24. After Priority became aware of the MFN (at 229:6-9), it reached a deal with Scheurer (at 245:20-246:7). Terry Joe Lutz believed that the MFN "may have been a factor." (at 247:8).

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

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

68. Juxtaposing this BCBSM theory and the antitrust theory advanced by plaintiffs, it is clear that testing one theory against the other can only be done on an individualized basis. Consider the two Ascension-Michigan hospitals that are in the "affected" group, St. John and Providence Park. Ascension-Michigan agreed to an MFN-plus clause, but neither plaintiffs nor Dr. Leitzinger opine that this had any effect on any BCBSM rival. Mr. Patrick McGuire stated that the MFNs did not impact the rates of any competing insurers.[87] This fits well with Mr. Darland's assertions that some MFN clauses were included to satisfy interests internal to BCBSM and were not intended to have any market effect. To analyze plaintiffs' antitrust theory, one would need to explain the anticompetitive motive for including an MFN provision that did not disadvantage rival insurers.

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

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

[87] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 186-189.

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

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

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

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

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

[88] See also Leitzinger Report, Exhibit 6.

[89] Plaintiffs' Motion at 7-8.

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

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

[92] Leitzinger Report at ¶ 101.

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

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

[93] Leitzinger Report at ¶¶ 102-103.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[100] Leitzinger Report at ¶ 35.

[101] BCBS lists as one of its "Guiding Principles" its willingness to develop a relationship with "any willing provider." Blue Cross, "Enhance Health Care ValueStrategy: 2008 Plan," 7/9/2010, BLUECROSSMI-E-0004031.

[102] Leitzinger Deposition at 76-80.

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

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

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

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

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

4. Hospitals can have significant bargaining power

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

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

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

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

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

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

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

requirements[111] place pressure on a payer to conclude a deal with those hospitals. For example, the CEO of Alpena stated that a payer would "probably not" be able to market a plan to local residents that did not include his hospital.[112] Such hospitals may leverage their value when negotiating with payers. All of these varying and individualized factors affect hospital bargaining power.

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

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

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

[112] Deposition of Karmon Bjella (Alpena), December 13, 2011, at 32. This is due to the fact that "in terms of inpatient care, the hospital ARMC is the only one in the multi-county area." (at 97).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Market definition

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

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

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

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

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

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

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

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

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

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

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

[128] Leitzinger Report at ¶ 79-84.

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

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

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

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

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

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

[133] Leitzinger Report at ¶ 94.

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

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

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

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

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

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

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

[138] Leitzinger Report ¶¶ 91-92.

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

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

[141] Leitzinger Report at ¶ 100.

[142] Further, such analysis ignores the *Guidelines* requirement to analyze *demand* rather than *supply* factors in market delineation ("Market definition focuses solely on demand substitution factors" *Guidelines §4*). Meanwhile, the Complaint admits that some class members "may have a strong preference for access to the network in one area and may not be particularly concerned about the quality or rates of the network elsewhere." CAC at ¶ 52.

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

c. There are many local geographic markets for hospital services

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

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

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

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

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

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

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

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

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

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

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

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

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

[149] Leitzinger Report at ¶ 84.

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

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

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

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

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

C. Dr. Leitzinger's overcharge analysis is flawed

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

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

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

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

[153] Leitzinger Report at ¶ 47.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[159] Leitzinger Report at ¶ 53.

[160] Leitzinger Report at note 128.

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

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

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

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

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

[163] See Plaintiffs' Motion at 5.

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

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

3. Interpreting Dr. Leitzinger's statistical results

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

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

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

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

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

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

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

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

[167] Leitzinger Report, Exhibit 6.

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

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

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

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

114. Analyses of Beaumont Hospitals' financial health as described in a detailed letter from Mr. Nickolas A. Vitale (Senior Vice President, Beaumont Hospitals) to Mr. Van Conway of Conway MacKenzie, Inc. (a Michigan-based restructuring and financial advisory firm), indicate the financial challenges Beaumont experienced in 2008 and the steps Beaumont was taking to regain and maintain financial stability.[169] Among other things, these steps included deferred capital expenditures, salary reductions, position reductions, employee pay practice changes, benefits changes and initiatives to enhance revenues, such as negotiating better rates with payers. The steep cut in the reimbursement rate Dr. Leitzinger's but-for analysis predicts for payments under BCBSM's PPO agreement with Beaumont Hospital – Grosse Point would essentially negate much of the progress Beaumont made during this period. Dr. Leitzinger admitted during his deposition that his DID method does not consider the financial implications of his findings on the affected hospitals.[170] Clearly, the feasibility of these reductions and their financial impact on Beaumont Hospital – Grosse Point should be analyzed. Extending this to other hospitals would require individualized analysis of each hospital.

115. Other information in the record also calls into question the reductions in the reimbursement rate Dr. Leitzinger predicts would take place at Beaumont hospitals absent the MFNs. According to an economic analysis conducted on behalf of Beaumont, during the period 2004-2008, Beaumont, specifically, and hospitals in Michigan, generally, were paid "consistently below national and regional norms."[171] During this period, the study concluded that

[169] Letter from Mr. Nickolas A. Vitale (Senior Vice President, Beaumont Hospitals) to Mr. Van Conway of Conway MacKenzie, Inc. (dated March 25, 2010).

[170] Leitzinger Deposition at 216:17-25 (stating that he did not consider what effect a reduction in revenue would have on Beaumont and this is irrelevant to his opinion).

[171] BEAU-DOJ-00064156 at BEAU-DOJ-00064158. The study was based on private inpatient hospital rates.

the Beaumont underpayments were sizeable and ranged between 11 percent and 21 percent (depending on the sample of comparison hospitals). In contrast, according to Dr. Leitzinger, Beaumont's two largest facilities (Royal Oak and Troy) were paid BCBSM reimbursement rates that were too high (under its non-HMO agreement) beginning in February of 2006.

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

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

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

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

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

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

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

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

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

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

[175] Leitzinger Report at ¶ 55.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[181] Leitzinger Report at ¶ 51.

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

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

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

130. Beaumont Health System. MFN agreements had a minimal effect on the rates paid by BCBSM at Beaumont, according to representatives of both BCBSM and Beaumont.

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

Beaumont considered itself to be very important to insurers,[183] and firmly believed that its value entitled it to get more reimbursement from BCBSM than it had been getting.[184] Its importance was acknowledged by BCBSM.[185] This provided Beaumont with considerable bargaining power, which was acknowledged by BCBSM: "Beaumont has a lot of leverage on their side."[186] Hence, the rate increases paid by BCBSM at Beaumont may have been, entirely or in part, due to bargaining power exercised by Beaumont and not to its agreement to include an MFN-plus provision. As discussed above, Mr. Darland, the negotiator for BCBSM, saw the MFN plus primarily as a bureaucratic device to appease other organizations within BCBSM and to prevent free riding, and not as something that affected hospital prices. Indeed, both Mr. Darland and Mr. Mark Johnson testified that the MFN-plus agreed to by Beaumont had little or no impact on negotiations.[187]

131. St. John Hospital and Medical Center and Providence Park Hospital. St. John and Providence Park are part of the Ascension-Michigan system. Along with Beaumont, the

[183] See Deposition of Kenneth Matzick (Beaumont), 11/13/2012, at 21:3-8 ("Beaumont has long been considered a must-have in the metro Detroit market, as a quality provider with very reasonable costs. So I think they wanted the opportunity to have us - - have Beaumont in their provider networks, as they tried to develop their products in the region."); 43:23-46:4; 82:8-10 ("… we were a must-have in the marketplace, so anybody that came to town would have said that, that Beaumont was a key to establishing a network in Southeast Michigan."); 82:23-83:14; Deposition of Mark Johnson (BCBSM), 10/30/2012, at 36 (stating that Beaumont is one of the largest hospitals in the country), 37 (stating that its significant size in the market makes it a preferred hospital), and 38 (stating that a plan without Beaumont would not be able to market insurance products in Detroit). Deposition of Suzanne Hall, 11/15/12 at 136:7-137:3.

[184] This was also acknowledged by BCBSM. Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 53 ("We knew we had a great discount at Beaumont…" and, referencing an increase in BCBSM's reimbursement to Beaumont. "We knew going in that we were going to have to give them some additional update."). Note that this point was as made in BEAU-DOJ-00064156.

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

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

[187] See Deposition of Mark Johnson (BCBSM), 10/30/2012, at 141:3-23, and Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 76:9-13.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PPO agreement is 2.9 percentage points [205] and is 13.6 percentage points for the BCBSM PPO agreement at Providence Park Hospital.[206] However, it is also important to note that, in the view of Mr. McGuire "the MFN was relatively ineffective."[207] It was both sufficiently vague and prescribed prices for rival insurers that Ascension-Michigan would have enacted anyway as they were in its "business interest."[208] He testified that no rates for any competing insurers were either raised or lowered because of an MFN.[209]

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

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

[205] Leitzinger Report, Corrected Exhibit 9.

[206] Leitzinger Report , Corrected Exhibit 9.

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

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

[209] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 186:2-189:11.

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

142. Allegan General Hospital. Like many other Peer Group 5 hospitals, Allegan's poor financial condition led Allegan to seek higher rates from its payers.[211] As Priority and United Healthcare ("United") were paying considerably lower rates than was BCBSM, the Allegan representative, Richard Harning, saw these payers as "opportunities" to get higher rates.[212] Allegan unilaterally offered BCBSM an MFN provision.[213] As for other payers, "I was going to increase Priority and United independent of any of this [MFN agreement], independent. The MFD, the Most Favored Discount clause, gave me leverage in negotiating with them."[214] Indeed, Allegan was able to negotiate rates with Priority and United that exceeded the levels necessary to comply with the MFN.[215]

143. To the extent that Mr. Harning intended to use the MFNs as a bargaining device with Priority and United, this would appear to be an effective, if unusual, strategy. This implies that any effect of the MFN at Allegan cannot inform their effect at any other hospital. Certainly, Dr. Leitzinger's comparison of Allegan rates to those of control group hospitals would be uninformative. Similarly, the conclusion reached on BCBSM's exercise of market power at some hospital other than Allegan may well not apply to Allegan. Equally important, only a careful

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

[211] Deposition of Richard Harning (Allegan), 11/7/2011, at 14:4-18, 75:12-14.

[212] Deposition of Richard Harning (Allegan), 11/7/2011, at 176:16-177:3.

[213] Deposition of Richard Harning (Allegan), 11/7/2011, at 66:21-67:4 ("Q. Was a Most Favored Discount clause something that Blue Cross indicated it was interested in at any point? A. No. Q. It was at your initiative to bring it up? A. We thought it would be helpful.").

[214] Deposition of Richard Harning (Allegan), 11/7/2011, at 63:13-17.

[215] Deposition of Richard Harning (Allegan), 11/7/2011, at 236:10-19, 241:4-17.

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

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

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

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

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

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

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

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

147. Because of the unique circumstances surrounding each of these negotiations, the results of such an analysis would not allow one to conclude anything about the impact of an MFN at other hospitals. For example, Ascension-Michigan knew that the potential departicipation of "a system like Ascension Health or St. John Providence… would harm Blue Cross" and thus wielded significant "leverage" and considerable bargaining power over BCBSM.[219] Conversely, Three Rivers generally saw itself as in a poor bargaining position with respect to BCBSM.[220] Departicipation "didn't seem like a viable option."[221] Furthermore, the above discussion of Ascension-Michigan highlights the fact that Ascension-Michigan never raised the rates of any BCBSM competitors at St. John and Providence Park due to its MFN.[222] Also both sides of the BCBSM-Beaumont negotiation thought the MFN of little importance.[223] Reflecting a very different bargaining strategy, the Three Rivers representative considered the MFN helpful to negotiations with Aetna. Hence, finding that the MFN caused the Aetna rate to

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

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

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

[222] Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 186:21-187:14.

[223] Deposition of Mark Johnson (BCBSM), 10/30/2012, at 141:3-23, and Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 75:22-76:13.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

157. Bronson LakeView Hospital ("Bronson"). As noted above, Dr. Leitzinger's DID approach simply compares reimbursement rates before and after some moment in time but fails to consider other contemporaneous events. The negotiations between Bronson LakeView and its insurers illustrates this problem as well. Dr. Leitzinger alleges that Aetna was negatively affected by an MFN as of January 1, 2008.[232] On the same date, Bronson Healthcare Group acquired and took over operations at LakeView Community Hospital.[233] The transition in ownership brought a new negotiating team, which renegotiated the existing agreement with Aetna. Under the new agreement, effective January 1, 2008, Aetna was to pay the renamed Bronson LakeView Hospital the higher rate contained in the Aetna's agreement with Bronson Methodist Hospital,

[232] Leitzinger Report Table 1.

[233] Deposition of Helen M. Hughes (Bronson), 8/21/2012, at 60:13-15; 302:20-24.

which had no MFN.[234] While a change in ownership and negotiating stance is likely, on its own, to have a significant impact on prices, Dr. Leitzinger simply attributes *any and all* price changes to the existence of MFNs. However, Ms. Helen Hughes, the representative of the Bronson Healthcare group, said that the Aetna rate did not result from the MFN:

> Q. So you don't believe that Plaintiff's 11, the 85 percent rate, was caused by the MFN?
> A. I do not believe it was.[235]

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

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

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

[234] Deposition of Helen M. Hughes (Bronson), 8/21/2012, at 59:8-23. Also see at 303:16-20 (stating that Bronson saw no reason why Aetna should be receiving lower rates at the newly-acquired Bronson LakeView than it was paying at Bronson Methodist.), and Plaintiffs' Exhibit 11 to the Hughes Deposition.

[235] Deposition of Helen M. Hughes (Bronson), 8/21/2012, at 304:15-22.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

170. The record evidence in this matter is in line with the conclusions of the economics literature in recognizing revenues as a driver of hospital quality. The hospitals that form part of the affected combinations are all non-profits, meaning that they are expected to use what would normally be called profits to improve hospital quality and further their community and social missions.[252] A common refrain by the hospital representatives is that increases in revenues make it possible to replace old equipment and that this improves quality of service at a hospital.[253] Ms. Jill Wehner of Harbor Beach expresses this point as follows:

> Q. And how do those additional monies affect the quality of service that Harbor Beach can provide?
> A. It would increase the quality that we can provide.

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

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

[252] See Deposition of Jill Wehner (Harbor Beach), 1/11/2012, at 287:10-12. See also the deposition of Timothy J. Johnson (Eaton Rapids Medical Center), 5/7/2012, at 242: 17-19; also Deposition of Jeffrey Longbrake (Huron Medical Center), 8/29/2012, at 43:5-19.

[253] Deposition of Jill Wehner (Harbor Beach), 1/11/2012, at 285:24-286:8; also Deposition of Timothy Johnson (Eaton Rapids Medical Center), 5/7/2012, at 242:16-243:13; Deposition of Michael Falatko (Hills and Dales), 12/16/2011, at 98:4-20; Deposition of Jeffrey Longbrake (Huron Medical Center), 8/29/2012, at 42:20-25.

> Q. And without those additional dollars, does that mean that the quality would not be as good?
> A. Correct.[254]

171. In addition, lack of revenue may force a hospital to cut back on special programs or services.[255] As Mr. Michael Falatko of Hills and Dales Hospital said:

> Q. And so it's your opinion as the CEO of Hills & Dales that for a hospital to maintain its quality and be able to invest sufficiently in new equipment, it needs to have a sufficient margin in order to stock its capital account?
> A. Correct. You're- - it's what an individual would look at it would look at it as a savings account or whatever…You're accumulating dollars in anticipation of future expenses to either buy new technology or replace your existing technology and buildings.
> Q. Is it fair to say these are savings in anticipation of future expenses?
> A. Yes.
> Q. That are necessary to maintain the quality of the hospital?
> A. Yes.[256]

Mr. Falatko went on to say:

> We've closed clinics in the outreaches that were no longer supporting themselves and we could not subsidize.[257]

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

[254] Deposition of Jill Wehner (Harbor Beach), 1/11/2012, at 286:3-286:8.

[255] Deposition of Michael Falatko (Hills and Dales), 12/16/2011, at 99:2-11; Deposition of William Patrick Miller (Caro Community Hospital), 12/20/2011, at 95:3-17.

[256] Deposition of Michael Falatko (Hills and Dales), 12/16/2011, at 98:4-20.

[257] Deposition of Michael Falatko (Hills and Dales)), 12/16/2011, at 99:6-8.

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

In some cases, extra revenue is essential to the hospital's continued operation.[259] Mr. Kevin Cawley of Sheridan Hospital stated:

> Unless I have a game changing event in terms of new service offerings here, and I'm working on some of those now, but without it, there's no question that this hospital will in fact eventually close.[260]

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

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

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

[259] Deposition of Kevin J. Cawley (Sheridan Hospital), 4/19/2012, 162:11-163:22

[260] Deposition of Kevin J. Cawley (Sheridan Hospital), 4/19/2012, at 163: 9-13.

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

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

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

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

[261] Leitzinger Report at ¶ 79.

[262] Leitzinger Report at ¶ 77.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

183. First, by accelerating negotiations, they improve bargaining efficiency,[270] saving hospitals and payers on negotiating costs, reducing the chance of negotiating breakdown, and reducing uncertainty.[271] These very real benefits must be weighed against any potential alleged anticompetitive harm. The costs of renegotiating a contract can be quite large.[272] In several ways, MFNs can reduce the costs of negotiation. For example, sometimes hospitals may desire MFNs

[269] Leitzinger Report at ¶ 111.

[270] Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 66:17-22 ("I want to clarify that renegotiating with these payors is not solely a result of what Blue Cross is doing but is basically - - we try to do this periodically, so I will say that in this case obviously the Blue Cross agreement accelerated that process …"), and at 270:18-22 ("…we would have went through that process regardless, yes. I can say that, going back to my initial comment, that obviously the Letter of Agreement [MFN] accelerated that process, it did."). Deposition of Richard Harning (Allegan), 11/7/2011, at 63:13-17 ("I was going to increase Priority and United independent of any of this (indicating), independent. The MFD, the Most Favored Discount clause, gave me leverage in negotiating with them.").

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

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

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

184. Second, for hospitals that would have obtained the same level of funding from its payers with or without an MFN, MFNs may shift who would have paid for the higher prices. This may depend on bargaining power and other factors. If the total funding is similar with or without MFNs then necessarily, as a simple arithmetical fact, for some to "lose" by paying more, others have to "win" by paying less. Thus, any aggregated class-wide damages would necessarily reward winners just as much as losers. Rival insurers are very much aware of this "cost shifting" phenomenon in Michigan.[273]

V. ANTITRUST INJURY AND DAMAGES

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

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

[273] Deposition of Kimberley Horn (Priority), 11/12/12 at 35:19-36:23.

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

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

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

[274] Plaintiffs' Motion at 5.

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

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

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

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David S. Sibley
Executed on February 3, 2014

APPENDIX I

CURRICULUM VITAE OF DAVID S. SIBLEY

DAVID S. SIBLEY

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

Education:

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

Teaching Fields:

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

Research Fields:

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

Professional Experience:

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

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

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

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

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

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

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

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

September 1978 – January 1980: Senior Staff Economist, Council of Economic Advisers, Executive Office of the President, Washington, D.C.

October 1973 – September 1978: Member of Technical Staff, Bell Laboratories, Holmdel, NJ.

Teaching:

September 1991 – Present: Introductory Microeconomics, undergraduate and graduate Industrial Organization, business strategy and antitrust law.

Fall 1989: Visiting Lecturer, Woodrow Wilson School of Public and International Affairs, Princeton University. Graduate course in regulation and public choice.

September 1983 – December 1983: Adjunct Lecturer in Economics, University of Pennsylvania. Graduate course on regulation.

Publications:

A. Journal Articles:

"A Note on the Concavity of the Mean-Variance Problem," *Review of Economic Studies*, July 1975.

"Permanent and Transitory Income Effects in a Model of Optimal Consumption with Wage Income Uncertainty," *Journal of Economic Theory*, August 1975.

"Optimal Foreign Borrowing with Export Revenue Uncertainty," (with J. L. McCabe), *International Economic Review*, October 1976.

"The Demand for Labor in a Dynamic Model of the Firm," *Journal of Economic Theory*, October 1977.

"Optimal Decisions with Estimation Risk," (with L. C. Rafsky, R. W. Klein and R. D. Willig), *Econometrica*, November 1977.

"Regulatory Commission Behavior: Myopic vs. Forward-Looking," (with E. E. Bailey), *Economic Inquiry*, June 1978.

"Public Utility Pricing Under Risk: The Case of Self-Rationing," (with J. C. Panzar), *American Economic Review*, December 1978. To be reprinted in *The International Library of Critical Writings in Economics*, Mark Blaug (ed.), Edward Elgar Press.

"A Dynamic Model of the Firm with Stochastic Regulatory Review," (with V. S. Bawa), *International Economic Review*, October 1980.

"Optimal Nonlinear Pricing for Multiproduct Monopolies," (with L. J. Mirman), *Bell Journal of Economics*, Autumn 1980. To be reprinted in *The International Library of Critical Writings in Economics*, Mark Blaug (ed.), Edward Elgar Press.

"Efficiency and Competition in the Airline Industry," (with D. R. Graham and D. P. Kaplan), *Bell Journal of Economics*, Spring 1983.

"Optimal Non-Uniform Pricing," (with M. B. Goldman and H. E. Leland), *Review of Economic Studies*, April 1984. To be reprinted in *The International Library of Critical Writings in Economics*, Mark Blaug (ed.), Edward Elgar Press.

"Reply to Lipman and Further Results," *International Economic Review*, June 1985.

"Public Utility Pricing Under Risk: A Generalization," *Economics Letters*, June 1985.

"Optimal Consumption, the Interest Rate and Wage Uncertainty," (with D. Levhari), *Economics Letters*, 1986.

"Regulating Without Cost Information: The Incremental Surplus Subsidy Scheme," (with D. M. Sappington), *International Economic Review*, May 1989.

"Asymmetric Information, Incentives and Price Cap Regulation," *Rand Journal of Economics*, Fall 1989.

"Optimal Two Part Tariffs for Inputs," (with J. C. Panzar), *Journal of Public Economics*, November 1989.

"Regulating Without Cost Information: Some Further Thoughts," (with D. M. Sappington), *International Economic Review*, November 1990.

"Compensation and Transfer Pricing in a Principal-Agent Model," (with D. E. Besanko), *International Economic Review*, February 1991.

"Thoughts on Nonlinear Pricing Under Price Cap Regulation," (with D. M. Sappington), *Rand Journal of Economics*, Spring 1992.

"Ex Ante vs. Post Pricing: Optional Calling Plans vs. Tapered Tariffs," (with K. Clay and P. Srinagesh), Journal of Regulatory Economics, 1992.

"Optimal Non-linear Pricing With Regulatory Preference over Customer Types," (with W. W. Sharkey), *Journal of Public Economics*, February 1993.

"Regulatory Incentive Policies and Abuse," (with D. M. Sappington), *Journal of Regulatory Economics*, June 1993.

"A Bertrand Model of Pricing and Entry," (with W. W. Sharkey), *Economics Letters*, 1993.

"Optional Two-Part Tariffs: Toward More Effective Price Discounting," (with R. Rudkin) in *Public Utilities Fortnightly*, July 1, 1997.

"Multiproduct Nonlinear Prices with Multiple Taste Characteristics," (with P. Srinagesh), *Rand Journal of Economics*, Winter 1997.

"The Competitive Incentives of Vertically-Integrated Local Exchange Carriers: An Economic and Policy Analysis," (with D. L. Weisman), *Journal of Policy Analysis and Management*, Winter 1998.

"Having Your Cake – How to Preserve Universal-Service Cross Subsidies While Facilitating Competitive Entry," (with M. J. Doane and M. A. Williams), *Yale Journal on Regulation*, Summer 1999.

"Raising Rivals' Costs: The Entry of a Upstream Monopolist into Downstream Markets," (with D. L. Weisman), *Information, Economics and Policy* 10:451-470

"Selected Economic Analysis at the Antitrust Division: The Year in Review," (with K. Heyer), *Review of Industrial Organizations* 23*:* 95-119, 2003

"Pricing Access to a Monopoly Input," (with M. J. Doane, M. A. Williams, and S. Tsai), *Journal of Public Economic Theory*, Vol. 6., No. 4, 2004.

"Antitrust Analysis of Bundled Discounts" with P. Greenlee and D. Reitman. *International Journal of Industrial Organization* 26(5), September, 2008, 1132-1152.
"Comment on Muris and Smith, "Antitrust and Bundled Discounts: An Experimental Analysis", with P. Greenlee and D. Reitman. *Antitrust Law Journal*, 77(2) 2011.

"Entry Timing and Second Mover Advantage". With Du Van Tran and Simon Wilkie. *Journal of Industrial Economics"*. 60(3) September 2012, 517-535.

B. Reports and Articles in Conference Volumes, and Other Publications

"The Dynamics of Price Adjustment in Regulated Industries," (with E. E. Bailey), in *Proceedings of IEEE Conference on Systems Control*, 1974.

"Optimal Non-Uniform Pricing for Electricity: Some Illustrative Examples," (with R. W. Koenker), in Sichel (ed.) *Public Utility Ratemaking in an Energy-Conscious Environment*, Praeger, 1979.

"Antitrust Policy in the Airline Industry," (with S. B. Jollie), Civil Aeronautics Board, October 1982. Transmitted by the CAB to Congress as part of proposed sunset legislation.

"Deregulation and the Economic Theory of Regulation," (with W. W. Sharkey), in *Proceedings of the Eleventh Annual Telecommunications Policy Research Conference*, 1983.

"An Analysis of Tapered Access Charges for End Users," (with W. E. Taylor, D. P. Heyman and J. M. Lazorchak), published in *the Proceedings of the Eighteenth Annual Williamsburg Conference on Regulation*, H. Treeing (ed.), Michigan State, 1987.

Report to the Governor, The Task Force on Market-Based Pricing of Electricity. Co-authored with D. M. Sappington, Appendix III.

"Optional Tariffs for Access in the FCC's Price Cap Proposal," (with D. P. Heyman and W. E. Taylor), in M. Einhorn (ed.), *Price Caps and Incentive Regulation in the Telecommunications Industry*, Kluwer, 1990.

"U.S. v. Microsoft: Were the Exclusionary Practices Anticompetitive " (with Michael J. Doane), Computer Industry Newsletter, American Bar Association, Spring 2000, Vol. 5., No. 1.

"Exclusionary Restrictions in U.S. vs. Microsoft," (with M.J. Doane and A. Nayyar), *UWLA Law Review*, 2001.

"U.S. v. Microsoft: Is the Proposed Settlement in the Public Interest?" (with Michael J. Doane), *Computer Industry Newsletter*, American Bar Association, Spring 2002, Vol. 7, No. 1.

"Raising Rivals' Costs: An Analysis of Barnes and Noble's Proposed Acquisition of Ingram Book Company," 2002, Book Chapter in *Measuring Market Power*, Edited by Daniel Slottje, North Holland (with Michael J. Doane).

C. Books:

The Theory of Public Utility Pricing, (with S. J. Brown), Cambridge University Press, 1986. Second printing 1986. Third printing 1989.

Co-editor of *Telecommunications Demand Analysis*: *An Integrated View*, North-Holland, 1989.

Editorial Duties:

Associate Editor of the *Journal of Regulatory Economics*.

Guest Editor of "Bundling Rebates: The Quest for an Antitrust Theory," *Antitrust Bulletin* 50(3), Fall 2005.

Editorial Board of *Review of Industrial Organization* 2005-present.

Unpublished Manuscripts and Revisions:

"Tying and Bundled Discounts: Equilibrium Analysis of Section 2 Liability Tests," with Matthew Sibley. Under Revision for *Antitrust Law Journal.*

"Network Congestion and the Unilateral Effects Analysis of Mergers", with Brijesh P. Pinto. Submitted to *International Journal of Industrial Organization.*

Other Professional Activities:

Consultant to the Governor of New Jersey's Task Force on Market-Based Pricing of Electricity.

Referee for National Science Foundation and numerous professional journals.

Consulting for Bell operating companies on a variety of pricing and public policy issues.

Memberships: American Economic Association, American Bar Association; listed in *Who's Who in the East* 1990.

Prior Reports and Expert Testimony within Past Four Years:

UNITED STATES DISTRICT COURT, DISTRICT OF DELAWARE
ZF Meritor LLC and Meritor Transmission Corporation v. Eaton Corporation
Expert Report (2013)

UNITED STATES DISTRICT COURT, MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION

In re: Photochromic Lens Antitrust Litigation
Expert report and deposition testimony (2012 - 2013)

DISTRICT COURT OF HARRIS COUNTY, TEXAS, 80TH JUDICIAL DISTRICT
Rx.com, Inc and Joe S. Rosson v. John M. O'Quinn & Associates, PLLC d/b/a The O'Quinn Law Firm, *et al.*
Statement of Opinions (2012) and deposition testimony (2012)

DISTRICT COURT OF HARRIS COUNTY, TEXAS, 234TH JUDICIAL DISTRICT
Stealth, L.P. v. Aetna Health, Inc., *et al.*
Statement of Opinions (2011) and deposition testimony (2011).

THE DISTRICT COURT OF THE 22ND JUDICIAL DISTRICT SITTING IN AND FOR SEMINOLE COUNTY, SEMINOLE DIVISION, STATE OF OKLAHOMA
Canadian Valley Electric Cooperative, Inc. v. Western Farmers Electric Cooperative, Inc.
Expert Report (2011) and deposition testimony (2011).

UNITED STATES DISTRICT COURT, EASTERN DISTRICT OF TEXAS, MARSHALL DIVISION
Wi-LAN, Inc. v. Acer, Inc., *et al.*
Expert Report (2010).

UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA, SOUTHERN DIVISION
Arminak & Associates, Inc. v. Saint-Gobain Calmar, Inc., now known as MeadWestvaco Calmar, Inc.
Expert Report (2010).

APPENDIX II

LIST OF DOCUMENTS CONSIDERED

COURT DOCUMENTS

Complaint, Civil Action No. 2:10-cv-14155-DPH-MKM (10/18/2010).
Class Action Complaint, Civil Action No. 2:11-cv-10375-DPH-VMM (1/28/2011).
Consolidated Amended Complaint, Civil Action No. 2:10-cv-14360-DPH-MKM (6/12/2012).
Defendant's Motion for Summary Judgment with Exhibits, Civil Action No. 11-cv-15346-DPH-MKM (10/25/2013)
Memorandum Opinion and Order, in re: Evanston Northwestern Corporation Antitrust Litigation, Civil Action No. 07-cv-04446, 2013 WL 6490152 (N.D.Ill.) (12/10/2013).
Plaintiffs' Motion for Class Certification and Appointment of Class Counsel (with exhibits), Civil Action No. 2:10-cv-14360-DPH-MKM (10/21/2013).

EXPERT REPORT OF DR. LEITZINGER

Expert Report of Jeffrey Leitzinger, Ph.D. in Support of Plaintiff's Motion for Class Certification (with exhibits and supporting material, including computer programs, input data files, and associated documentation), Civil Action No. 2:10-cv-14360-DPH-MKM (10/21/2013).

OTHER EXPERT REPORTS

Expert Report of David T. Scheffman, Ph.D. (with exhibits), Civil Action No. 2:11-cv-15346-DPH-MKM (4/17/2013).
Expert Report of Dr. Christopher A. Vellturo (with exhibits), Civil Action No. 2:11-cv-15346-DPH-MKM (6/07/2013).
Expert Report of Dr. David Dranove Supporting Motion for Class Certification (redacted version for public file), Master Docket No. 07-CV-4446 (2/18/2009).
Rebuttal Expert Report of Dr. Christopher A. Vellturo (with exhibits), Civil Action No. 2:11-cv-15346-DPH-MKM (6/7/2013).
Reply Report of Dr. David Dranove Supporting Motion for Class Certification (redacted version for public file), Master Docket No. 07-CV-4446 (12/8/2009).

ACADEMIC, INDUSTRY, AND GOVERNMENT PUBLICATIONS

Avalere Health LLC. "Valuing the Social Mission Activities of Blue Cross Blue Shield Michigan." January 2008.
Baker, Jonathan B. and Judith A. Chevalier (2013), "The competitive consequences of most-favored-nation provisions," *Antitrust* 27(2).
Bertrand, Marianne, Esther Duflo, and Sendhil Mullainathan (2004), "How Much Should We Trust Differences-In-Differences Estimates?" *Quarterly Journal of Economics* 119(1).
Brooks, John M., Avi Dor, and Herbert S. Wong (1997), "Hospital-Insurer Bargaining: An Empirical Investigation of Appendectomy Pricing," *Journal of Health Economics* 16(4).
Chen, Hsueh-Fen, Gloria J. Bazzoli, and Hui-Min Hsieh (2009), "Hospital Financial Conditions and the Provision of Unprofitable Services," *Atlantic Economic Journal* 37(3).
Cuellar, Alison Evans and Paul J. Gertler (2005), "How the Expansion of Hospital Systems has Affected Consumers," *Health Affairs* 24(1)
Dafny, Leemore, David Dranove, and Guillermo Israilevich, "Underpayment of Hospitals by Private Insurers: Risks to Health and Healthy Competition" (undated manuscript).
Deneffe, Daniel and Robert T. Mason (2002), "What do not-for-profit hospitals maximize?" *International Journal of Industrial Organization* 20.
Department of Justice, "Background to Closing of Investigation of UnitedHealth Group's Acquisition of Oxford Health Plans" (July 20, 2004) available at http://www.usdoj.gov/atr/public/press_releases/2004/204676.htm
Devers, Kelly J., et al. (2003) "Hospitals' Negotiating Leverage with Health Plans: How and Why Has It Changed?" Health Services Research 38(1) Part II.
Encinosa, William E. and Didem M. Bernard (2005), "Hospital finances and patient safety outcomes," *Inquiry* 42(1).

Gaynor, Martin and William B. Vogt, "Antitrust and competition in health care markets," chapter prepared for *Handbook of Health Economics*, Anthony J. Culyer and Joseph P. Newhouse (eds), April 30, 1999.
Hal Cohen, Inc. Health Care Consulting, "More than a Decade of Quality, Efficiency, and Value Improvements at Michigan Hospitals: 2009 Update." 2009.
Ho, Katherine (2009), "Insurer-Provider Networks in the Medical Care Market," *American Economic Review* 99(1).
Horwitz, Jill R. (2005), "Making profits and providing care: Comparing nonprofit, for-profit, and government hospitals," *Health Affairs* 24(3).
Hyman, David and William Kovacic (2004), "Monopoly, Monopsony, And Market Definition: An Antitrust Perspective on Market Concentration among Health Insurers," *Health Affairs* 23(6).
Lindrooth, Richard C., Gloria J. Bazzoli, and Jan Clement (2007), "The effect of reimbursement on the intensity of hospital services," 73(3).
Lynk, William J. (2000), "Some Basics about Most Favored Nation Contracts in Health Care Markets," *Antitrust Bulletin* 45.
Morrisey, Michael A. *Health Insurance*. Health Administration Press. Chicago, Illinois. 2008.
Porter, Robert H. (1983), "A study of cartel stability: The Joint Executive Committee, 1880-1886." *Bell Journal of Economics* 14(2).
Sallee, Caroline M., Darci R. Keyes, and Patrick L. Anderson (2007), "Role of Blue Cross in Michigan's Health Insurance Market," Anderson Economic Group, LLC.
Seshamani, Meena, Jingsan Zhu, and Kevin G. Volpp (2006), "Did postoperative mortality increase after the implementation of the Medicare Balanced Budget Act?" *Medical Care* 44(6).
Shen, Yu-Chu (2003), "The effect of financial pressure on the quality of care in hospitals," *Journal of Health Economics* 22.
Smith, Stephen (2013), "When Most-Favored is Disfavored: A Counselor's Guide to MFNs", Antitrust 27(2).
Sorensen, Alan T. (2003), "Insurer-Hospital Bargaining: Negotiated Discounts in Post-Deregulation Connecticut," *Journal of Industrial Economics* 51(4).
Tay, Abigail (2003), "Assessing Competition in Hospital Care Markets: The Importance of Accounting for Quality Differentiation," *RAND Journal of Economics* 34(4).
Town, Robert and Gregory Vistnes (2001), "Hospital competition in HMO networks," *Journal of Health Economics* 20(5).
U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC), Horizontal Merger Guidelines, 2010.
Varney, Christine A., FTC Commissioner, "New Directions at the FTC: Efficiency Justifications in Hospital Mergers and Vertical Integration Concerns," Remarks before the Healthcare Antitrust Forum, Chicago, May 2, 1995, available at http://www ftc.gov/speeches/varney/varht.shtm.
White, Chapin, Amelia M. Bond, and James D. Reschovsky (2013), "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power," *Center for Studying Health System Change Research Brief No* 27.

DEPOSITIONS AND/OR EXHIBITS

Deposition of Alan Byrnes (11/26/2012)
Deposition of Amy Ruedisueli (1/10/2012)
Deposition of Anne Patrice Noah (1/09/2014)
Deposition of Bill Berenson (10/11/2012)
Deposition of Brian Rodgers (12/07/2012)
Deposition of Christopher Vellturo (9/17/2013 & 9/18/2013)
Deposition of Chuck Nelson (9/19/2012)
Deposition of Dan Babcock (1/13/2012)
Deposition of David Brown (10/02/2012)
Deposition of David T. Scheffman (9/26/2013 & 10/27/2013)
Deposition of Donald Whitford (11/20/2012)
Deposition of Douglas Darland (11/14-15/2012)
Deposition of Eric Kropfreiter (9/18/2012)
Deposition of Gerald Messana (3/20/2012)
Deposition of Gerald Noxon (10/04/2012)
Deposition of Gretchen Kline (11/15/2012)
Deposition of Helen M. Hughes (8/21/2012)

Deposition of Jason Anderson (3/16/2012)
Deposition of Jeffrey Connolly (8/27/2012)
Deposition of Jeffrey Leitzinger (12/10/2013)
Deposition of Jeffrey Longbrake (8/29/2012)
Deposition of Jill Wehner (1/11/2012)
Deposition of Joan Budden (11/05/2012)
Deposition of Joan Janks (1/17/2014)
Deposition of John Dunn (10/12/2012)
Deposition of Joseph Fifer (8/23/2012)
Deposition of Karmon Bjella (12/13/2011)
Deposition of Kelly Wright (10/19/2012)
Deposition of Kenneth Matzick (11/13/2012)
Deposition of Kevin J. Cawley (4/19/2012)
Deposition of Kim Capps (3/29/2012)
Deposition of Kim Sorget (10/16/2012 & 10/17/2012)
Deposition of Kimberly Horn (11/12/2012)
Deposition of Kirk Rosin (11/27/2012)
Deposition of Laura Eory (11/12/2012)
Deposition of Mark Bertolini (12/03/2012)
Deposition of Mark Gross (11/15/2012)
Deposition of Mark Hall (11/14/2012)
Deposition of Mark Johnson (10/30/2012)
Deposition of Michael Falatko (12/16/2011 & 1/11/2012)
Deposition of Michael Grisdela (10/24/2012)
Deposition of Michael Koziara (11/19/2012)
Deposition of Nickolas Vitale (11/12/2012)
Deposition of Patrick McGuire (8/14/2012)
Deposition of Paula Reichle (8/08/2012)
Deposition of Peter Schonfeld (11/02/2012)
Deposition of Pramod Sahney (8/17/2012)
Deposition of Richard Felbinger (8/29/2012)
Deposition of Richard Harning (11/07/2011)
Deposition of Robert Milewski (10/11/2012)
Deposition of Robert Smith (11/14/2012)
Deposition of Ronald Crofoot (11/29/2012)
Deposition of Scott Wilkerson (10/31/2012)
Deposition of Steve Andrews (11/02/2011)
Deposition of Steven Leach (3/15/2012)
Deposition of Susan Baynard (1/13/2014)
Deposition of Suzanne Hall (11/15/2012)
Deposition of Terrence Burke (9/18/2012)
Deposition of Terry Lutz (1/12/2012)
Deposition of Thomas Sargent (12/14/2012)
Deposition of Timothy J. Johnson (5/07/2012)
Deposition of William Jackson (3/02/2012)
Deposition of William Patrick Miller (12/20/2011)
Deposition of William Roeser (8/08/2012)

WEBSITES

http://cah.org/
http://www.aetna.com/
http://www.aghosp.org/
http://www.aha.org/
http://www.ahd.com/

http://www.bcbsm.com/
http://www.beaumont.edu/
http://www.cms.gov/
http://www mercyhealthmuskegon.com/
http://www munsonhealthcare.org/
http://www.priorityhealth.com/
http://www.sparrow.org/
http://www.stjohnprovidence.org/
http://www.threeriversshealth.org/
https://www.bronsonhealth.com
https://www.hap.org

OTHER DOCUMENTS

BCN Responses to 1.9.2013 Class Questions re: BCN Data.
Blue Cross Blue Shield of Michigan 2010 Annual Report
Blue Cross Blue Shield of Michigan 2011 Annual Report
DOJ BCBSM BCN FACETS Questions, 11/19/2012.
DOJ BCBSM EDW Questions, 11/19/2012.
Letter from M. Alamo to D. Hedlund re: BCBSM Responses to DOJ's 11.19.2012 Questions Regarding BCN FACETS DATA, 1/22/2013.
Letter from M. Fait to S. Hessen re: Steven Andrews Deposition which is to take place on November 2, 2011., 10/31/2011.
Letter from Mr. Nickolas A. Vitale (Senior Vice President, Beaumont Hospitals) to Mr. Van Conway of Conway McKenzie, Inc. (dated March 25, 2010).
Letter from S. Wilson to J. Beach, re: Aetna v. Blue Cross Blue Shield of Michigan Litigation, 12/17/2012.
Letter from S. Wilson to J. Beach, re: Aetna v. Blue Cross Blue Shield of Michigan Litigation, 12/26/2012.
Letter from S. Wilson to R. Danks and J. Martin, re: Aetna v. Blue Cross Blue Shield of Michigan Litigation, 8/24/2012.
PHA+Workshop+-+All+Slides+Draft+-+2010-06-11+v3[1].ppt
Responses to Question re: Shane Group's Feb 14 2013 BCBSM Data Questions, 11/19/2013.
Supplemental Responses to Feb 14, 2013 Revised Questions for BCBSM Regarding EDW and BCN Data.

BATES NUMBERED DOCUMENTS

AETNA-00068037
AETNA-00070388
AETNA-00071138
AETNA-00071563
AETNA-00072525
AETNA-00075021
AETNA-00077640
AETNA-00176118
AGH-04-000049
AGH-04-00049
AGH-13-000241
AHGH-004035
AHSJP-044917
ASHLT-0127681
BEAU-DOJ-00064156
BLUECROSSMI-08-004240
BLUECROSSMI-08-023739
BLUECROSSMI-10-002455
BLUECROSSMI-98-000531

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HCRIS DATA

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HOSPITAL96CostCenterCodes.pdf
HOSPITAL96FileDataElements.xls
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HOSPITAL96WORKSHEET_CODES.pdf

HCRIS 2552-10:
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HOSP2010_CSTCODES.pdf
HOSP2010_README_UPDATE.txt
HOSP2010_Worksheet Codes.pdf

PERSONAL CONVERSATIONS

John Dunn
Gerald Noxon
Kim Sorget

APPENDIX III

TABLES AND FIGURES

TABLE 1
NET OPERATING MARGINS FOR "AFFECTED" HOSPITALS

Hospital Name & Measure[3]	2005	2006	2007	2008	2009	2010	2011	2012
Allegan General Hospital								
Net Patient Income ($)	-2,509,307	509,934	-511,670	409,019	39,592	1,556,226	-629	-391,293
Net Operating Margin (%)	-8.24	1.46	-1.34	1.02	0.11	3.62	0.00	-0.91
Beaumont Hospital - Grosse Pointe[4, 5]								
Net Patient Income ($)	-26,835,628	-27,817,602	-20,327,551	-16,968,545	-9,170,364	-5,739,597	2,250,686	9,970,740
Net Operating Margin (%)	-19.07	-19.14	-14.09	-11.40	-5.89	-3.70	1.35	5.65
Beaumont Hospital - Royal Oak								
Net Patient Income ($)	-12,120,662	-15,354,234	-5,501,000	1,914,912	19,785,554	37,043,959	30,513,722	43,593,812
Net Operating Margin (%)	-1.16	-1.43	-0.49	0.16	1.64	3.13	2.57	3.62
Beaumont Hospital - Troy								
Net Patient Income ($)	22,448,513	15,395,446	20,695,187	15,341,131	21,788,411	22,607,894	30,395,774	39,675,127
Net Operating Margin (%)	6.10	3.80	4.58	3.24	4.44	4.42	5.95	7.33
Bronson LakeView Hospital[4]								
Net Patient Income ($)	418,102	709,645	-3,706,974	412,685	-132,433	-1,083,091	1,482,246	-1,810,973
Net Operating Margin (%)	1.19	1.99	-9.40	0.92	-0.24	-1.92	2.45	-3.59

TABLE 1
NET OPERATING MARGINS FOR "AFFECTED" HOSPITALS
(CONTINUED)

Hospital Name & Measure[3]	2005	2006	2007	2008	2009	2010	2011	2012
Charlevoix Area Hospital[4]								
Net Patient Income ($)	630,633	-690,022	-722,252	-1,197,927	-1,736,332	-933,418	-3,659,690	-1,845,693
Net Operating Margin (%)	2.32	-2.49	-2.39	-3.80	-5.57	-2.83	-11.66	-5.18
Kalkaska Memorial Health Center[2, 4]								
Net Patient Income ($)	125,272	662,814	1,411,892	1,727,006	1,294,092	798,142	-8,071	-358,334
Net Operating Margin (%)	0.75	3.56	6.92	7.61	5.23	3.04	-0.03	-2.74
Mercy Health Partners, Lakeshore Campus[2, 4]								
Net Patient Income ($)	938,305	1,013,784	1,523,886	1,421,068	484,799	45,134	806,305	866,995
Net Operating Margin (%)	8.85	8.97	12.79	10.27	2.97	0.23	3.49	7.10
Paul Oliver Memorial Hospital[2, 4]								
Net Patient Income ($)	224,286	358,922	457,081	417,009	512,502	709,611	871,481	480,921
Net Operating Margin (%)	1.98	2.92	3.46	3.01	3.58	4.71	5.35	5.64
Providence Park Hospital[1, 2, 4]								
Net Patient Income ($)	11,015,864	23,384,537	19,138,256	-4,109,910	-20,750,569	-16,241,371	1,566,871	6,588,052
Net Operating Margin (%)	2.21	4.47	3.55	-0.72	-3.46	-2.67	0.26	2.15

TABLE 1
NET OPERATING MARGINS FOR "AFFECTED" HOSPITALS
(CONTINUED)

Hospital Name & Measure[/3]	2005	2006	2007	2008	2009	2010	2011	2012
Sparrow Ionia Hospital[/4]								
Net Patient Income ($)	-1,114,418	-1,689,274	-2,170,361	-1,915,442	-1,758,236	-580,255	-130,028	710,588
Net Operating Margin (%)	-6.20	-8.88	-10.58	-8.11	-6.69	-2.19	-0.48	2.39
St. John Hospital and Medical Center[/2, 4]								
Net Patient Income ($)	3,137,475	-352,795	-10,275,728	-8,950,707	619,304	-4,936,016	-14,239,860	-7,895,046
Net Operating Margin (%)	0.59	-0.06	-1.74	-1.42	0.10	-0.74	-2.05	-2.27
Three Rivers Health								
Net Patient Income ($)	-156,930	-90,585	-3,153,440	-6,315,514	-4,618,446	-4,510,730	-4,562,655	-1,219,151
Net Operating Margin (%)	-0.36	-0.19	-6.35	-13.30	-9.96	-9.19	-10.39	-2.60

Source: HCRIS FY2004-2012.
Notes:
/1 Reports jointly with Providence Hospital.
/2 Partial calendar year data for 2012.
/3 Net Patient Income equals Net Patient Revenues less Total Operating Expenses. Net Operating Margin equals Net Patient Income divided by Net Patient Revenues. Net Patient Revenues include revenue from inpatient and outpatient services.
/4 Financial measures adjusted to calendar year basis.
/5 Beaumont Hospitals acquired Bon Secours Hospital on October 1, 2007 and renamed the facility Beaumont Hospital – Grosse Pointe. See Beaumont Health System website, <https://www.beaumont.edu/press/news-stories/2007/10/beaumont-hospitals-acquires-bon-secours/> (January 17, 2014).

TABLE 2
SUMMARY OF ALTERNATIVE DID ANALYSES

Hospital Name	Insurer	Network	DID (MFN*Post Period)/1		
			Leitzinger Report/2 Quarterly	Alternative Model 1/3 Aggregated	Alternative Model 2/4 Aggregated
Beaumont Hospital - Grosse Pointe	BCBSM	PPO	0.158***	0.212*	0.194*
Beaumont Hospital - Royal Oak	BCBSM	PPO	0.009	0.009	0.014
Beaumont Hospital - Troy	BCBSM	PPO	0.028	0.032	-0.003
Providence Park Hospital	BCBSM	PPO	0.136**	0.200**	0.177*
St. John Hospital and Medical Center	BCBSM	PPO	0.029**	0.030	0.030
Allegan General Hospital	Priority	HMO	0.213***	0.181	0.105
Allegan General Hospital	Priority	PPO	0.246***	0.221	0.144
Charlevoix Area Hospital	Priority	PPO	0.289***	0.282	0.202
Kalkaska Memorial Health Center	Priority	PPO	0.446***	0.808	0.810**
Mercy Health Partners, Lakeshore Campus	Priority	HMO	0.433***	0.431**	0.381**
Mercy Health Partners, Lakeshore Campus	Priority	PPO	0.354***	0.350	0.270
Paul Oliver Memorial Hospital	Priority	HMO	0.333***	-0.440	0.642
Paul Oliver Memorial Hospital	Priority	PPO	0.403***	1.377	1.308
Sparrow Ionia Hospital	Priority	HMO	0.217***	0.211	0.178
Beaumont Hospital - Grosse Pointe	HAP	AHL	0.208***	0.207	0.153
Beaumont Hospital - Grosse Pointe	HAP	PHP	0.080***	0.173	-0.211
Beaumont Hospital - Royal Oak	HAP	AHL	0.103***	0.125	0.045
Beaumont Hospital - Royal Oak	HAP	HMO	0.115***	0.118	0.045
Beaumont Hospital - Royal Oak	HAP	PHP	0.086***	0.093	0.055
Beaumont Hospital - Troy	HAP	AHL	0.102**	0.127**	-0.044
Beaumont Hospital - Troy	HAP	PHP	0.090***	0.247	0.100
Bronson LakeView Hospital	Aetna	PPO	0.178***	0.301	0.266**
Three Rivers Health	Aetna	PPO	0.321***	0.313**	0.316**

Notes:
/1 Regression analysis using data used in Dr. Leitzinger's regression analysis. Symbols ***, **, and * denote statistical significance at the 1%, 5%, and 10% levels respectively.
/2 Coefficients reported in Leitzinger Report Exhibit 8 (corrected). Statistical significance is determined using p-values reported in Leitzinger Report Exhibit 8 (corrected).
/3 DID analysis is performed using a two-period dataset constructed by taking the averages of the dependent and independent variables in Dr. Leitzinger's pre and post periods. Statistical significance is determined using OLS standard errors.
/4 DID analysis is performed using a two-period dataset constructed by taking the averages of the dependent and independent variables in the following two periods: (1) the eight quarters preceding Dr. Leitzinger's first post-period quarter and (2) the first eight quarters in Dr. Leitzinger's post period. Statistical significance is determined using OLS standard errors.

TABLE 3
PLAUSIBILITY OF REDUCTION IN PAYMENTS FOR BEAUMONT HOSPITAL COMBINATIONS

Hospital Name	Insurer	Network	Reduction in Payments ($)	Net Patient Income[/1, 4] ($)	Actual Net Operating Margin[/5] (%)	But-For Net Operating Margin[/6] (%)
Beaumont Hospital - Grosse Pointe[/2]	BCBSM	PPO	36,017,576	-12,659,275	-2.65	-11.56[/7]
	HAP	AHL	1,158,977			
	HAP	PHP	907,994			
		Total	*38,084,547*			
Beaumont Hospital - Royal Oak[/3]	BCBSM	PPO	27,405,839	69,959,370	1.02	-0.06
	HAP	AHL	6,078,438			
	HAP	HMO	27,399,650			
	HAP	PHP	13,217,302			
		Total	*74,101,228*			
Beaumont Hospital - Troy[/3]	BCBSM	PPO	33,621,329	124,663,209	4.45	2.91
	HAP	AHL	3,574,952			
	HAP	PHP	7,053,896			
		Total	*44,250,176*			

Notes:
/1 Financial data from HCRIS.
/2 Financial data for 12-month reporting periods ending December 31 of 2009, 2010, and 2011. MFN effective January 1, 2009 through January 1, 2012.
/3 Financial data for 12-month reporting periods ending December 31 of 2006, 2007, 2008, 2009, 2010, 2011, and 2012. MFN effective February 7, 2006 through January 1, 2012. Financial data for 2006 adjusted to MFN effective period by multiplying financial measures by the ratio of number of days for which MFN is effective (328) to number of days in the year (365).
/4 Equals Net Patient Revenues less Total Operating Expenses.
/5 Equals Net Patient Income divided by Net Patient Revenues.
/6 Equals Net Patient Income less Reduction in Payments divided by Net Patient Revenues less Reduction in Payments.
/7 But-For Net Operating Margin for reduction in BCBSM PPO payments only is -11.04%.

TABLE 4
DID RESULTS FOR BCBSM AT AETNA AND PRIORITY "AFFECTED" HOSPITALS

Hospital Name	MFN Type	Insurer	Network	Hospital Peer Group	Control Peer Group	DID (MFN*Post Period)/1	p-value/1
Allegan General Hospital	Equal-to-MFN	BCBSM	PPO	5	4	0.5%	0.836
Bronson LakeView Hospital	Equal-to-MFN	BCBSM	PPO	5	4	1.1%	0.805
Charlevoix Area Hospital	Equal-to-MFN	BCBSM	PPO	5	4	-12.7%	0.000
Kalkaska Memorial Health Center	Equal-to-MFN	BCBSM	PPO	5	4	-21.4%	0.000
Mercy Health Partners, Lakeshore Campus	Equal-to-MFN	BCBSM	PPO	5	4	-13.9%	0.002
Paul Oliver Memorial Hospital	Equal-to-MFN	BCBSM	PPO	5	4	-12.4%	0.082
Three Rivers Health	Equal-to-MFN	BCBSM	PPO	5	4	-8.2%	0.000

Note:
/1 Regression using insurer claims data obtained from Dr. Leitzinger's backup material and SAS regression code. The post period is based on hospital MFN effective dates provided in Dr. Leitzinger's backup material. Control group selection is based on Dr. Leitzinger's methodology.

TABLE 5
DID RESULTS FOR HAP PHP "AFFECTED" COMBINATIONS WITH EXCLUDED CONTROL HOSPITALS

Hospital Name	Excluded Control Hospital	Hospital Peer Group	Control Peer Group	DID (MFN*Post Period)/1	p-value/1
Beaumont Hospital - Grosse Pointe	Lakeland Regional Medical Center-St. Joseph	2	2	3.18%	0.157
Beaumont Hospital - Grosse Pointe	McLaren Bay Regional	2	2	1.94%	0.427
Beaumont Hospital - Troy	Lakeland Regional Medical Center-St. Joseph	2	2	0.08%	0.970
Beaumont Hospital - Troy	McLaren Bay Regional	2	2	2.97%	0.172

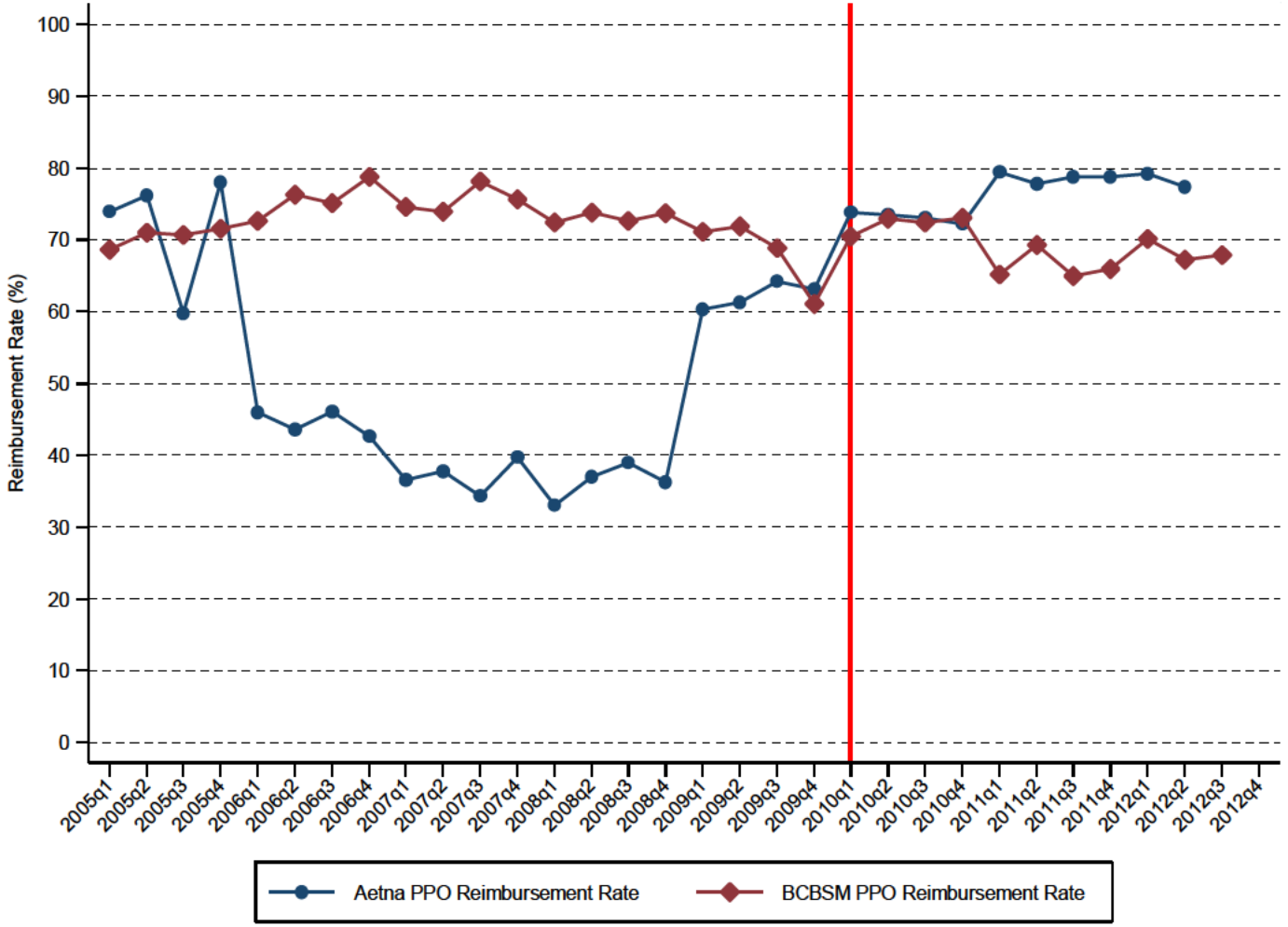
Note:
/1 Regression using insurer claims data obtained from Dr. Leitzinger's backup material and SAS regression code.

TABLE 6
DID RESULTS AT CONTROL GROUP HOSPITALS
"AFFECTED" COMBINATION: BEAUMONT HOSPITAL – ROYAL OAK HAP HMO

Control Hospital Considered Affected	Insurer	Network	DID (MFN*Post Period)/1	p-value/1
Detroit Receiving Hospital/University Health Center	HAP	HMO	8.79%	0.000
Doctors' Hospital of Michigan	HAP	HMO	14.41%	0.000
Garden City Hospital	HAP	HMO	-20.22%	0.000
Harper University Hospital / Hutzel Women's Hospital	HAP	HMO	-0.70%	0.849
Henry Ford Hospital	HAP	HMO	-1.79%	0.561
McLaren Flint	HAP	HMO	8.82%	0.000
McLaren Macomb	HAP	HMO	-9.56%	0.000
McLaren Oakland	HAP	HMO	-5.30%	0.078
Oakwood Hospital & Medical Center-Dearborn	HAP	HMO	7.67%	0.001
Sinai-Grace Hospital	HAP	HMO	-6.50%	0.002
St. Joseph Mercy Oakland	HAP	HMO	13.83%	0.029
University of Michigan Hospitals and Health Centers	HAP	HMO	-13.22%	0.000

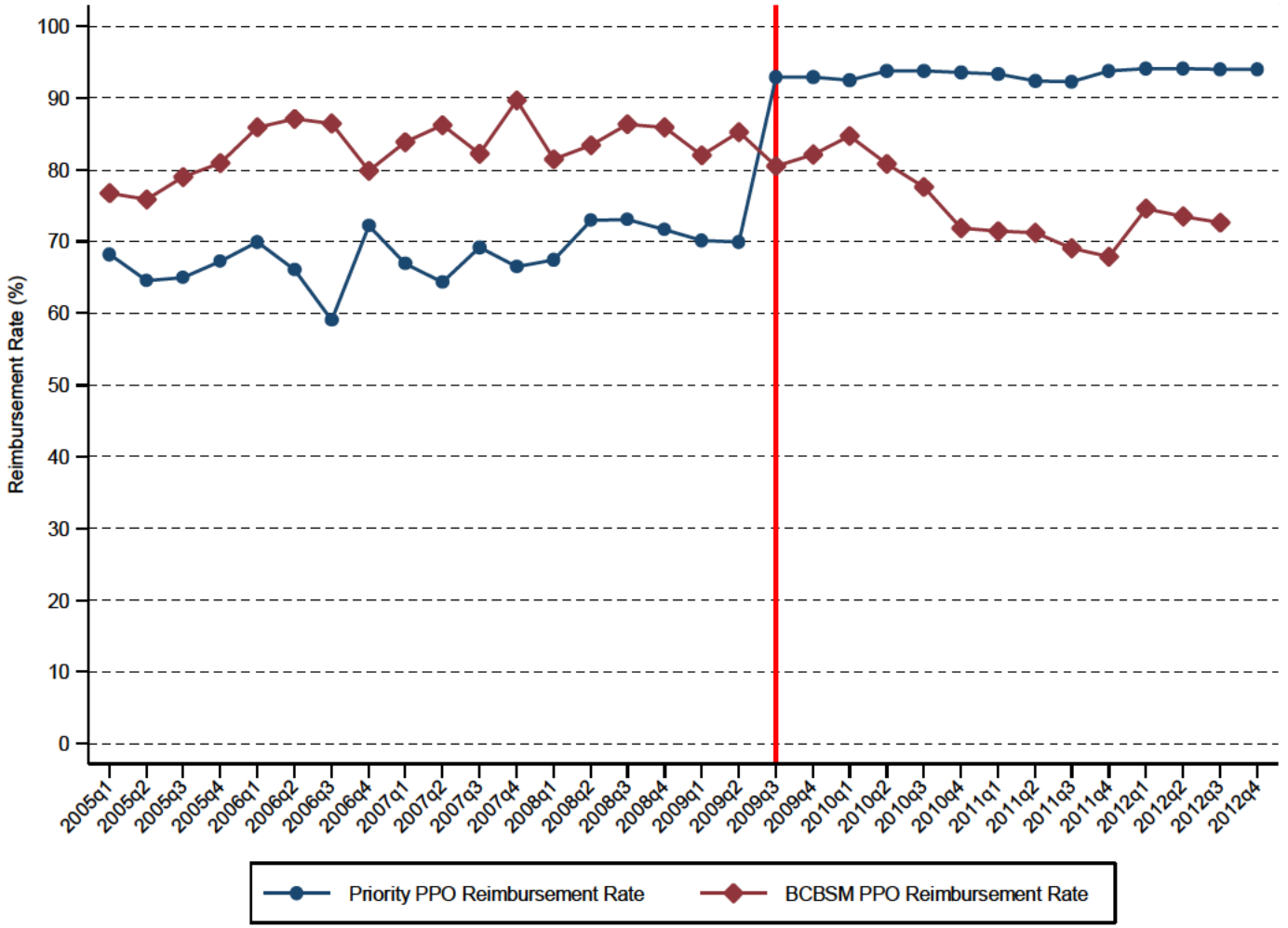
Note:
/1 Regression using insurer claims data obtained from Dr. Leitzinger's backup material and SAS regression code. Regression analysis based on post period used in Dr. Leitzinger's DID regression for the "affected" combination Beaumont Hospital - Royal Oak HAP HMO.

FIGURE 1
AETNA PPO & BCBSM PPO - THREE RIVERS HEALTH - REIMBURSEMENT RATES



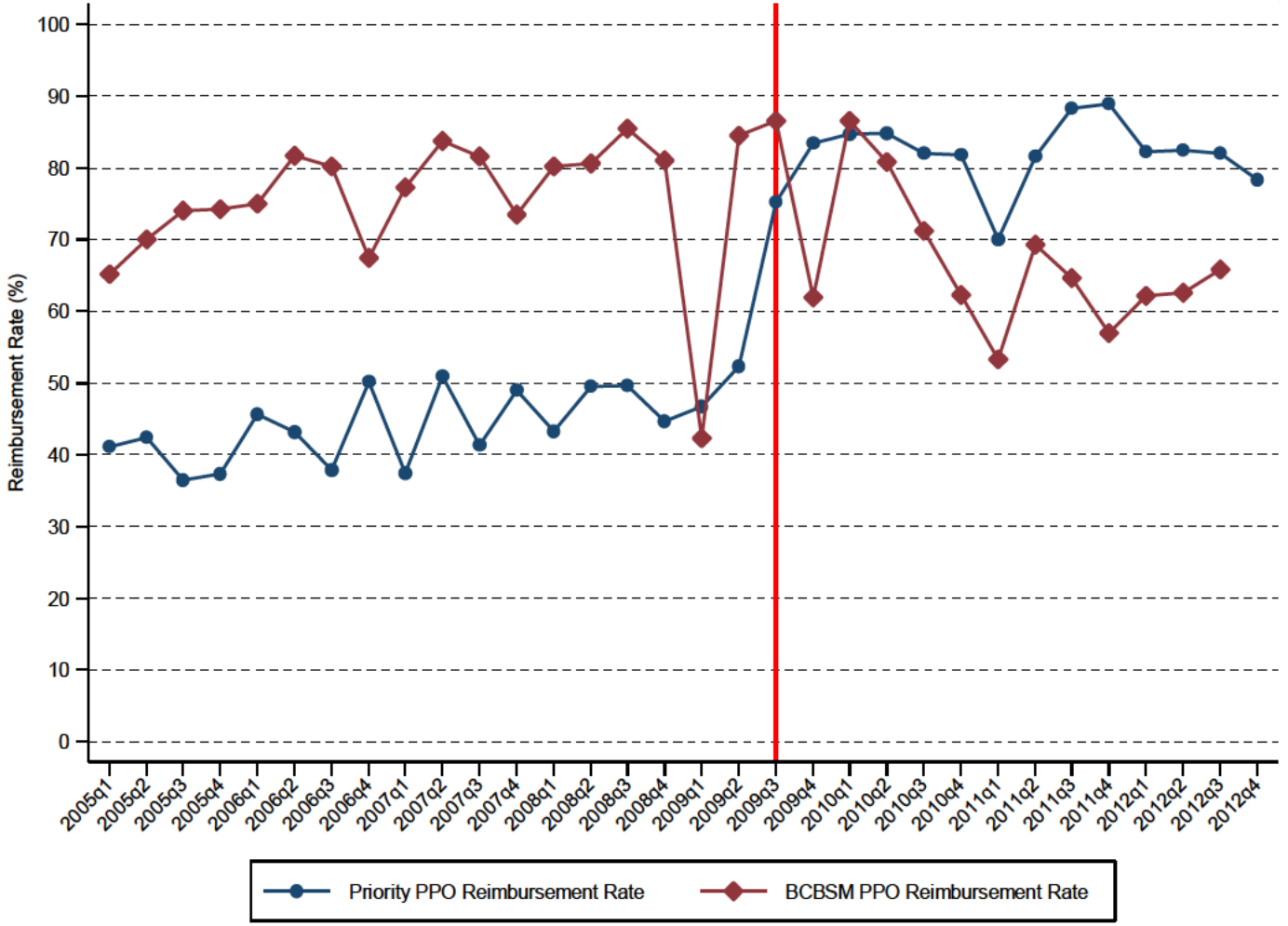
Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

FIGURE 2
PRIORITY PPO & BCBSM PPO - CHARLEVOIX AREA HOSPITAL - REIMBURSEMENT RATES



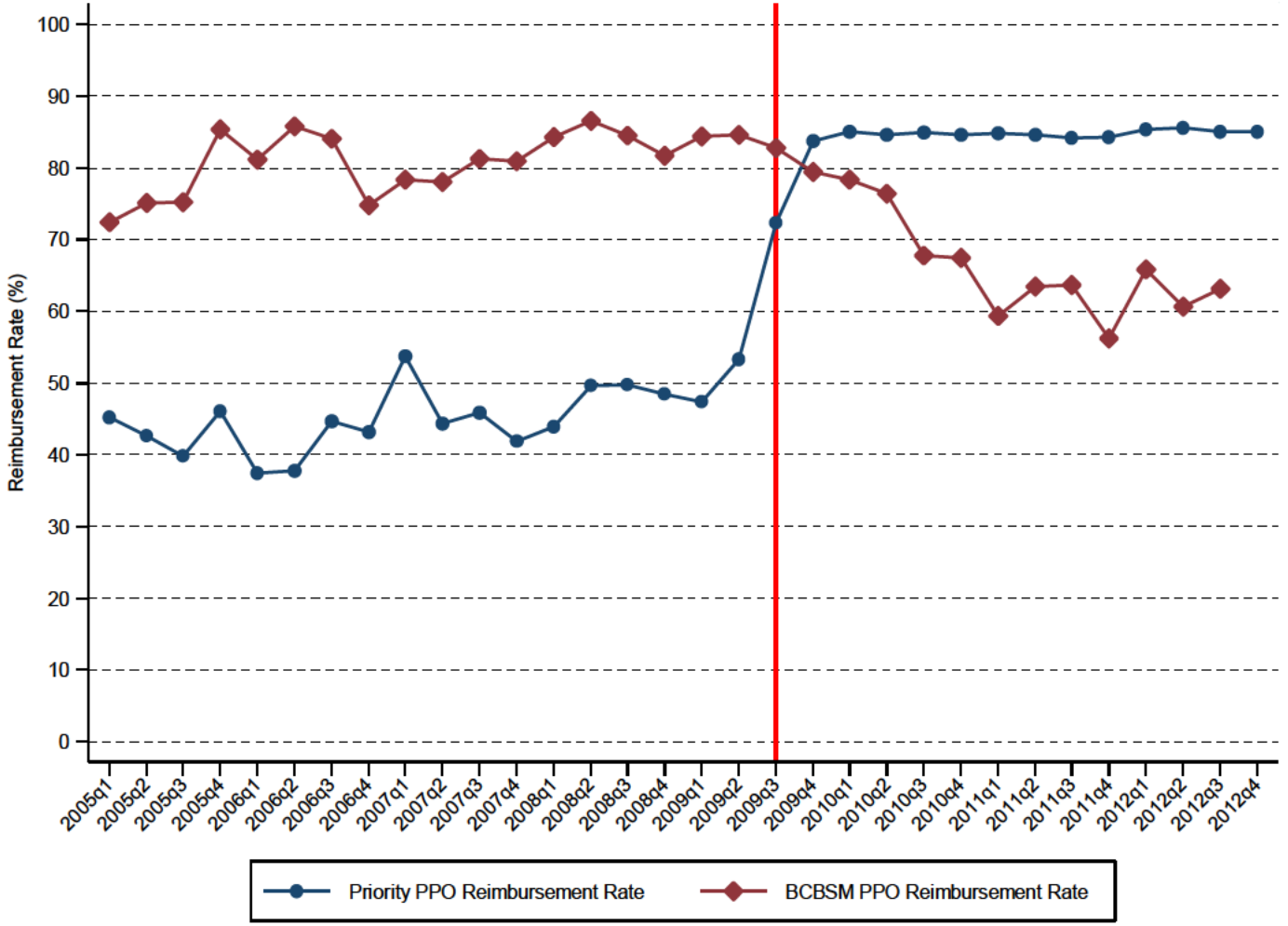
Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

FIGURE 3
PRIORITY PPO & BCBSM PPO - PAUL OLIVER MEMORIAL HOSPITAL - REIMBURSEMENT RATES



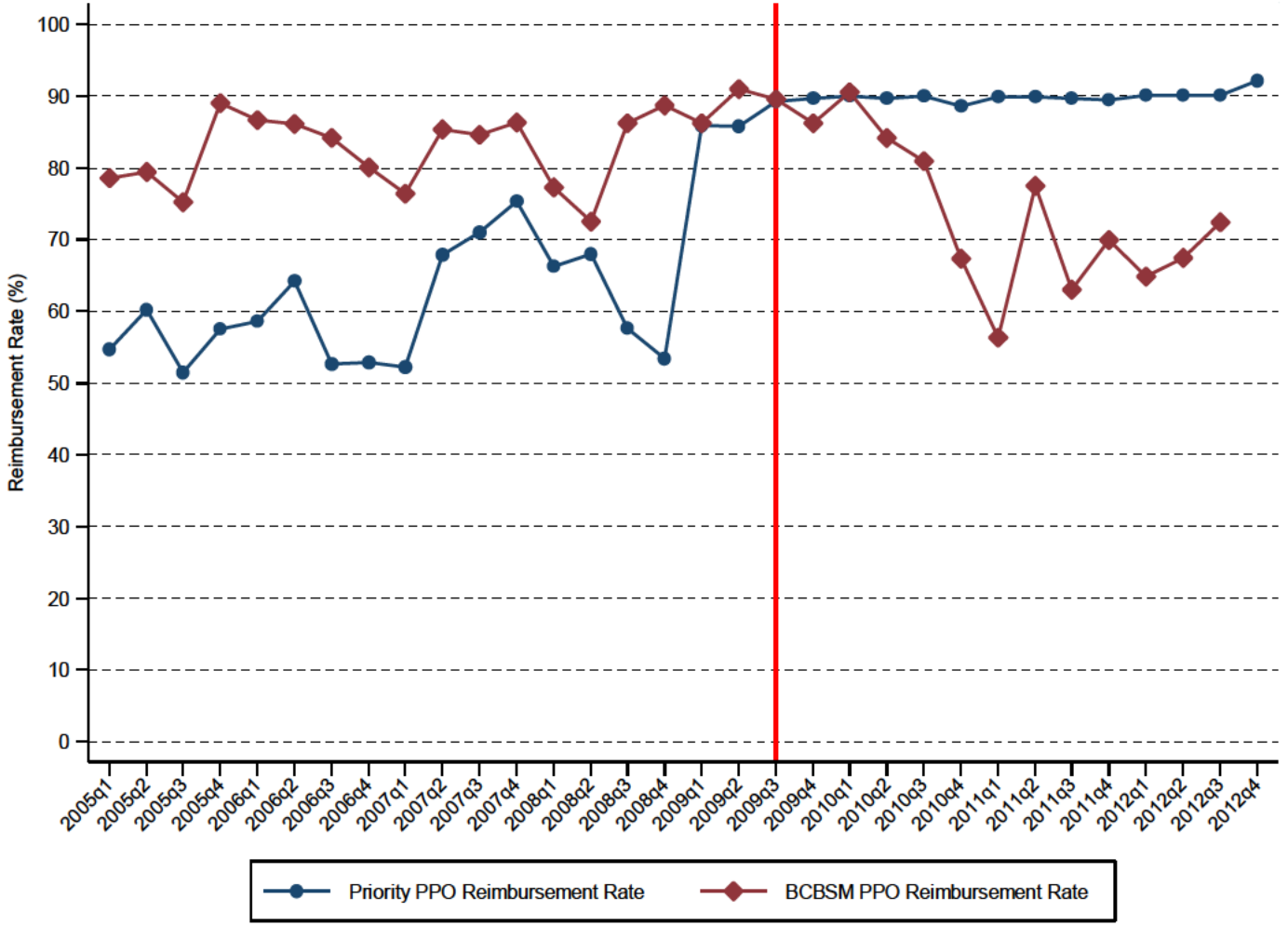
Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

FIGURE 4
PRIORITY PPO & BCBSM PPO - KALKASKA MEMORIAL HEALTH CENTER - REIMBURSEMENT RATES



Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

FIGURE 5
PRIORITY PPO & BCBSM PPO - MERCY HEALTH PARTNERS, LAKESHORE CAMPUS- REIMBURSEMENT RATES



Source: Insurer claims data provided in Dr. Leitzinger's backup material.
Note: Vertical line corresponds to MFN effective date.

APPENDIX 5

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

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

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

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

Lansing, Michigan
Wednesday, August 8, 2012

Confidential Video Deposition of:

PAULA M. REICHLE,

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

negotiations. Is it true in these negotiations that people threaten to walk away? **15:32:09**

A Oh, absolutely.

Q And why would you do that as a negotiator?

A Because it's -- sometimes it's just so time-consuming. And to be honest with you, you know, the payors have way more to lose than we do. Patients **15:32:21** are going to come to Sparrow regardless. They're just going to carry a different insurance card. So, you know, sometimes it's not worth our effort to negotiate with another payor. There's a lot of administrative duties and it's a lot of work to add more and more and **15:32:44** more contracts to your portfolio.

Q And so as a hospital negotiator of a billion-dollar-a-year organization, what do you feel is your most important piece of negotiating leverage if you're trying to get a higher rate from a commercial **15:33:01** payor?

A Access.

Q The threat to terminate?

A Or the threat not to -- I mean, some cases we're not terminating. We just won't -- you know, I **15:33:12** mean, you can have access; you just don't get access at the price point you want. I mean, anyone can have access through Cofinity or -- you know, you can get

APPENDIX 6

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

Tuesday, October 30, 2012

Confidential Video Deposition of:

MARK JOHNSON,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Bodman PLC, 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 9:18 a.m., when were present on behalf of the respective parties:

creation of doubt. I wanted to ask you why you thought during the course of the negotiations that creating doubt in Blue Cross's mind would be beneficial in any way to your efforts in negotiating with them? 12:27:23

MR. STENERSON: Object to the form.

THE WITNESS: So a hospital has a very few points of leverage with payers, generally. The most obvious one is that I terminate my agreement with Blue Cross. There was a variety of conversations I had with Beaumont executives, literally my entire six years there. Do you want to terminate the agreement with Blue Cross, threaten to terminate? The answer was no. So the most significant point of leverage that a hospital has was not on the table. 12:27:54 12:28:35

So that's actually a much more powerful lever than anything else I could bring to bear. And, in fact, Beaumont brought that to bear most recently. And it was pretty effective in terms of securing additional payment from Blue Cross. 12:28:55

Absent that, there's very little I can do to leverage the discussion. This doubt was an example of the leverage that I had short of a termination, a threat of termination between ourselves and Blue Cross in this instance, or Aetna previously, so.... 12:29:18

BY MR. TORZILLI:

APPENDIX 7

Reference Manual on Scientific Evidence

Third Edition

Committee on the Development of the Third Edition of the
Reference Manual on Scientific Evidence

Committee on Science, Technology, and Law
Policy and Global Affairs

FEDERAL JUDICIAL CENTER

NATIONAL RESEARCH COUNCIL
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Reference Guide on Statistics

DAVID H. KAYE AND DAVID A. FREEDMAN

David H. Kaye, M.A., J.D., is Distinguished Professor of Law and Weiss Family Scholar, The Pennsylvania State University, University Park, and Regents' Professor Emeritus, Arizona State University Sandra Day O'Connor College of Law and School of Life Sciences, Tempe.

David A. Freedman, Ph.D., was Professor of Statistics, University of California, Berkeley.

[Editor's Note: Sadly, Professor Freedman passed away during the production of this manual.]

CONTENTS

calculations—if not the appraised values themselves. In many contexts, the choice of an appropriate statistical model is less than obvious. When a model does not fit the data collection process, estimates and standard errors will not be probative.

Standard errors and confidence intervals generally ignore systematic errors such as selection bias or nonresponse bias (*supra* Sections II.B.1–2). For example, after reviewing studies to see whether a particular drug caused birth defects, a court observed that mothers of children with birth defects may be more likely to remember taking a drug during pregnancy than mothers with normal children. This selective recall would bias comparisons between samples from the two groups of women. The standard error for the estimated difference in drug usage between the groups would ignore this bias, as would the confidence interval.[96]

B. Significance Levels and Hypothesis Tests

1. What Is the p-value?

In 1969, Dr. Benjamin Spock came to trial in the U.S. District Court for Massachusetts. The charge was conspiracy to violate the Military Service Act. The jury was drawn from a panel of 350 persons selected by the clerk of the court. The panel included only 102 women—substantially less than 50%—although a majority of the eligible jurors in the community were female. The shortfall in women was especially poignant in this case: "Of all defendants, Dr. Spock, who had given wise and welcome advice on child-rearing to millions of mothers, would have liked women on his jury."[97]

Can the shortfall in women be explained by the mere play of random chance? To approach the problem, a statistician would formulate and test a null hypothesis. Here, the null hypothesis says that the panel is like 350 persons drawn at random from a large population that is 50% female. The expected number of women drawn would then be 50% of 350, which is 175. The observed number of women is 102. The shortfall is $175 - 102 = 73$. How likely is it to find a disparity this large or larger, between observed and expected values? The probability is called p, or the p-value.

96. Brock v. Merrell Dow Pharms., Inc., 874 F.2d 307, 311–12 (5th Cir.), *modified*, 884 F.2d 166 (5th Cir. 1989). In *Brock*, the court stated that the confidence interval took account of bias (in the form of selective recall) as well as random error. 874 F.2d at 311–12. This is wrong. Even if the sampling error were nonexistent—which would be the case if one could interview every woman who had a child during the period that the drug was available—selective recall would produce a difference in the percentages of reported drug exposure between mothers of children with birth defects and those with normal children. In this hypothetical situation, the standard error would vanish. Therefore, the standard error could disclose nothing about the impact of selective recall.

97. Hans Zeisel, *Dr. Spock and the Case of the Vanishing Women Jurors*, 37 U. Chi. L. Rev. 1 (1969). Zeisel's reasoning was different from that presented in this text. The conviction was reversed on appeal without reaching the issue of jury selection. United States v. Spock, 416 F.2d 165 (1st Cir. 1965).

The *p*-value is the probability of getting data as extreme as, or more extreme than, the actual data—given that the null hypothesis is true. In the example, *p* turns out to be essentially zero. The discrepancy between the observed and the expected is far too large to explain by random chance. Indeed, even if the panel had included 155 women, the *p*-value would only be around 0.02, or 2%.[98] (If the population is more than 50% female, *p* will be even smaller.) In short, the jury panel was nothing like a random sample from the community.

Large *p*-values indicate that a disparity can easily be explained by the play of chance: The data fall within the range likely to be produced by chance variation. On the other hand, if *p* is very small, something other than chance must be involved: The data are far away from the values expected under the null hypothesis. Significance testing often seems to involve multiple negatives. This is because a statistical test is an argument by contradiction.

With the Dr. Spock example, the null hypothesis asserts that the jury panel is like a random sample from a population that is 50% female. The data contradict this null hypothesis because the disparity between what is observed and what is expected (according to the null) is too large to be explained as the product of random chance. In a typical jury discrimination case, small *p*-values help a defendant appealing a conviction by showing that the jury panel is not like a random sample from the relevant population; large *p*-values hurt. In the usual employment context, small *p*-values help plaintiffs who complain of discrimination—for example, by showing that a disparity in promotion rates is too large to be explained by chance; conversely, large *p*-values would be consistent with the defense argument that the disparity is just due to chance.

Because *p* is calculated by assuming that the null hypothesis is correct, *p* does not give the chance that the null is true. The *p*-value merely gives the chance of getting evidence against the null hypothesis as strong as or stronger than the evidence at hand. Chance affects the data, not the hypothesis. According to the frequency theory of statistics, there is no meaningful way to assign a numerical probability to the null hypothesis. The correct interpretation of the *p*-value can therefore be summarized in two lines:

> *p* is the probability of extreme data given the null hypothesis.
> *p* is not the probability of the null hypothesis given extreme data.[99]

98. With 102 women out of 350, the *p*-value is about $2/10^{15}$, where 10^{15} is 1 followed by 15 zeros, that is, a quadrillion. See *infra* Appendix for the calculations.

99. Some opinions present a contrary view. *E.g.*, Vasquez v. Hillery, 474 U.S. 254, 259 n.3 (1986) ("the District Court . . . ultimately accepted . . . a probability of 2 in 1000 that the phenomenon was attributable to chance"); Nat'l Abortion Fed. v. Ashcroft, 330 F. Supp. 2d 436 (S.D.N.Y. 2004), *aff'd in part*, 437 F.3d 278 (2d Cir. 2006), *vacated*, 224 Fed. App'x. 88 (2d Cir. 2007) ("According to Dr. Howell, . . . a 'P value' of 0.30 . . . indicates that there is a thirty percent probability that the results of the . . . [s]tudy were merely due to chance alone."). Such statements confuse the probability of the

To recapitulate the logic of significance testing: If p is small, the observed data are far from what is expected under the null hypothesis—too far to be readily explained by the operations of chance. That discredits the null hypothesis.

Computing p-values requires statistical expertise. Many methods are available, but only some will fit the occasion. Sometimes standard errors will be part of the analysis; other times they will not be. Sometimes a difference of two standard errors will imply a p-value of about 5%; other times it will not. In general, the p-value depends on the model, the size of the sample, and the sample statistics.

2. Is a difference statistically significant?

If an observed difference is in the middle of the distribution that would be expected under the null hypothesis, there is no surprise. The sample data are of the type that often would be seen when the null hypothesis is true. The difference is not significant, as statisticians say, and the null hypothesis cannot be rejected. On the other hand, if the sample difference is far from the expected value—according to the null hypothesis—then the sample is unusual. The difference is significant, and the null hypothesis is rejected. Statistical significance is determined by comparing p to a preset value, called the significance level.[100] The null hypothesis is rejected when p falls below this level.

In practice, statistical analysts typically use levels of 5% and 1%.[101] The 5% level is the most common in social science, and an analyst who speaks of significant results without specifying the threshold probably is using this figure. An unexplained reference to highly significant results probably means that p is less

kind of outcome observed, which is computed under some model of chance, with the probability that chance is the explanation for the outcome—the "transposition fallacy."

Instances of the transposition fallacy in criminal cases are collected in David H. Kaye et al., The New Wigmore: A Treatise on Evidence: Expert Evidence §§ 12.8.2(b) & 14.1.2 (2d ed. 2011). In *McDaniel v. Brown*, 130 S. Ct. 665 (2010), for example, a DNA analyst suggested that a random match probability of 1/3,000,000 implied a .000033 probability that the DNA was not the source of the DNA found on the victim's clothing. *See* David H. Kaye, *"False But Highly Persuasive": How Wrong Were the Probability Estimates in* McDaniel v. Brown? 108 Mich. L. Rev. First Impressions 1 (2009).

100. Statisticians use the Greek letter alpha (α) to denote the significance level; α gives the chance of getting a significant result, assuming that the null hypothesis is true. Thus, α represents the chance of a false rejection of the null hypothesis (also called a false positive, a false alarm, or a Type I error). For example, suppose $\alpha = 5\%$. If investigators do many studies, and the null hypothesis happens to be true in each case, then about 5% of the time they would obtain significant results—and falsely reject the null hypothesis.

101. The Supreme Court implicitly referred to this practice in *Castaneda v. Partida*, 430 U.S. 482, 496 n.17 (1977), and *Hazelwood School District v. United States*, 433 U.S. 299, 311 n.17 (1977). In these footnotes, the Court described the null hypothesis as "suspect to a social scientist" when a statistic from "large samples" falls more than "two or three standard deviations" from its expected value under the null hypothesis. Although the Court did not say so, these differences produce p-values of about 5% and 0.3% when the statistic is normally distributed. The Court's standard deviation is our standard error.

APPENDIX 8

ALPENA REGIONAL MEDICAL CENTER

Compassionate Care. Cutting-edge Technology. Right Here.

December 2, 2009

Mr. Douglas Darland, Director
Blue Cross Blue Shield of Michigan
Hospital Contracting & Policy
27300 W 11 Mile Road – B790
Southfield, MI 48034

Dear Doug:

Please let me extend my thanks for taking the time to sit down and discuss our current Blue Cross contract and the economic stresses that Alpena Regional Medical Center (ARMC) is currently facing.

As we discussed, the current contract in effect, which is a ten year contract, was very favorable to BCBSM over the ten year period. In contrast, ARMC has had a larger than expected negative impact on hospital operations based on this contract. In short, our outpatient rates were discounted from approximately 62.2% to 54.95% for BCBSM Traditional subscribers. In additional to the decrease in Traditional rates, BCBSM migrated almost 90% of its subscribers to BCBSM Trust which decreased ARMC's reimbursement by another 4.0%.

On an annual basis, the effect of the contract is costing ARMC approximately $3.5 million dollars annually in reimbursement. The cumulative effect of the contract is even more concerning, with the estimated negative impact on cash flow exceeding $19 million dollars over the life of the contract. This shortfall of cash flow that ARMC has experienced over the life of the contract was managed internally by shortchanging the required capital replacements of equipment and facility maintenance, along with a deterioration of its balance sheet. Over the three year period of fiscal years 2005 through 2007, capital replacements were decreased below required levels by $8 million dollars. This amount was validated by an external engineering firm which completed a facilities analysis recently.

ARMC and its leadership recognize the need to control costs in today's healthcare market. The new leadership has begun to take immediate steps to reduce and control our costs throughout the organization. In June 2009, ARMC completed a staff benchmarking analysis which resulted in a workforce reduction. We have also stepped up our efforts to review and renegotiate all of our supply contracts. In short, we are committed to changing our operations so that we are comparable to industry best practices. As we continue our progress with operational changes, we still need to keep focused on our current and immediate needs, including making up for our historical capital expenditure shortfalls.

With our current cash on hand less that 10 days, we are finding this an upward hill to climb.

As we look into the future and the challenges we face, we are asking that BCBSM recognize its responsibility for being a part of the solution to ensure our ability to provide quality patient care to our community and your subscribers. We are proposing a new four year contract where our Blue Cross outpatient rates be adjusted to 62% of charges effective January 1, 2010. For a two year period, these rates will be adjusted by the full BCBSM adjustment factor. For the remaining two years of the contract, the adjustment factor will be equal to 50% of the BCBSM adjustment factor. Inpatient rates will be maintained at current levels.

In the spirit of cooperation, ARMC will agree to maintain its current discount rates with other payors and not decrease them below current contractual levels.

Please let us know if anything, in addition to what is noted here, will be needed to expedite our request and finalize a new contract. We are looking forward to building a cooperative working relationship that will benefit our community and your subscribers.

Regards,

Kevin J. Lancjotti
VP of Finance and Information Systems

Karmon Bjella
President and CEO

cc: Jeffrey L. Connolly, BCBSM

APPENDIX 9

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

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

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

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

Kalamazoo, Michigan

Wednesday, August 29, 2012

Highly Confidential Video Deposition of:

RICHARD L. FELBINGER,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Miller Canfield, 277 South Rose Street, Kalamazoo, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:06 a.m., when were present on behalf of the respective parties:

Q And have Blue Cross negotiators conveyed that sentiment to you? **15:07:31**

A Yes.

Q And, hypothetically -- we were talking about Medicare and Medicaid -- if Congress passed a law tomorrow that said effective immediately Medicare will pay cost plus 5 percent, and Michigan Ascension **15:07:48** facilities started getting a 5 percent margin on its Medicare business, what would that do to Blue Cross's leverage at Michigan Ascension hospitals --

MR. LIPTON: Object to the form.

MR. JOYCE: Object -- **15:08:04**

BY MR. STENERSON:

Q -- in your view?

A Their leverage wouldn't change because they're still a dominant player in Michigan. What might change was the need for the Michigan Ascension Health hospitals **15:08:21** to push Blue Cross into significantly higher rates, because we would have received them from the Federal Government at that point in time.

For us, it really is trying to hit an overall operating margin given the constraints that we **15:08:36** have. Medicare and Medicaid, we cannot negotiate those rates. For others we can easier than Blue Cross. But Blue Cross is such a big payer, we have to talk with

them to help us meet our goals so that we can stay in business. **15:08:57**

The last thing Blue Cross would need -- would like is for Borgess Health to shut down and have a one-hospital town. Wouldn't be able to deal with all the business and they would be at a total negotiating disadvantage at that point in time. So it's in **15:09:10** everybody's best interest to make sure that everybody kind of pays their fair share. In the absence of that, we have no alternative.

Q Right. It's not in Blue Cross's business to force your rates down so low that you can't operate; **15:09:20** correct?

A That's correct.

Q So let's talk about that. Let's talk about that a little bit in the negotiation of trying to find that right price. I think you mentioned that Blue **15:09:30** Cross's leverage wouldn't change if Medicare started paying cost plus 5 percent, but the hospital could approach negotiations in a different manner; correct?

MR. LIPTON: Object to the form.

THE WITNESS: That's correct. **15:09:49**

BY MR. STENERSON:

Q So is it true that negotiations depend on both sides of the table?

MR. LIPTON: Object to the form.

THE WITNESS: Could you rephrase that question? **15:09:55**

BY MR. STENERSON:

Q Sure. When you entered into the negotiations that resulted in Plaintiff's 9, the LOU with the effective date of July 1, 2008, did you tell Blue Cross Blue Shield of Michigan negotiators what your bottom line price was? **15:10:07**

A Yes.

Q Did the negotiation ultimately reach that price? **15:10:25**

A No.

Q Well, then, was it really your bottom line?

A Yes.

Q Can you explain?

A As I indicated before in one of the other exhibits where I made that quote at the end, you know, "Great deal," we were overruled. And, therefore, we had to accept what -- you know, what we received. That was not our goal. We did not achieve a 5 percent operating margin. We did not spend the capital that we needed to spend. So it's -- you know, sometimes you win in the game, sometimes you lose. **15:10:31** **15:10:51**

Our goal and our bottom line was to hit a

5 percent operating margin, and we needed to get certain rates from Blue Cross in that negotiation, amongst doing all kinds of other things with other payers and other costs, to get to where we need to go. 15:11:06

Q In your view, is there a difference in your mind between your goal amount and your bottom line in a negotiation? 15:11:20

A No. I happened to be overruled by someone higher than me.

Q Well, somebody within Ascension Health accepted an amount lower than what you personally would have accepted? 15:11:32

A That is correct. I still have to try to get my 5 percent operating margin some other way, though.

Q At the time the negotiations that resulted in Plaintiff's 9 began, do you recall what, converted to a percent of charge, the Blue Cross reimbursement rate was at Borgess Medical? 15:11:53

A I believe it was 37 to 39 percent of charges.

Q And do you know what it is under the -- well, strike that.

Is Plaintiff's 9 still in effect? 15:12:12

A It is until 2013, yes.

Q Do you know what Blue Cross's rate is today at Borgess Medical?

APPENDIX 10

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

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

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

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

Detroit, Michigan

Tuesday, November 13, 2012

Confidential Video Deposition of:

KENNETH MATZICK,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Miller Canfield Paddock and Stone, 150 West Jefferson, Suite 2500, Detroit, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:32 a.m., when were present on behalf of the respective parties:

fact that the deponent is not identified as a recipient.
MR. TORZILLI: Okay. Noted. 11:24:17
BY MR. TORZILLI:
Q And, sir, on or about January 11, 2006, you were also an employee of Beaumont Hospital; correct?
A Yes.
Q Okay. Now, you were not a -- you are not 11:24:27
indicated as a recipient of Mr. Johnson's e-mail that appears on the first page of Exhibit 4; correct?
A Correct.
Q Okay. Can you look at the second page of Exhibit Number 4. 11:24:46
Sir, what do you understand the second page of Exhibit Number 4 to be?
MR. GOURLEY: Objection, foundation.
THE WITNESS: Well, on the surface, it says "... Beaumont Hospitals Proposal to Blue Cross Blue11:25:01 Shield of Michigan...."
BY MR. TORZILLI:
Q Okay. And do you understand this to have been a proposal that you helped to deliver to Blue Cross on or about December 14th, 2005? 11:25:13
MR. GOURLEY: Objection, form, foundation.
THE WITNESS: The cover e-mail would

suggest that was the case.

BY MR. TORZILLI: 11:25:22

Q Okay. Do you remember the occasion of having delivered this proposal to Blue Cross Blue Shield of Michigan?

A In the e-mail, I assume Mike and Dan are Mike Schwartz and Dan Loepp of Blue Cross. 11:25:36

Q Okay.

A If that's the case, I did meet with Dan and Mike. It must have been this time frame, given the dates on the documents.

Q What do you remember about your meeting with 11:25:54 Dan and Mike that occurred in the approximate December 2005 time frame?

A I believe Mark Johnson and myself met with Dan and Mike at Blue Cross -- at Dan Loepp's office, in the Blue Cross headquarters. 11:26:18

Q What was the purpose of the meeting?

A Well, as the document reflects, we were proposing some payment changes to Beaumont to offset other issues that had occurred.

Q And are the payment changes that you were 11:26:43 proposing embodied in the first four items at the top half of the second page of Exhibit Number 4?

A That may -- those were the main points. There

may have been other issues there that were going on, we discussed as well, but obviously these were four points we wanted to make with them.

Q Okay. I want to ask you about the bottom half of the page. And what do you understand the points on the bottom half of the page to represent? 11:27:08

MR. GOURLEY: Objection, form. 11:27:26

THE WITNESS: Well, it reflects Beaumont's commitment to do those things enumerated, or work toward those things enumerated, should Blue Cross make the payment changes that are identified in the top half of the document. 11:27:46

BY MR. TORZILLI:

Q I want to ask you about the first of the four items on the bottom half of the page. I'll read it into the record, first.

It says, "Adopt a most favored nation clause that will insure BCBSM discount is the highest of any payor; outside/independent review to be conducted every two years." 11:27:56

Do you see that?

A Yes. 11:28:10

Q Was that one of the things that Beaumont was willing to commit to in exchange for the payment changes that it was looking to get from Blue Cross?

A I think it was a throw-away for this document, in that it already existed in what we called the PHA document, the Participating Hospital Agreement. 11:28:24

Q Okay. So at least to the best of your knowledge and recollection, you thought you were already bound by a most favored nation provision?

A Yes. 11:28:39

Q Okay. What, if any, benefits do you know of to Beaumont of Beaumont having a most favored nation provision in its Participating Hospital Agreement with Blue Cross?

MR. GOURLEY: Objection, foundation. 11:29:07

THE WITNESS: Well, I guess it assured -- in that it was integral to their contract, it was -- it assured us access to 60 percent of the market that they held as their client base.

BY MR. TORZILLI: 11:29:28

Q Do you mean assured access to Blue Cross subscribers?

A Yes.

Q Did -- at least as far as you know, did the most favored nation provision in the Blue Cross contract 11:29:42 affect in any way the quality of care that Beaumont delivered to its patients?

A No.

Cross was independent of the fact that that MFN was already there and was going to stay there? 13:30:07

MR. TORZILLI: Object to the form.

THE WITNESS: Yes. PHA dealt with issues like that and the methodology of reimbursement, the formulas to determine payment, as opposed to individual negotiations with the hospitals that would address 13:30:22 specific -- issues specific to those hospitals, excuse me.

BY MR. GOURLEY:

Q During your time at Beaumont, were you ever in a position to know whether or not Beaumont adjusted a 13:31:01 non-governmental payer's reimbursement rate in order to comply with a Blue Cross MFN in its contract?

MR. TORZILLI: Objection to the foundation.

THE WITNESS: I'm not aware of that ever13:31:16 having occurred.

BY MR. GOURLEY:

Q So you don't think it ever occurred?

A No.

MR. MATHESON: Object to the form and 13:31:34 foundation.

And, Jason, we do have an agreement that an objection by one Plaintiff's counsel is an objection

APPENDIX 11

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

UNITED STATES OF AMERICA, et al,

Plaintiffs,

vs. Case No. 2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD

OF MICHIGAN,

Defendant.

_____

The Videotaped Deposition of DAVID MARCELLINO,

Taken at 28050 Grand River Avenue,

Farmington Hills, Michigan,

Commencing at 9:25 a.m.,

Thursday, September 6, 2012,

Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

A. I am -- you know, I do remember, you know -- we must have had -- I don't remember the meeting specifically.
Q. Do you know if at or around the time of March, 2007, Botsford was looking for a, a rate increase to support cost plus 3%?
A. Yeah, that's based upon the Blue Cross model.
Q. Okay, and do you know in this approximate timeframe what Blue Cross's position was as to what reimbursement rate they were willing to provide to Botsford?
MR. STENERSON: Object to the form.
A. Well, because we were negotiating, it was obvious that it was their recognition of what our cost was, and they felt -- they came up with a different number than what we did. So it was part of the negotiation, was to try to get to the point, and that really relates back to the rebasing discussion in terms of what your starting point for cost.
BY MR. TORZILLI:
Q. Okay, and at this point in time, how -- could you describe how close Botsford and Blue Cross were to a final agreement?
A. I think we were getting fairly close, if I remember the meeting correctly. I think it was -- when Kim Sorget got involved, I think we were getting close to

APPENDIX 12

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
MARK GRONDA,
Taken at 4960 Towne Centre Road,
Saginaw, Michigan,
Commencing at 10:08 a.m.,
Thursday, December 13, 2012,
Before Rebecca L. Russo, CSR-2759, RMR, CRR.

Medicare and Medicaid losses trended?
A. Well, the volumes have gone up, both Medicare and Medicaid, and the losses have gotten more significant with Medicaid, because we're either getting no price increases, or in a couple cases we actually had takeaways, as the states manage their budget problems.
Q. So, if I understand correctly, in the past five years at Covenant, the Medicare and Medicaid shortfalls have increased both in terms of increased volume of patients and downward trending rates?
A. Rates that have not kept up with inflation, and with the example with Medicaid, I think they're actually downward, you know, less reimbursement, let alone inflation.
Q. Have Medicare rates in the past five years kept pace with inflation?
A. No.
Q. So in the past five years, Medicare rates at Covenant, as compared to inflation, have been trending downward?
A. They've eroded.
Q. And what are Covenant's options to make up for those sins of Medicare and Medicaid?
MR. ALLEN: Objection, form.
A. The only option we have is to look to the commercial payers, including Blue Cross.

A. I do.
Q. Why did you think it important to tell Blue Cross that even after a rate increase, they would have a reimbursement advantage of at least 13 percentage points?
A. It's a negotiating position, just to reinforce what a large advantage they had.
Q. Did anyone from Blue Cross express to you in the past the concern that because of Blue Cross' size, that hospitals might seek a larger portion of government shortfalls from Blue Cross?
A. Could you repeat that?
Q. Sure. Did anyone from Blue Cross express to you in the past that because of Blue Cross' size, hospitals like Covenant might seek to only seek increases from Blue Cross and not other commercial payers?
A. No.
Q. In the -- do you know whose handwriting is on this document?
A. Yeah, it's mine.
Q. I'd like to direct your attention to the handwriting on the top of page 2. Could you read that for us?
A. High 'caid/uncompensated care, services, economy.
Q. Do you know what you were writing a note about there?
A. Just some of the factors that we felt compelled us to

need higher reimbursement from Blue Cross because of the high Medicaid uncompensated care, and the fact that we were just going into a recession at that point.

Q. I was going to say, I know the economy has been less than ideal recently, but do you recall at this time, in or around November of '08, what the economic conditions in and around Saginaw were like?

A. Not specifically, but we've been in a downturn for two decades because of the downsizing of GM before this most recent recession, so it's -- we've had higher unemployment rates than the state and in the nation, as a rule. I couldn't tell you the exact unemployment rate unless I said it here. I don't see it.

Q. If you could go to page 3, in the paragraph that starts C, it says:

We believe that other hospitals in our area are benefitting from higher Blue Cross rates due to their having higher costs, not due to any superiority in terms of efficiency or quality.

Do you see that?

A. I do.

Q. It says:

As you are aware, one of the largest factors affecting operating costs is wages, yet the

APPENDIX 13

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

989.583.0000 Tel

COVENANT HealthCare

November 17, 2008

Mr. Doug Darland
Director, Hospital Contracting & Policy
Blue Cross Blue Shield of Michigan
27000 W. Eleven Mile Road
Mail Code B772
Southfield, MI 48034

Re: Reimbursement Changes

Dear Doug,

Recently, Blue Cross provided information to Covenant Medical Center concerning the market pricing initiative where outpatient pass through factors for certain services, such as radiology and lab, would match the fee screens for free standing facilities. This change is intended to be made in a budget neutral manner with a corresponding increase in our inpatient reimbursement rates. As part of this initiative, you provided us draft calculations of the new inpatient rates. We reviewed that information not only in the context of the budget neutrality principle, but more broadly in terms of the overall adequacy of Blue Cross payment. As discussed in more detail below, we believe an adjustment to our rates is merited and are hopeful that, working together, we can accomplish a change effective January 1st, the proposed effective date of the market pricing initiative.

Background

Covenant HealthCare is the largest provider of health care services in the mid-Michigan area, serving the communities of Saginaw, Midland and Bay City. We operate two acute care inpatient facilities and numerous outpatient centers. The hospital is the sole provider of obstetric and pediatric services in Saginaw, and we operate both a pediatric ICU and neonatal ICU. For Blue Cross, more than half of our top ten admissions are related to maternal and infant health.

Like other Michigan hospitals, the past years have been particularly challenging as the economy has worsened and more individuals are losing group health coverage. The local economy of Saginaw has been particularly affected by the downturn in automobile manufacturing. Over the past several years, our uncompensated care has more than doubled, from $14.8 million in fiscal 2004 to more than $33.7 million in fiscal 2008. In addition, Medicaid enrollment has increased considerably, and the impact to

Covenant is more pronounced due to the fact that we are the sole Saginaw provider of obstetric and pediatric care. In fiscal 2008, more than two-thirds of hospital charges related to Medicare (48.1%), Medicaid (16.1%) and uncompensated care (3.3%).

We have undertaken numerous efforts to control the rate of growth in costs. The most recent information from Blue Cross shows that the hospital's standardized cost per case ($6,242) is substantially below the statewide average ($6,797). In addition, the hospital's cost growth has been less than the growth in revenue. Notwithstanding our exceptional efforts to operate efficiently, the erosion in our payor mix adversely affects our financial results. In fiscal 2008, we had a negative patient margin and our total operating margin was only one-half of one percent, well below what is needed to fund operations and make needed capital investments.

In addition to our changing payor mix and worsening financial position, we note that due to changes in technology, more and more services are being performed on an outpatient basis. The shift from inpatient to outpatient among Blue Cross members is significant: from 2004 to 2008, the number of inpatient admissions has declined from 7124 to 6238, more than 12%. The continuing shift causes us concern that the market pricing implementation will not be budget neutral over time and will result in further loss of reimbursement.

Adjustment in Blue Cross Rates

We have reviewed our Blue Cross rates in light of our costs, service mix, payor mix and market position, and we request that Blue Cross increase our payment rates by 8%. Blue Cross currently enjoys the most significant discount of any commercial payor, and we estimate that, even with the requested increase, Blue Cross will have a reimbursement advantage of at least 13% percentage points. The rationale for our request is described more fully below.

1. *Below Market Rates.* Our Blue Cross payments are well below what Blue Cross pays other hospitals in the region. Our DRG rate, even after including the add-ons for capital and graduate medical education, was approximately $8,700 in fiscal 2007. This is considerably below what other hospitals of similar scale and teaching programs receive.

   a. Part of the reason for the lower rates is our cost structure. The most recent data shows that our standardized cost per case in 2006 ($6,242) was more than $500 below the statewide average ($6,797). This differential alone amounts to more than $3.0 million in 2006 ($500 * 5661 cases *1.0764 case mix). Over the past three years (2006-2008), the impact is more than $9.0 million.

   b. As part of Blue Cross' transparency efforts, it recently shared with us comparative payment data for 41 common procedures. The data was region specific, covering the Saginaw-Bay-Midland metropolitan

statistical area. In each case, the payments to Covenant are far below the market averages. For example, in the case of C-section and vaginal deliveries, Covenant's rates are $2600 and $2000 below the market averages, respectively. The degree of underpayment is even worse when one considers the fact that our low rates are in the "market average," and we are the sole provider of obstetric services in Saginaw.

c. We believe that other hospitals in our area are benefitting from higher Blue Cross rates due to their having higher costs, not due any superiority in terms of efficiency or quality. As you are aware, one of the largest factors affecting operating costs is wages, yet the Medicare wage index varies widely among the hospitals in the Saginaw-Bay-Midland area even though we are all competing for the same staff. For example, in fiscal 2009, St. Mary's Medicare wage index is 1.0769, yet our wage index is only .90. Bay Medical and MidMichigan have a .9410 wage index. The favorable wage index of our competitors results in more Medicare reimbursement. This, in turn, can lead to higher wages, thus increasing their Blue Cross cost base and reimbursement. For example, the average hourly wage for the past three years for St. Mary's was $30.47, more than 10% higher than the three year average hourly wage at Covenant $26.87. We do not expect Blue Cross to remedy Medicare wage index variations, but we hope that you can appreciate the challenge it poses for Covenant. The differences in Medicare reimbursement for two hospitals in the same town and the differences in service mix (contributing to larger Medicaid case loads) underscore why it is so important that we achieve appropriate reimbursement from Blue Cross and other commercial payors.

2. *Cost Exclusions.* The Blue Cross model for Peer Group 1 through 4 hospitals excludes certain costs. In fiscal 2004, the base year for the development of rates, non-reimbursable costs were $38.8 million, more than 10% of our cost base. Blue Cross only recognized $2.96 million or 7.6%. This is considerably below the share that Blue Cross recognized of other costs (around 20%). We note that, even if Blue Cross were to recognize its share of the non-reimbursable costs, the hospital would still have a standardized cost per case below the statewide average. This supports the conclusion that the hospital is efficiently operated even if Blue Cross recognizes its full share of non-reimbursable costs.

a. Some of the costs that were excluded result from our unique service mix. We must employ various physicians given our obstetric and pediatric services. For example, the hospital employs pediatric intensivists, hospitalists and pediatric surgeons. These employment arrangements result in losses which Blue Cross did not take into account in the development of our rates.

b. We also believe that the manner for allocating costs to Blue Cross members results in some aberrations, particularly as respects obstetrics services. The costs associated with this service are higher than the average costs of "adults and pediatrics general routine care," yet for cost allocation purposes, the average cost was used. As noted earlier, more than half of our top ten admissions for Blue Cross members relate to maternity care.

c. While the cost exclusions may have been consistent with the model, it had a disproportionate effect on Covenant. Not only did the exclusion result in lower rates, it results in even more costs having to be shifted to other commercial payors. The commercial payors are already picking up an extraordinary cost shift due to the fact that Blue Cross does not recognize the cost of Medicaid underfunding.

3. *BCN Margin.* In 2004, the hospital agreed to convert its BCN rates to the equivalent of TRUST rates. This resulted in a significant reduction in the hospital's BCN reimbursement since BCN rates were more on par with what the hospital had established with other commercial payors, such as HealthPlus. Simply put, the margin on the BCN business far exceeded the Blue Cross target margin (4%). When the change was made, it was handled on a budget neutral basis so that the reduction in BCN reimbursement was offset by an increase in Blue Cross reimbursement. Hence the hospital protected the BCN margin. Under the new PHA model, BCN reimbursement is set at the TRUST level and reimbursement is subject to the same margin assignment (4% in our case). This has resulted in lower reimbursement over time to the hospital. Both the original deal and the 2004 conversion to TRUST "protected" the BCN margin; the current arrangement does not.

4. *Uncompensated Care Growth.* The hospital's uncompensated care expense has more than doubled since fiscal 2004. For fiscal 2008, it was over $33.7 million. While we understand that the standard model rebases uncompensated care annually, there is a three year lag. This lag is creating significant hardship for the hospital given the exceptional high growth in this cost.

5. *Shift to Outpatient.* As noted earlier, the hospital has experienced a consistent decline in admissions each year since 2004. In addition, some services, such as PTCA, are now performed on an outpatient basis, yet were previously handled on an inpatient basis. This change alone has had a material impact since the difference in PTCA reimbursement is around $2,800. During the nine month period of October 1, 2007 through June 30, 2008, we had 41 procedures, resulting in a loss of reimbursement exceeding $110,000. Our request for additional reimbursement is supported by this and other expected shifts that will arise as technology continues to improve. We also raise this issue in relation to market pricing. The market pricing implementation does not protect against this or other

PHA Advisory Comm ? Spence

2007 is base year

shifts from inpatient to outpatient. We believe that this shift should be estimated and taken into account in developing rates under the market pricing initiative.

For the reasons discussed above, we believe our request for an adjustment to our rates is warranted. We would like the opportunity to meet to discuss this request in detail and provide you with supporting documentation. I will contact your office in the near future to set up a time to meet.

As a final matter, we are aware that Blue Cross is interested in establishing a Medicare Advantage PPO product. We have some concerns relative to the proposed contract and reimbursement terms, and we may be willing to participate if those concerns can be adequately addressed. Our intention is to complete our negotiations concerning this matter first before addressing the Medicare Advantage PPO product.

In the event that you have any questions or comments concerning the matters addressed in this letter, please contact me.

Very truly yours,

Mark Gronda
Vice President and Chief Financial Officer

MG/ms

cc: Mr. Spencer Maidlow

APPENDIX 14

From: Milewski, Robert <RMilewski@bcbsm.com>
Sent: Saturday, October 6, 2007 12:01 AM
To: Parris, Bernadette <BParris@bcbsm.com>
Subject: FW: Meeting

Bernie, FYI

From: Connolly, Jeffrey
Sent: Fri 10/5/2007 8:28 AM
To: Milewski, Robert; Sorget, Kim; Darland, Doug; Noxon, Gerald
Subject: Re: Meeting

Melissa, can you set up a meeting through Bob's office on this. I would like Ken D there as well.

Thanks

----- Original Message -----
From: Milewski, Robert
To: Connolly, Jeffrey; Sorget, Kim; Darland, Doug; Noxon, Gerald
Sent: Fri Oct 05 08:25:54 2007
Subject: Re: Meeting

I agree that we should meet and have a strategy session.

We need to sort out why we are receiving these current requests. From the input I have received from Kim, Doug and Jerry, we have always received some of these requests.

Some requests could be related to our heightened commitment to relationship and service. Some CEO may falsely read our kindness as weakness or oppotunity.

We need to use objective data to assess each request and see how the requests line up with strategies which will benefit the Blues. We need to look for measurable win-win situations if we are going to make exceptions to the standard PHA. The business leaking into Wisconsin in the UP may be an example.

Bob

----- Original Message -----
From: Connolly, Jeffrey

To: Sorget, Kim; Crofoot, Ron; Milewski, Robert
Cc: Darland, Doug
Sent: Fri Oct 05 07:54:47 2007
Subject: Re: Meeting

I agree. At some point I believe we need to have a high level discussion about other hospitals and their perceived needs. We seem to be getting some requests for support (ie northern michigan hospital, metropolitan,etc). What is our position on this? Not sure how we have addressed historically or if this is new given the economy. Both Ken and Mark Bartlett have commented on this recently as well.

Thanks

----- Original Message -----
From: Sorget, Kim
To: Connolly, Jeffrey; Crofoot, Ron
Cc: 'IMCEAMAILTO-RMilewski+40bcbsm+2Ecom@dchs.org' <IMCEAMAILTO-RMilewski+40bcbsm+2Ecom@dchs.org>; Darland, Doug
Sent: Thu Oct 04 21:21:09 2007
Subject: Re: Meeting

Ron can you set up the meeting. I think we should see the proposal before we come up with any solution on the product shift.

----- Original Message -----
From: John Schon <John.Schon@dchs.org>
To: Sorget, Kim; Connolly, Jeffrey; Crofoot, Ron
Cc: Milewski, Robert <IMCEAMAILTO-RMilewski+40bcbsm+2Ecom@dchs.org>
Sent: Thu Oct 04 18:37:27 2007
Subject: RE:Meeting

Hi Everyone,

As we discussed at our last UP Blue Steering Committee meeting, we were going to set up a meeting to discuss my/DCHS's proposal to Blue Cross to help our Healthcare System financially to strengthen our ability to retain more market share in Dickinson County/the UP. In that regard, I have been working with my staff to layout the current status of our market share data by MDC/specialty as well as identify those physician specialties that we need to recruit/retain in our community.

Hopefully, we can determine the cost/benefit to allow Blue Cross to reimburse DCHS and our physicians better and allow our hospital the ability to recruit new physicians to our community and, as well, retain those physicians currently on our medical staff that are threatening to relocate their practices across our boarder into Wisconsin. If we are successful, the result will be that we retain more market share for DCHS and lower claims cost for our local employers and Blue Cross.

One additional item that hopefully can be addressed is the fact that the promotion of Blue Cross/UP Blue is starting to negatively impact our hospital financially. Through August or eight months into our fiscal year, our Blue Cross patient revenues are $2,635,000

higher than anticipated and our Commercial Insurance revenues are $2,422,000 lower than anticipated. This shift has cost out hospital approximately $900,000 to $1 Million dollars so far this year due the 40 to 45% decrease in reimbursement that we receive when an employer switches their coverage from a Commercial Insurance carrier to Blue Cross. Hopefully we can address this issue; otherwise the potential increase in our hospitals' Blue Cross patient utilization (created through the sale of the UP Blue product) will never offset this 40 to 45% reduction in our reimbursement.

Let me know potential dates that we can meet to discuss these issues in more detail and hopefully come to a resolution that is beneficial to both parties.

Thanks,

John

From: Milewski, Robert [mailto:RMilewski@bcbsm.com]
Sent: Monday, September 17, 2007 12:12 PM
To: John Schon
Cc: Sorget, Kim; Connolly, Jeffrey; Crofoot, Ron
Subject: Follow Up from UP Council Meeting

John,

I enjoyed speaking with you after the Council meeting last week. I look forward to working with you on the challenges you face in delivering high quality healthcare to your community of Iron Mountain. Please follow up with Ron Crofoot on some of the ideas we discussed. Developing solutions to keep Michigan healthcare business in Michigan hospitals is in all of our best interest. My contact information is below. I look forward to our ongoing dialogue.

God Bless,

Bob

Robert Milewski

Senior Vice President, Contracting and Hospital Relations

Blue Cross Blue Shield of Michigan

27300 W. 11 Mile Road, B792

Southfield, MI 48034-6147

Bernie Parris, Executive Assistant

Phone: 248-448-6903

APPENDIX 15

Discussions With BCBSM

DCH SYSTEM

Participants From BCBSM:
- Ron Crowfoot
- Doug Darland

Participants From DCHS:
- John Schon, Administrator and CEO
- John Lee, CFO
- Deb Hanson, Reimbursement Coordinator

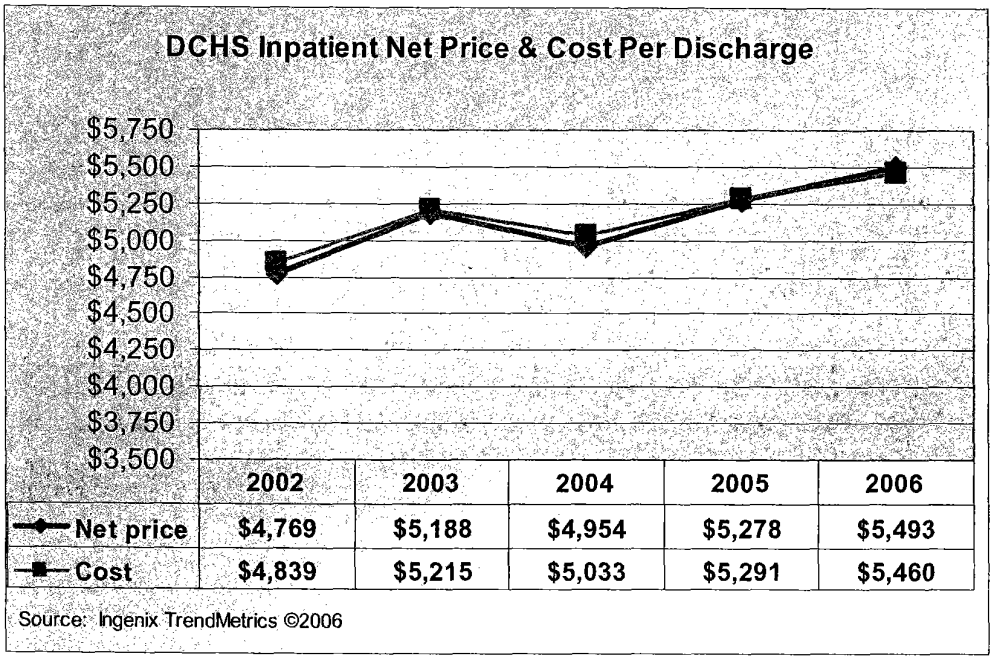
DCHS Proposal to Partner with BCBSM

- Decrease out-migration of BCBSM members to Wisconsin providers by supporting and enhancing programs at DCHS that meet member needs.
- Jointly approach area businesses to promote affordable healthcare insurance solutions that assist with these goals.
- Increase DCHS reimbursement rates to fund strategic initiatives in support of these goals.
  - Offset lost revenue from other private plans with higher reimbursement rates from BCBSM.
  - Reduce competitive disadvantage compared to both Wisconsin providers and neighboring, smaller Peer Group 5 hospitals.
  - Create a Peer Group 4 ½ for DCHS to achieve these goals.

DCHS Financial Challenges

- The following slides present current and historical information since 1997, the first full year in our present hospital facility.
- Because of the decline in charge based payers and overall changes and decreases in patient volumes there are increased financial pressures.
- DCHS has maintained effective control on variable costs, while the fixed costs related to the new facility have been covered despite the volume decline.
- At the same time, DCHS has been proactive in physician recruiting both on our own and jointly with MGHS and BellinHealth. DCHS has also been successful in nurturing cooperation and partnership with tertiary providers both to the North and to the South.
- DCHS' ongoing efforts and initiatives include development of a hospitalist program using existing and potential Internal Medicine candidates.
- DCHS' initiatives do address out migration of BCBSM members and restoring and improving overall market share by working with present physicians and recruiting specialist where needed.

DCHS Operates on a Thin Margin



	2002	2003	2004	2005	2006
Net price	$4,769	$5,188	$4,954	$5,278	$5,493
Cost	$4,839	$5,215	$5,033	$5,291	$5,460

Source: Ingenix TrendMetrics ©2006

- Thin margin with high gross prices, relatively low BCBSM reimbursement.
- Costs are well-controlled, but there is a high level of fixed costs.

DCHS Payer Mix and Revenue Composition

	Eight Months Ended 8/31:		At three year intervals:			
	2007	2006	2006	2003	2000	1997* *First full year in new facility
Present and historical Payer Mix:						
Medicare	43%	42%	43%	43%	43%	44%
Michigan Medicaid	9%	8%	8%	8%	6%	6%
BCBSM	24%	23%	23%	26%	22%	16%
Other	19%	21%	21%	20%	25%	29%
Self pay	5%	5%	5%	5%	5%	5%
Total	100%	100%	100%	100%	100%	100%
Based on total Healthcare System gross charges.						
Gross revenue in $000's:						
Inpatient	$ 33,689	$ 32,397	$ 46,945	$ 45,342	$ 36,605	$ 29,651
Hospital outpatient	71,767	66,089	100,208	76,199	53,794	31,444
Sub-total - Hospital	105,456	98,486	147,153	121,541	90,399	61,095
Physician services	4,367	3,337	5,207	4,476	4,030	3,368
Total	$ 109,823	$ 101,823	$ 152,360	$ 126,017	$ 94,429	$ 64,463
% change in total revenue -						
Eight-month period comparison	7.9%					
Three-year Inervals			20.9%	33.5%	46.5%	
Inpatient Hospital Revenue %	31.9%	32.9%	31.9%	37.3%	40.5%	48.5%

- Inpatient volumes and revenue have decreased dramatically.
- Payer mix has shifted causing an adverse effect on net revenue.
- BCBSM now 24% of gross charges, up in 10 years from 16%.
- Other (charge based payers) now 19% of gross charges, down in 10 years from 29%.

DCHS
Net Revenue, Allowances and Bad Debts

	Eight Months Ended 8/31:		At three year intervals:			
	2007	2006	2006	2003	2000	1997*
Net revenue and allowances in $000s:						
Gross revenue	$ 109,823	$ 101,823	$ 152,360	$ 126,017	$ 94,429	$ 64,463
Allowances (excludes bad debt provisions)	(63,711)	(57,457)	(82,373)	(64,651)	(48,845)	(23,210)
Net revenue	$ 46,112	$ 44,366	$ 69,987	$ 61,366	$ 45,584	$ 41,253
Net revenue percentage of gross revenue	42.0%	43.6%	45.9%	48.7%	48.3%	64.0%
Provision for doubtful accounts	$ 3,102	$ 2,405	$ 3,865	$ 3,151	$ 2,399	$ 1,717
Provision as percentage of gross revenue	2.8%	2.4%	2.5%	2.5%	2.5%	2.7%

*Special note: 1997net revenue includes $750,000 one-time net reimbursement effect of the sale of the old hospital facility. When adjusted, net revenue would have been 62.8% of gross without that one-time net reimbursement.

- From ten years ago, net revenue declined to 42% of gross revenue compared to 63% in 1997, the first full year in the new facility.
- As a result of increased deductibles and coinsurance and an increase in the uninsured, bad debts have increased in 2007.

DCHS
Change in 2007 Payer Mix

Estimated Net Revenue Impact - Projected 2007 Payer Mix change from 2006 Actual			
	Gross Revenue	**Payment Rate**	**Net Revenue Impact**
BCBSM	$ 2,109,487	40.0%	$ 843,795
Other Private Plans	$ (2,109,487)	89.1%	$ (1,879,553)
Net Impact			$ (1,035,758)

The decrease in gross charges from other private plans could be attributable to both a switch by employers from other plans to BCBSM and to a loss in market share from other plans coinciding with increased market share from BCBSM Members.

- DCHS has continuously conducted community education and has communicated directly with the general public and community leaders about our service lines, programs and capabilities.
- We intend to continue our communications and other efforts to keep and grow our market share.
- Controlling our prices to charge-based payers now that, generally speaking, deductibles are higher is also an important strategy.

DCHS
Effective, Efficient, Viable

- The following slides show financial information and benchmark comparisons of DCHS prices and costs.
- DCHS continues to operate efficiently and controls costs to justify its role as a viable partner with BCBSM to provide care in Michigan and decrease out migration of its members to Wisconsin providers.

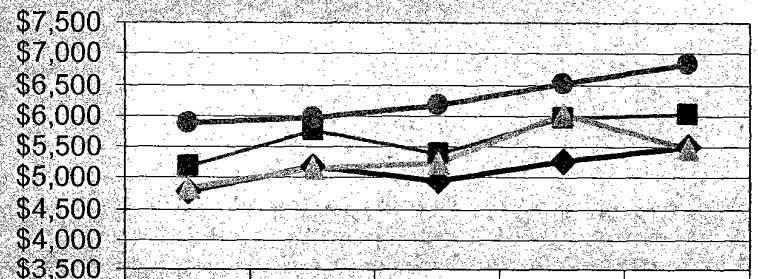
DCHS
Productivity and Staffing

	Eight Months Ended 8/31:		At three year intervals:			
	2007	2006	2006	2003	2000	1997*
Productivity and efficiency:						
Revenue per full-time equivalent employee	$115,844	$111,367	$111,275	$100,655	$88,077	$77,135
Worked hours per adjusted discharge	90.7	92.3	89.5	91.4	107.1	NA
Salaries as percentage of total costs	44%	44%	45%	46%	46%	44%
Fringe benefits as percentage of salaries	28%	29%	30%	30%	21%	25%
Staffing level - total employment:						
Total paid full-time equivalent employees	632.3	627.3	629.0	615.6	580.2	545.5
Paid hours / adjusted discharge (IP discharges / ratio of IP revenue to Total)	104.33	107.98	107.64	108.56	110.18	117.94
% increase in employment:						
Eight month periods	1%					
Three-year intervals			2%	6%	6%	
% improvement: Staff level relative to patient volumes						
Eight month periods	3%					
Three-year intervals			1%	1%	7%	

- Staffing is controlled relative to patient volumes.
- DCHS is the largest employer in Dickinson County and has provided steady employment with good job growth.
- As a tactic, could leverage these facts in efforts to win support from community.

DCHS Price Comparison

Net Price Per Discharge Comparison
CHIPS Database Medians



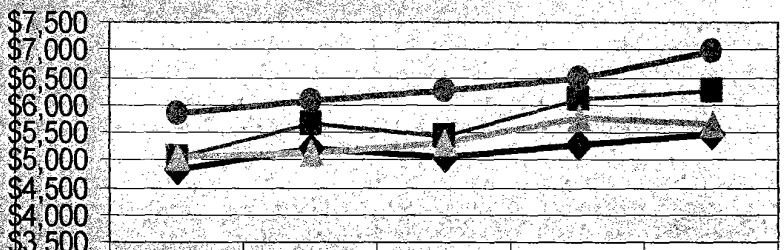
	2002	2003	2004	2005	2006
DCHS	$4,769	$5,188	$4,954	$5,278	$5,493
Michigan	$5,184	$5,774	$5,380	$5,968	$6,036
East North Central	$5,887	$5,964	$6,161	$6,525	$6,839
Rural E. No. Central <100 beds	$4,834	$5,149	$5,247	$6,034	$5,467

Source: Ingenix TrendMetrics ©2006

- Compares favorably except to small hospitals.
- BCBSM Peer 5 hospitals receive better reimbursement and can set prices lower.
- Wisconsin hospitals receive better reimbursement and can set prices lower.
- Unfavorable competitive situation.

DCHS Cost Comparison

Cost Per Discharge Comparison
CHIPS Database Medians

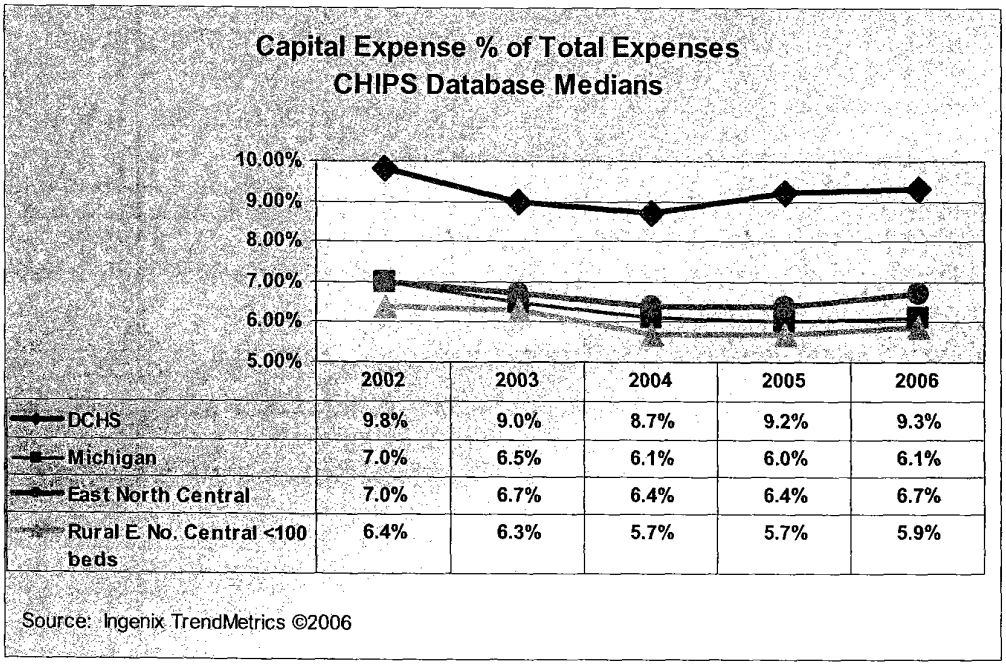


	2002	2003	2004	2005	2006
DCHS	$4,839	$5,215	$5,033	$5,291	$5,460
Michigan	$5,032	$5,649	$5,425	$6,112	$6,251
East North Central	$5,850	$6,052	$6,241	$6,494	$6,978
Rural E. No. Central <100 beds	$5,032	$5,136	$5,309	$5,761	$5,650

Source: Ingenix TrendMetrics ©2006

- Cost per discharge is low compared to other peer group medians.
- High capital costs (fixed) cause increase in cost/discharge when volumes decline.
- Inpatient census needs to be "steady" to cover fixed costs.

DCHS Capital Expense as % of Total Expenses



	2002	2003	2004	2005	2006
DCHS	9.8%	9.0%	8.7%	9.2%	9.3%
Michigan	7.0%	6.5%	6.1%	6.0%	6.1%
East North Central	7.0%	6.7%	6.4%	6.4%	6.7%
Rural E. No. Central <100 beds	6.4%	6.3%	5.7%	5.7%	5.9%

Source: Ingenix TrendMetrics ©2006

- Relatively new facility occupied in November 1996.
- Additional debt beginning in 2005 for building addition, new MRI.
- Hospital facility and attached medical office building serves to attract physicians to area.

DCHS
Physician Strategies

- The following slides show our current losses on physician practices and information on our proactive recruiting efforts and other strategies.
- We have identified direct relationships between our historic periodic shortage in orthopedic coverage of the emergency department and historic losses in market share for surgeries (not just orthopedic).
- We are working with present orthopedists to increase efforts to increase market share in order to justify an additional orthopedic surgeon.
- Existing orthopedists do knee and hip procedures, but not spines. We would recruit a new orthopod with ability to do spinal surgeries when additional volumes would justify it.
- We have identified an increase of transfers of emergency cases to other hospitals because of lack of coverage to treat cases medically and other reasons.
- A Hospitalist program that provides coverage to treat medically the surgical cases, including emergency cases, is a key component of our strategy. A proposal from BellinHealth to hospitalists at a cost of $950,000 is being considered.

DCHS

Physician Recruiting Information – Potential Benefit and Cost by Specialty

Specialty	Average Revenue Generated	Average Starting Salary*
Cardiology *(invasive)*	$2,662,600	$342,000
Orthopedic Surgery	$2,312,168	$370,000
Cardiology *(non-invasive)*	$2,240,286	$342,000
Neurosurgery	$2,100,000	$489,000
Internal Medicine	$1,987,253	$162,000
General Surgery	$1,947,934	$272,000
Hematology/Oncology	$1,624,246	$275,000
Family Practice	$1,615,828	$145,000
Obstetrics & Gynecology	$1,413,426	$234,000
Gastroenterology	$1,336,133	$315,000
Pulmonology	$1,332,534	$248,000
Urology	$1,272,563	$320,000
Psychiatry	$888,911	$174,000
Nephrology	$865,214	$225,000
Pediatrics	$697,516	$151,000
Ophthalmology	$584,310	N/A
Neurology	$557,916	$210,000

**2006 Merritt, Hawkins & Associates' Recruitment Incentives Survey.*

DCHS
Physician Practice Losses & Recruiting Activity

Practice specialty	YTD: 9/30/2007	FYE: 12/31/2006
Orthopedics	$ (130,000)	$ (238,000)
Pediatrics	$ (89,000)	$ (229,000)
Internist	$ (214,000)	$ (326,000)
Obstetrics	$ (18,000)	N/A
Overall, including outlying clinics	$ (1,032,000)	$ (1,498,000)

Special note: The hospitalist program is projected to add $250,000 to $400,000 to annual losses.

Physician Recruiting Activities:

- Current recruiting report shows active status of candidates, including internal medicine, pulmonology and obstetrics.
- Recruiting successes include 2 pediatricians and an ENT.
- Present Internist/Nephrologists plus recruiting candidates in Internal Medicine and Pulmonology could also form the core for a Hospitalist Program.
- Planning discussions with present general surgeons about recruiting a gastroenterologist are ongoing.

APPENDIX 16

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

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

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

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

Marquette, Michigan

Thursday, December 6, 2012

Confidential Video Deposition of:

Jerry L. Worden,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Marquette General Hospital, Wallace Building, 420 Magnetic Street, Marquette, Michigan, before Michele E. French, RMR, CRR, of Capital Reporting Company, a Notary Public in and for the State of Michigan, beginning at 9:36 a.m., when were present on behalf of the respective parties:

THE WITNESS: Would you repeat that.
BY MR. SANDBERG: 13:32:34
Q I posited 60 percent.
A You started at 60 percent.
Q So, therefore, a 40 percent discount?
A Yes.
MR. SANDBERG: Okay. Thank you very much. 13:32:42
MR. GRINGER: Scott, Mr. Warheit, anything?
MR. WARHEIT: I have no questions for him. 13:32:48
MR. GRINGER: Mr. Stenerson.
MR. STENERSON: One second, please.
EXAMINATION
BY MR. STENERSON:
Q Good afternoon. Mr. Worden. My name is Todd Stenerson. I represent Blue Cross. 13:33:05
When you joined Marquette General in the spring of 2008, what was the hospital's financial condition?
A They were just about to report a $10 million operating loss. They had had Wellspring, which was a nationally known turn-around firm, that was here. They had just gone through an early retirement program. They 13:33:18

had gone through some management reorganization, and they were extremely financial -- financially distressed. And their day's cash I believe was just a little bit over 50 days cash, and they were about to default on several bond covenants.

Q Do you know how close Marquette was in defaulting on their bond covenants?

A We did default on it.

Q You did default?

A We did.

Q Do you know how many covenants were defaulted?

A Three. I know it very well.

Q And this is in the spring of 2008?

A It actually -- our fiscal year ends June 30, and so when we issued the financial statements in September, we would have had to issue default notices on the covenants that we defaulted on.

Q And while the agreement that's reflected in Worden Number 3 had yet to be signed when you joined, did you understand why -- or, strike that.

Did you come to learn why Marquette General was seeking additional reimbursements from Blue Cross that ultimately resulted in the agreement that's Worden Number 3?

A Yes.

APPENDIX 17

Darland, Doug

From: Seitz, Kevin
Sent: Tuesday, May 22, 2007 5:41 PM
To: Sorget, Kim; Milewski, Robert; Connolly, Jeffrey
Cc: Darland, Doug; Noxon, Gerald; Crofoot, Ron; Carlson, Jeanne; Klobucar, Kevin
Subject: RE: Marquette General Hospital

agree with your option 3. We can also offer to split upside risk on the HMO(not necessarily 50/50).

Please keep in mind Kevin Klobucar's advice. BCN would like to go into the U.P., but BCBSM should not sacrifice for this to happen.

would like to bring this to closure quickly. Can we give them a deal/no deal deadline of June 30th? I also want to understand our final proposal so that Bob and I can brief the BCBSM Board chair. Thanks.

From: Sorget, Kim
Sent: Thursday, May 17, 2007 10:38 AM
To: Seitz, Kevin; Milewski, Robert; Connolly, Jeffrey
Cc: Darland, Doug; Noxon, Gerald; Crofoot, Ron
Subject: Marquette General Hospital

Doug, Ron, and I had a face to face meeting with Nemacheck, his CFO, and Reimbursement Director yesterday to understand their issues with the new model and what it would take for them to participate in the BCN product.

Although not totally surprising at least it was very disappointing what MGH desires is modifying their existing LOU to provide the following enhancements:

1) Expand their P4P to include outpatient, as the new model prescribes
2) Take advantage of the new model update methodology
3) Utilize the new model methodology to set their inpatient prices
4) Recognize their funding needs for their Ortho program when they know them (probably in July)

In essence they want to keep their current deal and want all the advantages of the new model contract. Most current data approximates they are over the model by nearly $10 million of a $50 million BCBSM payments per year, which is primarily driven by their outpatient deal where we are paying nearly 70% of charges. The net effect of their request (points 1-3 above) approximates $5 million or an overall increase of roughly 10%.

The basis of their argument for these needed changes is to support programs where they see us as partner to launch their Ortho program as well as other not yet fully defined strategic programs they intend to launch over the next couple of years. They see this added cash as seed money and ongoing costs to manage their initiatives.

I explained to them that providing them all the added values of the new PHA without making other new model adjustments was very problematic and our goal is to move them over time to the model and narrow the gap in reimbursement differences versus widening the gap. I knew this would be a non starter for them, but wanted to get it on the table and then suggested we were open to considering some extension of their current deal without the positive new model features they sought. Their position was that they needed the reimbursement enhancements to fund these strategic "partnering" initiatives. We pressed for what they believed were the funding requirements for the initiatives and were advised it was in the area of $3-$4 million a year. I think once they know the value of what they actually requested their need will raise to the $5 million number.

We advised them that we were definitely interested in partnering in programs where ROI's could be achieved, but would be looking at it as some form of risk arrangement, which they were not much supportive. Their primary concern was over measurements.

We closed the meeting on the note that what they requested in terms of LOU enhancements was going to be a problem for us as presented, but we would consider other ways that might provide for some funding for their "partnering" initiatives and would get back to them in a couple of weeks.

Following this Bill wanted to know if BCBSM would be willing to grant a 4 year loan to them to cover a pension shortfall they

have this year. According to Bill they need about $5 million in cash to meet their bond holder requirements for cash on hand. The thing that was a little bothersome is that they want the money for four years, but they don't want to start repayments until year three. This prompted us to ask about their financial status in which they indicated they lost $6 million last year on operations, but did not comment on investment income. I let him know I would check into it, but I was not aware of any such arrangements we had done in the past.

Doug, Ron and I met following the meeting and came up with what we believe our options are in responding to MGH, which are as follows:

1) Force the issue on adopting the model when they current LOU expires (not a likely option)
2) Do nothing and let the current LOU continue without the requested enhancements
3) Extend the current LOU and offer some gain sharing option relative (assuming we can deal with the ASC funding issues)
4) Give them what they asked for, which results in about a 10% increase.

Other sweeteners to consider with the desired option above:

a) Provide a "Pilot Grant" for their strategic initiatives as seed money, but not ongoing operation costs
b) Expectation they purchase our dental and pharmacy programs if we give them any concessions
c) Provide a low interest loan to fund their pension shortfall

Our group tended to want to develop something along the lines of Option 3 and consider one or more of the sweeteners. Before we spend a great deal of time on proposing something we seek your input to these ideas or any others you might have. Thanks, KIM

- extend current 3 year
- w/o Model Pricing + sharing (over model by $10M)
- May consider funding opportunity when your plans are ready to be shared "support partnership" etc.
- BCN open to gain/sharing
- Separate gain share program w/ BC

5/24/2007

APPENDIX 18

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

UNITED STATES OF AMERICA, et al,

Plaintiffs,

vs. Case No. 2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD
OF MICHIGAN,

Defendant.

_____

The Confidential Videotaped Deposition of
TIMOTHY SUSTERICH,
Taken at 5900 Byron Center Avenue,
Wyoming, Michigan,
Commencing at 9:17 a.m.,
Tuesday, November 20, 2012,
Before Rebecca L. Russo, CSR-2759, RMR, CRR.

Q. And how has that mix changed, if at all, say in the past five years?
A. I wouldn't say it's changed significantly.
Q. Been fairly constant?
A. Yeah, pretty much.
Q. Do the government payers cover cost of providing service to government patients?
A. They do not.
Q. Do you know why not?
A. No, I don't.
Q. Do you -- why don't you go and negotiate a higher rate with Medicare?
A. It's a government program.
Q. They don't let you negotiate?
A. No, we do not negotiate with the government.
Q. Why don't you go negotiate higher rates with Medicaid?
A. It's a government agency, as well.
Q. So Medicaid won't negotiate with you?
A. No.
Q. Do you know approximately, in the current year, how much money in government underpayment -- well, strike that.

We can give a little background for folks who aren't in the hospital industry. When you say that government payers don't pay costs, how does that

affect Metro Health's financial position?
A. Well, obviously, it's a burden that we have to bear.
Q. So do you know, in rough estimates, what percentage of cost Medicare reimburses Metro Health for services provided to Medicare patients?
A. I don't know exactly.
Q. Do you have a combined number for Medicare and Medicaid as to how much under cost those programs reimburse Metro Health for providing care to their patients?
A. We calculate it annually. I just don't remember the exact number.
Q. Do you know the dollar range of the -- well, strike that.

So do I understand correctly that if the hospital provides service to a patient and it costs a hundred dollars to provide the service, and it's only reimbursed, say, $80, it has a $20 loss on that service?
A. That'd be accurate.
Q. And if you add those individual patient losses up over the course of the year, is there a label that you give that bucket of money?
A. Community benefit.
Q. And when you use the phrase community benefit, what is

MARKED FOR IDENTIFICATION:
BLUE CROSS EXHIBIT 1057
10:35 a.m.

A. It is.

BY MR. STENERSON:

Q. Thank you. Let me hand you what I'm marking as Blue Cross 1058 --

MARKED FOR IDENTIFICATION:
BLUE CROSS EXHIBIT 1058
10:35 a.m.

BY MR. STENERSON:

Q. -- and ask you to review it.

A. Okay.

Q. Is 1058, Blue Cross 1058 an email correspondence you had with Mr. Darland at Blue Cross?

A. Apparently, yes.

Q. Does this document refresh your memory about any of the discussions you had with Blue Cross in or around 2008?

A. I'm aware that we were negotiating, yes.

Q. And is this document in or around the time when you, on behalf of Metro Health, had approached Blue Cross to seek an increase in reimbursement rate?

A. It would have been, yes.

Q. Do you know how -- do you recall how long the --

excuse me. Do you recall how long the negotiations lasted?

A. I do not recall.

Q. Is it -- suffice it to say you had more than one conversation regarding the request for an increased rate?

A. Yes.

Q. Now, Mr. Darland's email is asking, in the first bullet, how do our rates come to the rates Priority pays to your hospital.

Do you see that?

A. I do.

Q. And to other commercial payers, do you see that?

A. I do.

Q. Do you recall earlier today when you mentioned that you thought it was a relevant fact for Metro Health to understand what its competitors were being paid by Blue Cross?

A. I do.

Q. Did you find anything wrong with the fact that Mr. Darland was concerned with where Priority's rates were?

MS. BHAT: Objection to form.

A. I was.

BY MR. STENERSON:

Q. I'm sorry?
A. I was.
Q. You were what?
A. I was concerned with him asking that question.
Q. Okay. And did you respond to Mr. Darland's question?
A. That we had a confidentiality agreement in all of our contracts, that we don't discuss rates.
Q. And Mr. Darland, in his third bullet, asks whether or not Priority's been approached, do you see that?
A. I do.
Q. Do you recall if you responded to that?
A. I don't recall.
Q. At the time that Mr. Darland was asking this, do I understand correctly that you were already in discussions with Priority?
A. I don't know if we were already, but we did have discussions with Priority, yes.
Q. Let me ask it this way. Prior to Mr. Darland's email in Blue Cross 1058, had Metro Health already made the decision to approach Priority for an increase in rates?
A. We had.
Q. Am I correct in understanding that nothing that Mr. Darland asked you in this email caused you to seek additional reimbursement rates from Priority?

MS. BHAT: Objection to form.

A. No, we were already in -- we already made a decision that we needed to approach all payers -- not all payers, but the significant payers, relative to rates.

BY MR. STENERSON:

Q. In your discussions with Priority, did they seek to determine what your reimbursement rate was with Blue Cross?

A. Don't recall.

Q. In your negotiations with Blue Cross, did you seek to determine what Blue Cross' reimbursement rate was to other hospitals in Grand Rapids?

A. I did not.

Q. How did you learn what you believe to be the rates that Blue Cross was paying other hospitals in Grand Rapids?

A. Well, Blue Cross or Blue Care Network is our TPA for our employees, so we obviously have claims that are paid to the other institutions.

Q. So you were able to roughly reverse-engineer those issues?

A. Correct.

Q. Would you describe Mr. Darland as a hard negotiator?

A. I would.

MS. BHAT: Objection to form.

BY MR. STENERSON:
Q. And what do you mean by hard negotiator?
A. Unwilling to -- well, unwilling to get to where I would like it to be.
Q. Do you think Mr. Darland is in the practice of paying hospitals like Metro Health higher reimbursement than he needs to?
A. No.
MS. BHAT: Objection to form.
MR. MATHESON: Objection to form.
MS. BHAT: And foundation.
BY MR. STENERSON:
Q. At the same time, did you find that Mr. Darland would listen to your actual financial needs in determining whether or not to agree to an increase?
MR. MATHESON: Objection to the form and to the leading.
A. He was -- he did listen, yes.
BY MR. STENERSON:
Q. Let me ask it this way. In your negotiations with Mr. Darland, what did you find to be an effective way to get Mr. Darland to consider a potential increased reimbursement?
MR. MATHESON: Objection, based on earlier leading.

A. The cost structure of the organization had changed.

MR. STENERSON: That's a new one.

MR. MATHESON: It's worked before.

BY MR. STENERSON:

Q. Any other factors that you found -- what if any other factors did you find effective in negotiating for higher reimbursements with Mr. Darland?

A. That was the basis for going forward with it at that time.

Q. Let me show you what I'm gonna mark as Blue Cross 1059.

MARKED FOR IDENTIFICATION:

BLUE CROSS EXHIBIT 1059

10:42 a.m.

A. Just stick this here?

BY MR. STENERSON:

Q. Yes, sir. If you would take a moment and review Blue Cross 1059 --

A. The whole document?

Q. -- just to familiarize yourself with it.

A. I'm familiar with it.

Q. Do you recognize Blue Cross 1059?

A. I do.

Q. And what is it?

A. It's a letter of understanding between Blue Cross and

APPENDIX 19

From: Sorget, Kim
Sent: Friday, January 25, 2008 1:49 PM
To: Milewski, Robert; Connolly, Jeffrey
Cc: Dallafior, Ken; Darland, Doug
Subject: RE: Metro

We will do some research on this but it may take a month or more. Doug and team have some very tight timelines on the Market Based Outpatient Pricing Initiative with the hospital industry and the MHA, as well as the PG5 deployment in addition to us opening up negotiations with Marquette General. KIM

-----Original Message-----
From: Milewski, Robert
Sent: Wednesday, January 23, 2008 9:10 AM
To: Connolly, Jeffrey
Cc: Sorget, Kim; Dallafior, Ken
Subject: RE: Metro

I don't know how much work it is, but I am good with this being the next step, if Kim is OK. I suspected that we would receive a request from Metro eventually because of their new facility.
Bob

Robert Milewski
Senior Vice President, Contracting and Hospital Relations
Blue Cross Blue Shield of Michigan
27300 W. 11 Mile Road, B792
Southfield, MI 48034-6147

Bernie Parris, Executive Assistant
Phone: 248-448-6903

-----Original Message-----
From: Connolly, Jeffrey
Sent: Wednesday, January 23, 2008 9:08 AM
To: Milewski, Robert; Sorget, Kim
Cc: Dallafior, Ken
Subject: Re: Metro

Very very well said...I completely agree with you. Tim Susterich (their CFO) expects a response. Is the next step to have Doug assess the dollars?

Thanks

----- Original Message -----
From: Milewski, Robert
To: Connolly, Jeffrey
Cc: Sorget, Kim
Sent: Wed Jan 23 09:00:29 2008
Subject: RE: Metro

I agree; it would be good to know the cost of what they are requesting. I suspect that they will be in some serious financial trouble for a while due to their new facility, but once they get over the hump the combination of the new facility and location will result in a very successful operation. It is certainly important to keep them as a friend, but I don't want them playing us against Priority. If we are going to help them, I would like to see some return in our investment relative to their loyalty (increased market share). Therefore, if we are going to help them, what is the TANGIBLE plan to support our growth?
Bob

Robert Milewski
Senior Vice President, Contracting and Hospital Relations
Blue Cross Blue Shield of Michigan
27300 W. 11 Mile Road, B792
Southfield, MI 48034-6147

Bernie Parris, Executive Assistant
Phone: 248-448-6903

-----Original Message-----
From: Connolly, Jeffrey
Sent: Wednesday, January 23, 2008 8:54 AM
To: Milewski, Robert
Subject: Fw: Metro

Hi Bob....see below. Should we just initially have Doug look at what the cost would be to us to accelerate their rebasing formula (scheduled to be in 2010 per contract)?

Thanks

----- Original Message -----
From: Connolly, Jeffrey
To: Sorget, Kim
Sent: Wed Jan 23 08:51:28 2008
Subject: Re: Metro

They do have a contract with priority...not as competitive (from what I hear) as ours, but very important point to consider as we assess our contract.

Thanks

----- Original Message -----
From: Sorget, Kim
To: Milewski, Robert
Cc: Connolly, Jeffrey
Sent: Wed Jan 23 08:25:20 2008

Subject: RE: Metro

I think Metro has a contract with Priority, but would rely on Jeff to confirm. I know that Metro was in contract negotiations for months with Priority regarding their ASF, but understand they now have an agreement with Priority. KIM

-----Original Message-----
From: Milewski, Robert
Sent: Wednesday, January 23, 2008 8:21 AM
To: Sorget, Kim
Subject: RE: Metro

Does Metro accept Priority?

Robert Milewski
Senior Vice President, Contracting and Hospital Relations
Blue Cross Blue Shield of Michigan
27300 W. 11 Mile Road, B792
Southfield, MI 48034-6147

Bernie Parris, Executive Assistant
Phone: 248-448-6903
-----Original Message-----
From: Sorget, Kim
Sent: Tuesday, January 22, 2008 7:45 AM
To: Connolly, Jeffrey; Darland, Doug
Cc: Seitz, Kevin; Milewski, Robert
Subject: RE: Metro

Jeff, we I don't see we have any contractual obligation to rebase them ahead of schedule, unless BCBSM believes we have a good business reason to do so. To my knowledge neither Kevin or Bob, or the facility for that matter has made such a request. Kevin, is this something you think that should pursued? KIM

-----Original Message-----
From: Connolly, Jeffrey
Sent: Monday, January 21, 2008 6:20 AM
To: Sorget, Kim; Darland, Doug
Subject: Metro

Kim and Doug,

Had a brief meeting with Tim Susterich (CFO) at Metro. They are requesting that we advance the "rebasing" of their costs this year as opposed to 2010 (per contract). Given the new facility, he feels that it would equate to more needed reimbursement for the hospital. Apparently, Ken Nyson met with Kevin Seitz and made the same request. What are your thoughts??

Jeff

APPENDIX 20

MidMichigan Health / Blue Cross Blue Shield Agreement
CONFIDENTIAL

On September 5, 2008 MidMichigan Health and Blue Cross Blue Shield of Michigan reached a verbal agreement on contract terms after nearly nine months of negotiations. The contract terms are summarized as follows:

- The initial contract term is 3 years (fiscal year 2009, 2010 and 2011) it then becomes evergreen (automatically renews each year) with either party able to open it for negotiations with 120 days notice.

- Initially and annually thereafter, rates will increase by the market basket (NIPI) plus 0.3% at Midland and Gratiot and by the market basket at Clare and Gladwin. After the initial year, rate increases will be capped by the Standard Model Participating Hospital Agreement rate increase. Under these terms, Midland receives approximately $5.5 million per year of enhanced payments relative to the standard Blue Cross agreement.

- Gratiot will be reimbursed 100% of the Blue Cross share of the new patient tower and ER capital cost. This enhances payment to Gratiot by over $1.2 million each year.

MHA

- Gladwin and Clare will continue to receive the lucrative "Peer Group 5" discount off charges reimbursement without implementation of any significant terms of the new Standard Peer Group 5 Participating Hospital Agreement. This continues to enhance annual payments to Gladwin by approximately $1.5 million and Clare by $1.1 million relative to other Peer Group 5 hospitals in Michigan. Successful past negotiation of Clare into Peer Group 5 (they qualify as a Peer Group 4 hospital) enhances their payment an additional $1.8 million, or $2.9 million per year relative to their peers.

- Blue Cross will increase overall payments by 0.4 points for each .75% increase in Blue Cross activity to compensate for migration from other commercial payors to Blue Cross.

- The Blue Cross Traditional Indemnity and PPO plan payments will be blended to a single budget neutral rate, eliminating the differential and negative impact of migration from indemnity to PPO plans.

- MidMichigan Health agrees to provide an 8% greater discount to Blue Cross than it does to any other independent commercial payor for hospitals in the aggregate excluding ConnectCare. There will not be any retrospective audit and simple attestation will be adequate documentation of the favored rates.

- RATE INCREASE AUDIT

ΔπEXHIBIT 19
Deponent GOVT Rodgers
Date 12-7-12 Rptr. [illegible]
WWW.DEPOBOOK.COM

1954

APPENDIX 21

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

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

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

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

Traverse City, Michigan
Thursday, March 15, 2012

Confidential Video Deposition of:

STEVEN LEACH,

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

THE WITNESS: Yes.

BY MR. GRINGER: **10:52:36**

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...? **10:52:54**

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 **10:53:01** 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. **10:53:18**

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 **10:53:33** ahead.

The only other thing, and maybe I shouldn't answer the question until I'm asked, but I

A 551.

MR. McCANN: Exhibit B. 14:45:00

THE WITNESS: Yeah.

BY MR. GRINGER:

Q Do you see there several Peer Groups listed and some hospital characteristics?

A Yes. 14:45:14

Q What Peer Group is Munson Medical Center?

A It's 2.

Q So --

A Can I -- it doesn't matter anymore, though, for reimbursement purposes. 1 through 4 are paid 14:45:25 exactly the same, in the logic.

Q And what Peer Group are Kalkaska and Paul Oliver?

A They're both Peer Group 5.

Q And is Peer Group 5's reimbursement logic 14:45:39 different than 1 through 4?

A Yes.

Q If I could ask you now to turn the page to the "Model Reimbursement Methodology from Peer Group 1 - 4 Hospitals." And that starts in Government Leach Exhibit 14:46:03 13 on the page ending 52. And the first section is entitled, "Reimbursement Principles." Do you see that, Mr. Leach?

APPENDIX 22

Jerry Noxon

Dear Jerry:

I appreciate you and Kim Sorget spending time with me on the phone on December 13, 2007 to clarify your proposal letter dated November 28, 2007.

I understand BCBSM's desire to have all hospitals on the revised PHA payment methodology and am supportive of this concept. However, your proposed increase of 1.8% does not cover the BCBSM pro rata share of new capital and operating costs that Sparrow will incur as a result of opening our new West Wing next month not to mention just general cost inflation. After our discussion I rolled forward our costs from the last rebasing using our actual annual increases in our costs per adjusted discharge. That analysis suggested that our current BCBSM rates are about $2 million higher than the PHA methodology would support, not the $9 million you reference in your letter. The following proposal would move us to the standard PHA agreement in year 2 and provide Sparrow with slightly lower annual rate increases to offset this estimated $2 million difference.

- Year 1- Sparrow to receive an update of 2.6% for hospital inpatient and outpatient charge based services with an application of the incentive program to all services consistent with the standard PHA agreement. In addition, Sparrow will be allowed to retain the $560,000 "PHA signing bonus" to partially offset the incremental costs in 2008 associated with opening the new West Wing.

- Year 2- Sparrow to receive the full PHA update factor less 1% plus the application of all provisions of your standard PHA agreement.

- Year 3- Sparrow to receive the full PHA update factor.

You have indicated that since 2010 is the beginning of a new base year cycle that rebasing will occur using 2007 data. As noted earlier Sparrow is opening its new West Wing in 2008 and 2007 will not be totally reflective of the increased costs to serve BCBSM beneficiaries and members. We would propose that 2007 costs be adjusted to include the new capital and operating costs in the rebasing process.

Thank you for your time to review our counterproposal. We stand prepared to meet with you as soon as practicable to conclude these payment discussions.

APPENDIX 23

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN

UNITED STATES OF AMERICA and the STATE OF MICHIGAN, Plaintiffs, vs. BLUE CROSS BLUE SHIELD OF MICHIGAN, Defendant.	Case No. 2:10-CV-14155 DPH-MKM

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF MICHIGAN

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

VIDEOTAPED DEPOSITION OF JOSEPH FIFER

HIGHLY CONFIDENTIAL

rendering care to Medicare and Medicaid patients.

Q. I still don't understand. Can you explain further?

A. When we get paid from Medicare and Medicaid reimbursement, that's less than providing the care to the patients; so we lose money on those patients. **14:35:12**

Q. How -- Well, strike that.

At the time you left in 2012, were you losing money at the Spectrum Health facilities for providing care to Medicare patients? **14:35:26**

A. Yes.

Q. At the time you left Spectrum in 2012, were you losing money on providing care to Medicaid patients?

A. Yes. **14:35:36**

Q. Is that the same answer for the three smaller facilities?

A. It is definitely the same for Medicaid. I'm not a hundred percent sure on Medicare for all three. **14:35:56**

Q. Do you know what your annual, in dollars, Medicare and Medicaid shortfall was at the Spectrum Health facilities at the time you left?

MR. LIPTON: Objection to form.

BY THE WITNESS:

A. It was approximately a hundred million dollar loss -- Strike that.

Just Medicare and Medicaid was probably around $80 million. **14:36:22**

Q. And if I'm understanding you correctly, that means if you take all the costs of providing patient care to a year's worth of Medicare and Medicaid patients, the payments you receive from those government programs add up to $80 million less than it costs you to provide the care? **14:36:39**

A. That's correct.

Q. And what are some of the ways that a hospital like Spectrum Health can make up for those tens of millions of dollars of shortfalls? **14:36:55**

A. There's only one other way, and that is to be paid by the commercial payors in rates adequate enough to make up for that.

Q. Did I hear you correctly that there's only one way to make up for the government shortfalls, and that is to get it from the non-government payors? **14:37:10**

A. That's my opinion. And actually, that's by fact. I don't know how else it would happen.

Q. You mentioned in your answer an additional source of losses that the hospitals incurred -- sorry. Your answer of a hundred million intimated there may be another source of potential losses?

A. No. My first hundred-million-dollar number, I was remembering the community benefit calculation that we used to do. That includes other things where that hospital supports the community above and beyonds losses on Medicare and Medicaid. It's got nothing to do with Medicare and Medicaid. **14:37:40** **14:37:58**

Q. Are you referring MHAs, community benefit reports?

A. There's several calculations, but that's one of them.

Q. What is the annual community benefits report the hospital fills out as part of the MHA? **14:38:09**

A. What is it?

Q. Yes.

A. What is the report? Again, MHA has a definition of community benefit that they recommend that hospitals complete, and MHA gathers that data from hospitals. And that definition of community benefit includes things like losses on Medicare and Medicaid as well as community programs. **14:38:18**

Q. Does it include charity care?
A. Yes.
Q. What is charity care?
A. Charity care is care that's provided for patients that don't have the resources to and don't have insurance and don't have the money to pay for it. **14:38:45**
Q. Does it include bad debt?
A. I don't remember. I don't remember if that's in the MHA calculation or not. **14:39:03**
Q. And so shifting back to the methods in which a hospital -- Strike that.
Shifting back to the only method you believe a hospital can use to make up for the failures of Medicare and Medicaid payments, who is your largest payor, commercial payor at Spectrum Health facilities? **14:39:22**
MR. LIPTON: Objection to form.
BY THE WITNESS:
A. Blue Cross. **14:39:36**
Q. And do you know who your second largest payor is at Spectrum Health?
A. That would be Priority Health.
Q. And do you know how their annual revenues

compare at Spectrum?

A. About when I was there, yes.

Q. And how do they compare?

A. Well, actually the number I can remember more distinctly would be the percent of our revenue. Blue Cross was somewhere around 17 percent of our revenue, and Priority Health was somewhere around 13 percent of our revenue. **14:39:56**

Q. And the Medicare and Medicaid losses of approximately $80 million annually at the time you left, has that number been relatively constant in the past 5 years? **14:40:17**

A. It's grown.

Q. And where has it grown from, if you recall? **14:40:29**

MR. LIPTON: Objection. Form.

BY THE WITNESS:

A. I don't recall the number 5 years ago. But 10 years ago, between the two programs it was zero.

Q. Really? So in 2002, Spectrum Health facilities did not have any government shortfall for Medicare and Medicaid patients? **14:40:40**

A. If you combine the programs together, correct.

Q. What has happened in the past 10 years that has caused government payors to go from covering cost to creating upwards of an $80 million loss to Spectrum?

MR. LIPTON: Objection to form. Foundation. **14:41:06**

BY THE WITNESS:

A. The rising cost of healthcare, and increases from those payors that were either nonexistent or at a lesser rate than the cost increases. **14:41:24**

Q. I'm sorry. I didn't follow your answer.

A. The percent payment increase from those payors has been significantly less than the percent increase in the cost of delivering that care.

Q. Just let me understand. So the actual cost at Spectrum Health facilities in the past 10 years has significantly outpaced the payment increases from Medicare and Medicaid? **14:41:39**

A. Yes.

Q. Do you know what -- Well, strike that. **14:41:54**

Did the Blue Cross MFN provision have anything to do with Spectrum Health facilities increased cost in the past decade?

MR. LIPTON: Objection to form.

APPENDIX 24

KERRI NELSON
March 22, 2012

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 KERRI NELSON,

Taken at 1 North Atkinson Drive,

Ludington, Michigan,

Commencing at 10:08 a.m.,

Thursday, March 22, 2012,

Before Rebecca L. Russo, CSR-2759, RMR, CRR.

A. Unpaid costs for government program patients.
Q. What is that?
A. That would be our Medicare and Medicaid shortfalls.
Q. Okay. And what are Medicare and Medicaid shortfalls?
A. It's the difference between the cost of providing service to those patients that have Medicare and Medicaid versus what we get paid in reimbursement.
Q. Okay. We'll circle back to this in a few minutes, but, in your opinion, what is the impact of Medicare and Medicaid shortfalls on the hospital's financials?
MS. ARIAS: Objection to form.
A. It actually reduces our operating income.
BY MR. LASKEN:
Q. Is that positive for the hospital?
A. Not -- no.
Q. Does it help the hospital stay in business?
MS. ARIAS: Objection to form, foundation.
A. No.
BY MR. LASKEN:
Q. Does it help the hospital provide better care?
MS. ARIAS: Objection to form, foundation.
A. No.
BY MR. LASKEN:
Q. Does it help the hospital buy new equipment?
A. No.

APPENDIX 25

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 JEFFERY LONGBRAKE,

Taken at 1100 South Van Dyke Road,

Bad Axe, Michigan,

Commencing at 9:31 a.m.,

Wednesday, August 29, 2012,

Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

It's near 20% in some cases. So that's what I was referring to in terms of people in our market, so...

Q. Can you explain to me what you mean by payer mix?

A. Yeah, payer mix is the different types of payers that pay the hospital for services, Medicare being one.

Q. And you said Medicare makes up approximately 50% of Huron Medical Center's payer mix?

A. Approximately.

Q. And Medicaid can be anywhere from an additional 10 to 20.

A. 8 to 10 in the general population, higher in OB, but yes, 8 to 10 is accurate.

MR. GOURLEY: I'll hand you what we'll mark as Exhibit 658.

MARKED FOR IDENTIFICATION:
BLUE CROSS LONGBRAKE EXHIBIT 658
10:40 a.m.

BY MR. GOURLEY:

Q. Mr. Longbrake, do you recognize this document?

A. Yes.

Q. And what is it?

A. It was provided as part of the information request. It's a description of our payer mix for fiscal year 2006.

Q. And at least for fiscal year 2006, Medicare was 46.7%

of Huron Medical Center's payer mix, correct?
A. That's correct.
Q. And Medicaid was 10.62%?
A. That's correct.
Q. Okay. Does Medicare cover the actual costs of medical services that Huron Medical Center provides?
A. Not typically.
Q. And what is the current Medicare reimbursement rate that Huron Medical Center receives?
A. About 48 cents on the dollar, somewhere in that neighborhood, depending on the services.
Q. And what is the current Medicaid reimbursement rate that Huron Medical Center receives?
A. Somewhere between 20 and 30 cents on the dollar, again, depending on the services.
Q. So is Huron Medical Center losing money on its Medicare and Medicaid patients?
A. In some cases.
Q. When you're receiving 48 cents on a dollar of Medicare and 20 --
A. Of charges.
Q. Of charges, correct. So you're not covering your costs, correct?
A. In some cases we don't.
Q. And what impact does that have on the financial

condition of Huron Medical Center?
A. It just makes it challenging at times. I mean, typically Medicare, as you know, is settled by cost report, so you get some of those costs back, but it's out four or five years in the future in many cases. So typically we don't cover the total charge, the total cost.
Q. How does Huron Medical Center make up for the fact that it doesn't receive or that Medicare reimbursement doesn't cover the actual cost?
A. Well, we provide services to the payer mixes that are listed here. In some cases we get reimbursed better by some other payers. We try to, of course, do as much Medicare volume as we can and as much volume as we can with all payers, and also, we as one of the documents referred about operating -- operating income is one thing, but net income is the bottom line that most people look at, and that's influenced by other activities such as investment income.
Q. I think you mentioned one area where you were able to recoup some of that, some of the money lost to Medicare patients, is from getting greater reimbursement from other payers; is that correct?
A. That's correct.
Q. And that would be from the other commercial payers?

APPENDIX 26

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

Tuesday, August 21, 2012

Confidential Video Deposition of:

HELEN M. HUGHES,

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 9:01 a.m., when were present on behalf of the respective parties:

A Say that again.
Q Sure. In fact, is there a reason why Bronson Methodist might actually want a higher rate from Aetna at the LakeView facility than it would want to receive at the main campus here in Kalamazoo? 16:52:38
A When the MFN was -- when we were aware of the MFN implications, we needed a higher rate, yes.
Q But it's also a Critical Access Hospital; correct?
A It's also a Critical Access Hospital. 16:52:52
Q And you said you don't recall whether or not the renegotiation that is in Plaintiff's Hughes Number 11 was initiated by the MFN; is that right?
A I do not believe it was.
Q So you don't believe that Plaintiff's 11, the 85 percent rate, was caused by the MFN? 16:53:05
A I do not believe it was.
Q Why?
A Because if it would have been in relationship to the MFN, I would have gone for 87. 16:53:15
Q And you went for 85?
A I went for 85.
Q Do you know how much business LakeView had from Aetna/Cofinity in or around January of 2008?
A Not much. 16:53:33

APPENDIX 27

UNITED STATES DEPARTMENT OF JUSTICE

EASTERN DISTRICT OF MICHIGAN

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

United States and State :
of Michigan, :
: :
Plaintiffs, :
: :
vs : Civil Action No.
: 2:10-cv-14155-DPH-MKM
Blue Cross Blue Shield :
of Michigan, :
: :
Defendant. :

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

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

MR. SMALL: Object.

MR. GRINGER: Object.

THE WITNESS: No.

BY MR. STENERSON:

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

MR. GRINGER: Object to foundation.

MR. SMALL: Object to foundation.

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

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

(Off the record.)

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

APPENDIX 28

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

Monday, November 12, 2012

Confidential Video Deposition of:

NICKOLAS VITALE,

was called for oral examination by counsel for Plaintiff, pursuant to Notice, at Miller, Canfield, Paddock and Stone, 150 W. Jefferson, Suite 2500, 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 9:30 a.m., when were present on behalf of the respective parties:

A When it was made public in the press is my recollection of when I was made aware of that.

Q Okay. And I believe through some conversations with Mr. Matheson we determined that was around the October 2010 time frame? 12:41

A Right.

Q Okay. So I assume that prior to October of 2010, the most favored nations provision in Beaumont's contract with Blue Cross didn't impact any business decision that you made on behalf of Beaumont? 12:41

A It did not.

Q During that time period prior to October of 2010, say from 2006 to October of 2010, you didn't take (sic) any business decision on behalf of Beaumont as a result of the MFN provision in Beaumont's 12:41 contract with Blue Cross?

A I did not. I would not have been in a position to have an impact on contracting, so --

Q Okay.

A -- it wasn't relevant. 12:41

Q To your knowledge, did Beaumont ever adjust a commercial insurer's reimbursement rate to comply with the most favored nations provision in its contract with Blue Cross/Blue Shield of Michigan?

MR. MATHESON: Objection to foundation. 12:42

THE WITNESS: To my knowledge, no.
BY MR. GOURLEY:
Q So, to your knowledge, Beaumont never adjusted Aetna's reimbursement rate in order to comply with the most favored nations provision in its contract with Blue Cross, correct? 12:42
MR. MATHESON: Objection, foundation.
THE WITNESS: Correct. Correct.
BY MR. GOURLEY:
Q I believe you testified earlier that you don't remember specifically bringing up removal of the most favored nations provision when you were negotiating with Blue Cross in the 2011 time frame; is that correct? 12:43
A No. What I recall is there was a brief discussion very early on in the negotiations and Blue Cross requested that we table that for now and go through all the business aspects of the discussion and that we would circle back to that at the end of the agreement. 12:43
Q Okay. So the most favored nations provision wasn't a sticking point in negotiations during that time period?
MR. MATHESON: Object to characterization. 12:43

APPENDIX 29

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:

the most favored nations provision?

A I can only speak to St. John Providence. We **14:28:48**
do not coordinate any other contracts on a statewide basis other than Blue Cross. But for St. John Providence specifically, we have -- we have not made any changes to any contracts because of the MFN.

Q And when you -- thank you for that. But when **14:29:11**
you say "St. John's Providence," does that include all the facilities in Detroit?

A Yes.

Q Okay. So I just want to be clear. When we're
talking about St. John's Providence, you're talking **14:29:20**
about the Providence Hospital and Medical Center in Southfield; correct?

A Providence Hospital in Southfield, Providence Novi, St. John Hospital, St. John Macomb, St. John
Oakland, St. John River District. **14:29:32**

Q Okay. So I'd like to ask a series of questions about the St. John Hospitals --

A Okay.

Q -- using that definition; okay? Has St.
John's hospitals raised the rate of Aetna because of the **14:29:44**
Blue Cross MFN?

A We have not.

Q Has St. John Hospitals raised the rate of

United because of the Blue Cross MFN?
A We have not. **14:29:54**
Q Has St. John's raised the rate of HAP because of the Blue Cross MFN?
A We have not.
Q Has St. John Hospitals raised the rate of HealthPlus because of the Blue Cross MFN? **14:30:04**
A We have not.
Q Has St. John's Hospital raised the rate of any payer because of the Blue Cross MFN?
A No.
Q Has any single payer paid a penny more to St. **14:30:12**
John's Hospital because of the Blue Cross MFN?
A No.
Q Has St. John's Hospital refused to lower any payer's rate because of the Blue Cross MFN?
MS. LEWIS: Object to the form. **14:30:28**
THE WITNESS: No.
BY MR. STENERSON:
Q Has Blue Cross [sic] refused to lower Aetna's rate because of the Blue Cross's MFN?
MS. LEWIS: Object to the form. **14:30:36**
THE WITNESS: I'm sorry?
BY MR. STENERSON:
Q I'm sorry. Has St. John's refused to lower

APPENDIX 30

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.

Videotape Deposition of RICHARD HARNING, taken in the above-entitled matter before Notary Public, Patricia A. Lutza, CSR, CRR, at Varnum Riddering, 333 Bridge St., N.W., Grand Rapids, Michigan, on Monday, November 7, 2011, commencing at about 9:30 a.m.

multifaceted-pronged approach that we hit on all cylinders. This was a major part of the hospital's turnaround without a doubt.

Q. When did the hospital have negative days cash on hand?

A. Spring of 2008.

Q. And that was right around the time when you were negotiating with Blue Cross; is that right?

A. Yeah.

Q. And you said as part of your multi-pronged approach, you said you targeted Priority Health and United, what did you mean by that?

A. Improvement in rates.

Q. And am I correct that even without a Blue Cross Most Favored Nation clause, the hospital would still have sought to increase the rates of Priority and United?

A. Yes.

Q. Why?

A. When you compare rates by competing

entities, you have to look at opportunities, and, if you looked at both of those payors, there would be an opportunity just from looking at the rate.

Q. And, from your perspective as a CFO, when you looked at the existing rates of Priority and United, what specifically did you look at to determine that there was an opportunity there for initial reimbursements?

A. They were less than Blue Cross's.

Q. And why when you saw that their rates were less than Blue Cross's rates did you determine there was an opportunity?

A. Because we have a Most Favored Discount clause with Blue Cross.

Q. My initial question, sir, was, if you hadn't had a Most Favored Nation clause with Blue Cross, would you have still seen an opportunity to raise the rates of United and Priority?

MR. GRINGER: Objection, asked and answered.

THE WITNESS: Yes.

BY MR. STENERSON:

Q. Why is that?

A. Because when you look at various payment rates by a like category of customers, there is disparity there.

Q. And that is separate and apart from the existence of any Most Favored Nation clause; correct?

A. Yes.

Q. Let me have you look at the first page of Blue Cross Exhibit 11. I want to talk to you a little bit about what are known as Blue Cross BIP payments, okay? What are Blue Cross BIP payments?

A. They are Blue Cross interim payments. We get a weekly allowance payment from Blue Cross that approximates the last 12-months average, claims incurred by Blue Cross patients at a given payment rate, it is an allowance.

Q. How do those Blue Cross BIP payments help the hospital operate?

A. They are imperative to stability and cash flow.

Q. Why is that?

THE WITNESS: Can you repeat the question?

BY MR. STENERSON:

Q. Sure. Are all the rate increases that you sought after you had an MFN with Blue Cross all the rate increases from United that you sought?

MR. GRINGER: The same objection.

MR. STENERSON: Let me start over. Withdraw.

BY MR. STENERSON:

Q. After you had an MFN -- well, strike that. Any increase you sought from United Healthcare in '08 and '09, were those increases you would have sought even if you did not have an MFN with Blue Cross?

A. Yes.

Q. Why is that?

A. Opportunities to improve the financial viability for Allegan General Hospital.

Q. If you could go to number 9, please. This is the group of documents related to negotiations with Priority; correct?

A. Yes.

Q. In this time frame in September of 2008, even if you had not had an MFN with -- well, strike that.

In September 2008 and forward, are all the increases you sought from Priority increases you would have sought even if there was no MFN with Blue Cross?

MR. GRINGER: Object to form.

THE WITNESS: Yes.

BY MR. STENERSON:

Q. Why is that?

A. Disparity in rates would lead one to conclude that you have an opportunity to increase your rate.

Q. Can you explain that to me.

A. The disparity in the rates of like commercial competitors would lead one to conclude that you have an opportunity to renegotiate a higher rate.

Q. So, when you recognize that Priority was lower than Blue Cross, that's what you are

APPENDIX 31

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

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

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

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

Charlevoix, Michigan

Friday, March 2, 2012

Confidential Video Deposition of:

WILLIAM JACKSON,

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

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

Is that consistent with your memory?

A Yes.

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

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

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

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

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

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

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

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

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

BY MR. STENERSON:

APPENDIX 32

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF MICHIGAN

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

Lansing, Michigan

Wednesday, August 8, 2012

Confidential Deposition of:

WILLIAM ROESER,

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

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

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

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

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

Q Can you explain what you mean by that?

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

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

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

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

APPENDIX 33

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
MARK GROSS,
Taken at 955 South Bailey Avenue,
South Haven, Michigan,
Commencing at 9:07 a.m.,
Thursday, November 15, 2012,
Before Rebecca L. Russo, CSR-2759, RMR, CRR.

present, in your experience?
A. I can only respond to that, to the facilities that I've worked at, it has not changed.
Q. In your position, are you willing to accept a lower reimbursement rate from Blue Cross because they have higher volume?
A. In theory, yes.
Q. Why?
A. In theory, from an economic perspective, it's my opinion that if someone provides you something, whether that's patients or widgets, or wants to buy something from you, that bigger customers tend to get a better discount.
Q. And is that, in part, because they account for a larger percent of revenue?
A. Yes.
Q. And at South Haven, Blue Cross accounts for approximately fifteen percent of revenue, correct?
A. Yes.
Q. Is Priority the next-closest commercial payer to Blue Cross, at five percent?
A. Yes.
Q. So Blue Cross has three times its nearest -- the nearest commercial insurer in terms of volume at South Haven?

UNPUBLISHED CASES

Not Reported in F.Supp.2d, 2007 WL 1219036 (E.D.Mich.)
(Cite as: 2007 WL 1219036 (E.D.Mich.))

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Only the Westlaw citation is currently available.

United States District Court,
E.D. Michigan,
Southern Division.
WALBRIDGE ALDINGER COMPANY, Plaintiff,
v.
AON RISK SERVICES, INC. OF PENNSYLVANIA, Defendant.

No. 06-CV-11161-DT.
April 25, 2007.

Anthony J. Abate, Daniel J. Deleo, Abel Band, Sarasota, FL, Stuart H. Teger, Honigman, Miller, Detroit, MI, for Plaintiff.

Jenice C. Mitchell, Mark A. Aiello, John P. Kuriakuz, Foley & Lardner, Detroit, MI, for Defendant.

OPINION AND ORDER GRANTING "DEFENDANT AON RISK SERVICES, INC. OF PENNSYLVANIA'S MOTION TO STRIKE PLAINTIFF'S EXPERT REPORT"

ROBERT H. CLELAND, United States District Judge.

***1** Pending before the court is "Defendant Aon Risk Services, Inc. of Pennsylvania's ["Aon's"] Motion to Strike Plaintiff's Expert Report." The court has reviewed the briefing in this matter [FN1] and received argument on the motion during an April 4, 2007 hearing. For the reasons stated below, the court will grant the motion.

FN1. The extensive briefing in this matter includes Defendant's motion, Plaintiff's response, Defendant's reply, Plaintiff's sur-reply and Plaintiff's supplemental memorandum as requested by the court.

I. BACKGROUND

The following facts are uncontested. Plaintiff Walbridge Aldinger Company ("Walbridge") requested, in writing, that Aon, a surety broker, procure a conditional payment bond for Walbridge's Florida construction project (the "Project"). Aon then presented Walbridge with a written contract for an unconditional payment bond, which Walbridge signed. After the owner of the Project failed to pay Walbridge for its work, numerous subcontractors and suppliers asserted claims against Walbridge for the work that they performed. Walbridge alleges that it faces liability from its subcontractors and suppliers because the payment bond was an unconditional, rather than a conditional bond. Walbridge claims to have paid its subcontractors and suppliers over three million dollars to date.

Walbridge initiated the above-captioned matter in this court on March 17, 2006. In its complaint, Walbridge asserts a breach of contract claim against Aon for failure to provide a conditional bond as requested. On February 23, 2007, Aon filed the instant motion seeking to strike Walbridge's expert report by Mr. Brian Downey because the report is allegedly irrelevant and unreliable.

II. STANDARD

A. Federal Rule of Civil Procedure 26

Federal Rule of Civil Procedure 26 requires that an expert report contain:

> a complete statement of all opinions to be expressed and the basis and reasons therefor; the data or other information considered by the witness in forming the opinions; any exhibits to be used as a summary of or support for the opinions; the qualifications of the witness, including a list of all publications authored by the witness within the preceding ten years; the compensation to be paid for the study and testimony; and a listing of any other cases in which the witness has testified as an expert at trial or by deposition within the preceding four years.

Fed.R.Civ.P. 26(a)(2)(B). Where a party "fails to disclose information required by Rule 26(a)," that party "shall not, unless such failure is harmless, be permitted to use as evidence at a trial, at a hearing, or on a motion any witness or information not so disclosed." Fed.R.Civ.P. 37(c)(1). Minor omissions, however, do not support striking an expert's report. *See Chapple v. State of Alabama*, 174 F.R.D. 698, 700 (M.D.Ala.1997) (Although the expert "has not explicitly stated how much he is charging the plaintiff for his work ... [t]hat omission would not be a ground for an order precluding [the expert's] testimony.").

B. Federal Rule of Evidence 702

Federal Rule of Evidence 702 provides that:

> If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

***2** In *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, the Supreme Court held that, when faced with a proffer of expert scientific testimony, the trial judge is assigned "the task of ensuring that an expert's testimony both rests on a reliable foundation and is relevant to the task at hand." 509 U.S. 579, 580, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993). This ruling was later interpreted by the Court to apply to all expert testimony, not only scientific testimony. *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 141, 119 S.Ct. 1167, 143 L.Ed.2d 238 (1999).

The party proffering the expert bears the burden of persuading the trial court that the expert has specialized knowledge that will aid the fact finder in understanding the evidence or determining a fact at issue. *Nelson v. Tennessee Gas Pipeline Co.*, 243 F.3d 244, 251 (6th Cir.2001) (citing *Daubert*, 509 U.S. at 592 n. 10). The trial court has wide discretion when determining whether to admit or exclude opinion testimony. *United States v. Paris*, 243 F.3d 286, 288 (6th Cir.2001).

Further, expert testimony on ultimate issues for the trier of fact is not *per se* inadmissible, but the court has latitude to restrict testimony that is not helpful to jurors. Fed.R.Evid. 704; *United State v. Sheffey*, 57 F.3d 1419, 1425 (6th Cir.1995); *Shahid v. City of Detroit*, 889 F.2d 1543, 1547-48 (6th Cir.1989) (exclusion of expert testimony is not proper if expert's opinion on the ultimate issue amounts to a "legal conclusion"). Expert opinions should not be admitted if they merely tell the jury what result to reach. *Woods v. Lecureux*, 110 F.3d 1215, 1220 (6th Cir.1997) ("It is, therefore, apparent that testimony offering nothing more than a legal conclusion-i.e, testimony that does little more than tell the jury what result to reach-is properly excludable under the Rules.").

III. DISCUSSION

Defendant first argues that Mr. Downey's testimony is irrelevant because it relates to Defendant's alleged breach of a duty of care when the only issue in this case is a breach of contract claim. (Def.'s Reply at 3-4 (citing Fed.R.Evid. 402 ("Evidence which is not relevant is not admissible.")).) Plaintiff contends that Mr. Downey's testimony is relevant in that it speaks to the implied contractual duty to "perform skillfully, carefully, diligently, and in a workmanlike manner." (Pl.'s Sur-Reply at 4.)

Even if relevant, the court agrees that Mr. Downey's testimony will not assist the trier of fact to understand the evidence or to determine a fact in issue. *Nelson*, 243 F.3d at 251 (citing *Daubert*, 509 U.S. at 592 n. 10). Mr. Downey's report merely recites uncontested facts (that Plaintiff requested a conditional bond and Defendant provided an unconditional bond), and then concludes that Defendant "failed to perform its obligations in

accordance with generally accepted surety industry standards of due care ....“ (Downey Report at 3, Def.'s Ex. A.) Mr. Downey's extensive deposition testimony similarly fails to include the bases and, more significantly, the reasons for his conclusions or the manner in which he arrived at those conclusions. Furthermore, Mr. Downey's unsupported conclusion that Defendant violated an implied contractual duty of care is a legal conclusion, and therefore problematic. *See Torres v. County of Oakland*, 758 F.2d 147, 150 (6th Cir.1985) (“The problem with testimony containing a legal conclusion is in conveying the witness' unexpressed, and perhaps erroneous, legal standards to the jury. This invades the province of the court to determine the applicable law and instruct the jury as to that law.”).

***3** Further, Mr. Downey's testimony is not “the product of reliable principles and methods,” as required by Federal Rule of Evidence 702, and does not include “the basis and reasons” supporting its conclusion as required by Federal Rule of Civil Procedure 26(a)(2) (B). Plaintiff contends that the expert report is reliable because, (a) Mr. Downey is an expert, (b) he consulted a number of documents filed by the parties and (c) has 33 years of experience in the surety industry. The court disagrees. Federal Rule of Evidence 702 requires that the testimony be given by an expert, rely on “sufficient facts or data,” *and* be “the product of reliable principles and methods.” Plaintiff unavailingly presents the expert's qualifications (comprising both points (a) and (c) noted above) and that he relies on record facts in its attempt to satisfy the independent requirement that the report must be “the product of reliable principles and methods.” Fed.R.Evid. 702. Even in Plaintiff's supplemental briefing, Plaintiff provides no basis for Mr. Downey's “opinion regarding generally accepted surety industry standards” other than Mr. Downey's “personal experience.” (Def.'s Supp. Br. at 4 (citing Downey Dep. at 97, 99-100, Def.'s Ex. B).) Mr. Downey does not reveal what the relevant “surety industry standards” consist of, nor does he detail any principles, methods or comparative cases that he utilized in forming his opinion. His qualifications and lengthy service in the industry alone cannot satisfy this requirement. To allow mere years of experience to substitute for an actual reasoned explanation would be to permit an opinion to be supported by not much more than “because I said so .” Accordingly, the court finds that Mr. Downey's proposed testimony fails to meet the requirements of Federal Rule of Evidence 702 and Federal Rule of Civil Procedure 26(a)(2)(B), and should be excluded on that basis.

Finally, Defendant argues that Mr. Downey's testimony should be excluded under Federal Rule of Civil Procedure 26 because he misrepresents his qualifications [FN2] and does not identify the compensation he is to be paid by Walbridge for his testimony. (Def.'s Mot. at 11-12; Def.'s Reply at 16-18.) That there are components of Mr. Downey's résumé that are-or appear to be-misleading is unfortunate, as is his failure to disclose the compensation he is to receive from Walbridge as required by Rule 26. These omissions and inaccurate representations provide a secondary basis for the court to exclude Mr. Downey's proposed testimony.

> FN2. Mr. Downey's résumé claims that he “published” articles in *Forbes* and *Engineering News Record* when it appears that these articles were instead authored by others and merely quoted Mr. Downey. (Downey Résumé, Def.'s Ex. A; Downey Dep. at 53-55, Def.'s Ex. B.) Furthermore, Mr. Downey's résumé lists one of his titles as “Surety Claims Attorney,” whereas although he did graduate with a law degree, he failed to pass the bar and is not licensed to practice law. (Downey Résumé, Def.'s Ex. A; Downey Dep. at 59, Def.'s Ex. B.)

IV. CONCLUSION

For the reasons stated above, IT IS ORDERED that Defendant's “Motion to Strike Plaintiff's Expert

Report" [Dkt. # 22] is GRANTED.

E.D.Mich.,2007.
Walbridge Aldinger Co. v. Aon Risk Services, Inc. of Pennsylvania
Not Reported in F.Supp.2d, 2007 WL 1219036 (E.D.Mich.)

END OF DOCUMENT

Not Reported in F.Supp.2d, 2004 WL 5496244 (S.D.Ohio)
(Cite as: 2004 WL 5496244 (S.D.Ohio))

United States District Court,
S.D. Ohio,
Western Division,
THE IAMS COMPANY, Plaintiff,
v.
NUTRO PRODUCTS, INC., Defendant.

No. 3:00-CV-566.
June 30, 2004.

Named Expert: Dr. James A. Langenfeld
Donald Jeffrey Ireland, Faruki Ireland & Cox PLL, Dayton, OH, for Plaintiff.

James M. Hill, James M. Hill Co., Dayton, OH, for Defendant.

DECISION AND ORDER GRANTING IN PART AND DENYING IN PART PLAINTIFF'S MOTION *IN LIMINE* TO EXCLUDE AND STRIKE THE TESTIMONY AND EXPERT REPORT OF DR. JAMES A. LANGENFELD

MICHAEL R. MERZ, United States Magistrate Judge.

***1** This case is before the Court on Motion *in Limine* of Plaintiff and Counter-Defendant The Iams Company and Counter-Defendant The Procter & Gamble Company [FN1] to Exclude and Strike the Testimony and Expert Report of Dr. James A. Langenfeld (Doc. No. 206). Nutro opposes the Motion (Doc. No. 246) and Iams has filed a Reply in Support (Doc. No. 312).

FN1. The Iams Company and The Procter & Gamble Company are referred to herein collectively as “Plaintiffs” or “Iams”.

Iams makes the instant Motion pursuant to Fed.R.Evid. 103, 104, 402, 403, 702, and 703 and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993). Iams asserts that Dr. Langenfeld offers opinions beyond the scope of his expertise as an economist and that the multiple regression analysis he offers is fatally flawed. Iams further asserts that, even if the testimony is acceptable under Fed.R.Evid. 702, it should be excluded under Fed.R.Evid. 403 as unduly prejudicial.

Federal Rule of Evidence 702 establishes the requirements for admitting expert testimony:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

The wording of the rule reflects the now-standard inquiry under *Daubert.* That case

> set forth a non-exclusive checklist of factors for trial courts to use in assessing the reliability of scientific expert testimony. These include 1) whether the expert's scientific technique or theory can be, or has been, tested; 2) whether the technique or theory has been subject to peer review and publication; 3) the known or potential rate of error of the technique or theory when applied; 4) the existence and maintenance of standards and controls; and 5) whether the technique or theory has been generally accepted in the scientific community. *Daubert*, 509 U.S. at 592-95; *Hardyman v. Norfolk & W. Ry.*, 243 F.3d 255, 260 (6th Cir.2001). If the evidence is deemed to be reliable and relevant, the judge must then determine if the probative value of the evidence is outweighed by its prejudicial effect. *Daubert*, 509 U.S. at 595.

United States v. Beverly, 369 F.3d 516 (6th Cir.2004). The question whether to admit or exclude proffered expert testimony is committed to the discretion of the trial judge. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152, 119 S.Ct. 1167, 143 L.Ed.2d 238 (1999); *First Tenn. Bank Nat. Ass'n v. Barreto*, 268 F.3d 319, 331 (6th Cir.2001).

Dr. Langenfeld is to be offered by Nutro as a witness on causation of injury, the fifth element of Nutro's cause of action against Iams for violation of the Lanham Act. *See American Council of Certified Podiatric Physicians and Surgeons v. American Bd. of Podiatric Surgery, Inc.*, 185 F.3d 606, 613 (6th Cir.1999). Nutro's theory is that Iams' new feeding guidelines for adult dogs, printed on its bags, available on its website in part through a feeding calculator, and advertised in a number of printed items, are false or misleading and that they caused consumers of adult dog food to switch from Nutro's brands to Iams' brands, causing Nutro damage.

***2** In his Revised Expert Report dated March 5, 2003 (Exhibit B to Doc. 206), Dr. Langenfeld offers the following opinions which are intended to be introduced at trial:

> A. Iams' revised feeding instructions and associated advertisements damaged Nutro. This conclusion is based on the logical economic impact of the feeding instruction revisions and associated advertisements; the nature of the competition between Iams and Nutro; the efforts made by Nutro in addressing the claims; and a quantitative analysis of Nutro's sales.
>
> B. A portion of the damages to Nutro occurred in the form of increased costs in responding to the feeding instructions and advertisements at issue. I calculate these damages to amount to approximately $486,000. In addition, Nutro suffered lost profits due to lost sales. I calculate these lost profits to be as much as $46.4 million.
>
> C. Iams' advertisements associated with the revised feeding instructions at issue were apparently intended to lead customers to believe Iams' products were less expensive on a per day feeding basis than those of rivals, including Nutro [footnote omitted]. Contrary to some Iams commentary in the press, economic analysis and evidence from Iams suggest that advertising lower required feeding amounts can lead to higher profits for Iams.

Id. at 2-3. The second of these two opinions-the damage control costs opinion-is addressed in a separate motion filed by Iams and will not be dealt with in this Decision.

Iams seeks to exclude Dr. Langenfeld's testimony for a number of reasons.

First of all, Iams claims Dr. Langenfeld has offered an opinion outside his area of expertise as an economist. Specifically, he has opined that consumers would take a price message away from some of the advertisements Iams produced. Iams claims that such an opinion could only properly come from a consumer psychology expert, but the Court rejects that overly-narrow constriction of an economist's area of expertise.

Secondly, Iams claims Dr. Langenfeld's multiple regression analysis is fatally flawed because it is based in several ways on an improper model: (1) there is no valid support for adopting the ratio he uses as a dependent variable, (2) the ratio is unreliable because inconsistent with important evidence, (3) the ratio does not control for major variables in the marketplace, (4) the ratio is assumed to be stable over time absent adverse impact from Iams' advertising

The principal analytic tool used by Dr. Langenfeld to determine if Iams' allegedly unlawful behavior caused Nutro to lose sales or profits was a multiple regression analysis. A useful explanation of multiple regression analysis is found in the Reference Guide on Multiple Regression by Daniel L. Rubinfeld in Reference Manual on Scientific Evidence 2d, Federal Judicial Center (2000).

Professor Rubinfeld explains:

> Multiple regression analysis is a statistical tool for understanding the relationship between two or more variables. Multiple regression involves a variable to be explained-called the dependent variable-and additional explanatory variables that are thought to produce or be associated with changes in the dependent variable....
>
> ***3** Multiple regression analysis is sometimes well suited to the analysis of data about competing theories in which there are several possible explanations for the relationship among a number of explanatory variables.

Id. at 181.

Professor Rubinfeld emphasizes the importance of proper construction of the model to be used in the regression analysis. *Id.* at 185-91. Iams' changed feeding guidelines at issue relate only to its adult dry dog food. Dr. Langenfeld hypothesized that, if the feeding guidelines were going to have an adverse impact on Nutro's sales, they would only affect Nutro's sales of the same kind of product, adult dry dog food, as compared with other parts of Nutro's product line, e.g., puppy food, dry cat food, kitten food, etc. (Langenfeld Depo., Vol. 1, p. 70). He further reasoned that using a ratio of Nutro's adult dry dog food sales to one of the other products as the dependent variable in his analysis would "factor out" other possible causes of changes in Nutro's overall sales, since other factors in the marketplace would be expected to affect both the numerator and the denominator of the ratio equally.

The Court agrees with Plaintiff that Dr. Langenfeld's regression analysis is fatally flawed for a number of reasons.

First of all, Dr. Langenfeld assumes that, because Iams and Nutro are direct competitors in the pet specialty market, that a reduction in Iams' price will lead consumers to switch from Nutro to Iams. As he explains, this is assumed to be the "logical economic impact of the feeding instruction revisions." This is based on the further assumption that consumers will perceive a reduction in feeding guidelines as a reduction in price. While that is a logical assumption, whether it is true in fact is measurable but has not been measured in this case. *See Bickerstaff v. Vassar College*, 196 F.3d 435, 449-50 (2nd Cir.1999).

Assuming, however, that the feeding instruction reductions are perceived by the consumer as a price reduction, the next question is whether a price reduction of Iams' products will lead to a consumer switch. In economic terms, this depends upon the cross-elasticity of demand of these two products. FN2 Such cross-elasticity is also a measurable quantity, as is the intra-brand elasticity of demand (i .e., whether a decrease in price or perceived price will lead the consumer to buy more of the brand of dog food he is already buying), but neither has been measured in this case. Dr. Langenfeld's analysis thus assumes without evidence a major basis for his theory of damages. While the assumptions are "logical" in that it is logical to assume that people are economically rational, substituting less-expensive goods for more expensive goods of the same kind, mere logical assumptions do not provide a **scientific** basis for Dr. Langenfeld's conclusion that Nutro was damaged. Put another way, perfect cross-elasticity of demand of the Iams and Nutro products is a logical economic hypothesis, but it is untested by the evidence in this case, either evidence generated by Dr. Langenfeld or generated by others and considered by him in his analysis.

> FN2. See Nicholson, Microeconomic Theory (8th ed.), pp. 176-79.

***4** Secondly, the Court agrees that Dr. Langenfeld's economic model is misconstructed, both with respect to the dependent variable and because of failure to test for the potential impact of plainly relevant independent variables.

The effect which Dr. Langenfeld as an

economist wishes to explain in this case is Nutro's lost sales.[FN3] He acknowledges that many factors will affect those sales, so he wishes to substitute for sales in his analysis a dependent variable which Iams' conduct will affect differentially from other factors. As noted above, he chose a ratio of Nutro's dry adult dog food sales to its dry puppy food sales.[FN4] As Iams points out, there is no rationale in the economic literature for using that sort of ratio for measuring this kind of effect. Dr. Langenfeld responds that the use of ratios as dependent variables in multiple regression analyses is well known,[FN5] but that misses the point of the criticism. The fact that use of a ratio as a dependent variable in some areas of analysis might be appropriate does not demonstrate that it is appropriate to use such a ratio for measuring the effect sought to be measured and explained in this case. None of the ratios used in the sample analyses he cites provides support for using this ratio in this industry to measure this alleged cause.

> FN3. Actually, lost potential sales, since Nutro's actual sales increased substantially over the period of time in question. The theory is that they would have increased even more in the absence of Iams' false feeding guidelines and associated advertising.
>
> FN4. He actually tested several other similar ratios such as Nutro's dry adult dog food sales to its dry cat food sales.
>
> FN5. See Langenfeld Declaration, ¶ 10, Exhibits N-R.

In addition to this logical problem-essentially a lack of foundation for use of the ratio as a dependent variable-Iams points out other problems with the ratio. In particular, the evidence in this case shows that the ratio is not stable in the face of other factors besides Iams' conduct. David Kravis, Nutro's chief operating officer and its Fed.R.Civ.P. 30(b)(6) witness on injury, testified that Iams' feeding guideline reductions had an adverse impact on all parts of Nutro's business.[FN6]

> FN6. Nutro argues that Dr. Langenfeld could not have considered this testimony because the Kravis deposition occurred after Dr. Langenfeld filed his report. However, reading his deposition transcript should not have been the only way Dr. Langenfeld could have received information from Mr. Kravis. Additionally, since Mr. Kravis was Nutro's designated 30(b)(6) witness on this topic, Dr. Langenfeld should have taken the testimony into consideration and revised his report if necessary to reflect it, since it is binding on Nutro.

In addition to the Kravis testimony, market data collected by ASW Roper for Nutro shows that during 2000 and 2001 Nutro's share of the dry puppy food market decreased from 16.3 percent to 15.8 percent while its share of the dry adult dog food market increased from 19.2 to 20.0 percent. During the same period, Iams' share of the dry puppy food market decreased from 33.9 percent to 33.7 percent while its share of dry adult dog food also decreased from 24.5 percent to 22.0 percent. Here again the ratio does not remain stable and moves in ways completely unpredicted by Dr. Langenfeld's model.

Besides problems with the dependent variable, Dr. Langenfeld's analysis suffers from failure to test for a number of very significant or likely to be significant independent variables. The most important of these is the potential impact on Nutro's sales from Iams' entry into the grocery and club market. Prior to 1999, Iams sold its products only through the pet specialty chain of distribution, but in 1999, it began to market through supermarkets and various other mass marketers. This was an extremely important event for the premium pet food market. Indeed, Nutro's owner described it as "seminal"[FN7] and Nutro has argued at other points in this litigation that Iams reduced its feeding guidelines in order to enable it to enter the grocery

market successfully. Both Iams and Nutro expected this to impact their competition because they expected consumers to be drawn away from the pet specialty stores altogether: they could buy pet food at the same time as they bought other groceries and would not need to make a separate trip to the pet specialty store. Even though the parties to the case believed this was an extremely important event likely to impact competition, Dr. Langenfeld did not test for potential causal impact of this event on his dependent variable.

FN7. Traitel Deposition, Vol. 1, p. 24.

***5** A second potential independent variable omitted from the analysis is the change in Nutro's own feeding guidelines. If, as Dr. Langenfeld's damages theory posits, sales of premium dog food are price elastic and changes in feeding guidelines are perceived by consumers to be price changes, then Nutro's increase in its feeding guidelines would be expected to have a negative impact on its sales. However, this potentially important independent variable is also not measured for its impact.

Multiple regression analysis is a generally accepted method in the science of statistics. In this sense, as a technique it meets the *Daubert* standards. However, it can be seriously misapplied, providing results which are not helpful to the trier of fact. By analogy, infrared spectrophotometry is a generally accepted technique for quantitative analysis of the chemical composition of compounds. Properly applied, it can give the alcohol content of human breath, a key question in the trial of a driving while under the influence case. FN8 One could also use an infrared spectrophotometer to measure the alcohol content of a skin sample taken from an allegedly intoxicated person-it is a general technique for quantitative chemical analysis. However, the results would be of no use in a DUI trial because the alcohol content of the skin does not bear a known and relatively invariant relationship to the level of blood alcohol, which is the determinant of the effects of alcohol on human behavior. Just because the infrared spectrophotometer can measure alcohol content of a specimen accurately does not mean that any result obtained from using that method of analysis would be admissible in a DUI trial.

FN8. One machine commonly used by law enforcement to measure breath alcohol, the Intoxilyzer, is a narrow band infrared spectrophotometer.

Case law recognizes the admissibility of multiple regression analyses in appropriate cases. *Bazemore v. Friday*, 478 U.S. 385, 106 S.Ct. 3000, 92 L.Ed.2d 315 (1986). In that case, the district court had excluded a regression analysis because it did not include all of the variables which the district judge believed were relevant. Justice Brennan wrote in his concurrence

> The Court of Appeals erred in stating that petitioners' regression analyses were "unacceptable as evidence of discrimination," because they did not include **"all measurable variables** thought to have an effect on salary level." The court's view of the evidentiary value of the regression analyses was plainly incorrect. While the omission of variables from a regression analysis may render the analysis less probative than it otherwise might be, it can hardly be said, absent some other infirmity, that an analysis which accounts for the major factors "must be considered unacceptable as evidence of discrimination." *Ibid.* Normally, failure to include variables will affect the analysis' probativeness, not its admissibility.

Id. at 400 (emphasis added). In citing *Bazemore*, Nutro emphasizes language from *Daubert* which directs district courts to consider the methodology used by experts rather than the conclusions they reach (Opposition, Doc. No. 246, at 6). But *Bazemore* supports the distinction between considering all measurable variables, which is not required for valid regression analysis, and omitting major potentially explanatory

variables, which renders the analysis invalid. As Giannelli and Imwinkelried write:

> ***6** The courts have been increasingly receptive to regression analysis. The analysis does not have to be complete in the sense that the model includes every relevant variable. However, if the court decides that a major variable has been omitted from the underlying model or that an essential assumption of regression analysis does not hold true in a particular case. As in the case of errors in sampling, not every technical error automatically leads to the exclusion of regression evidence. However, the model's omission of any obviously influential variable or the absence of a major assumption of regression analysis often results in the inadmissibility of the evidence

Paul C. Giannelli and Edward J. Imwinkelried, Scientific Evidence 3rd, 719-20 (1999). Case law supports this academic analysis in declaring regression analysis inadmissible when it omits one or more major variables. *See, e.g., Bickerstaff v. Vassar College,* 196 F.3d 435, 449-50 (2nd Cir.1999); *Bullington v. United Air Lines, Inc.,* 186 F.3d 1301, 1313 n. 8 (10th Cir.1999); see also *People Who Care v. Rockford Bd. of Edn.,* 111 F.3d 528, 537-38 (7th Cir.1997).

Nutro also relies on *Conwood Co., L.P. v. U.S. Tobacco Co.,* 290 F.3d 768 (6th Cir., 2002), in which the appellate court concluded it was not an abuse of discretion to admit regression analysis to prove damages. In that case, however, the plaintiff's economist had ruled out all plausible alternatives for which he had data and all variables raised by the defendant's economist. Here Dr. Langenfeld omitted several important potentially explanatory variables, particularly Iams' entry into the mass market outlets and Nutro's own increase in its feeding guidelines. For this reason as well, his regression analysis testimony is inadmissible under Fed.R.Evid. 702.

Conclusion

The Motion *in Limine* of Plaintiff and Counter-Defendant The Iams Company and Counter-Defendant The Procter & Gamble Company to Exclude and Strike the Testimony and Expert Report of Dr. James A. Langenfeld (Doc. No. 206) is GRANTED to the extent that it seeks to preclude Dr. Langenfeld from testifying to the conclusions expressed in his various expert reports, except that his opinions regarding Nutro's damage control costs are dealt with separately. To the extent the Motion can be read as a motion to strike his deposition testimony and his expert report(s), it is denied; however, neither is admissible in evidence at trial.

S.D.Ohio,2004.
The Iams Co. v. Nutro Products, Inc.
Not Reported in F.Supp.2d, 2004 WL 5496244 (S.D.Ohio)

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Not Reported in F.Supp.2d, 2013 WL 1721651 (E.D.Mich.), 2013-1 Trade Cases P 78,350
(Cite as: 2013 WL 1721651 (E.D.Mich.))

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Only the Westlaw citation is currently available.

United States District Court,
E.D. Michigan,
Southern Division.
Pat CASON–MERENDA and Jeffrey A. Suhre,
Plaintiffs,
v.
DETROIT MEDICAL CENTER, et al., Defendants.

No. 06–15601.
April 22, 2013.

Stephen F. Wasinger, Stephen F. Wasinger PLC, Royal Oak, MI, Daniel Cohen, Cuneo, Gilbert, David P. Dean, James and Hoffman, Washington, DC, Mark A. Griffin, Raymond J. Farrow, Tana Lin , Keller Rohrback, Seattle, WA, for Plaintiffs.

David A. Ettinger, Honigman, Miller, Schwartz and Cohn LLP, Detroit, MI, Rodger D. Young, Sara Klettke MacWilliams, Young & Associates, Farmington Hills, MI, David Marx, Jr., David L. Hanselman, Jr., Stephen Y. Wu, McDermott, Will, Chicago, IL, Terrence J. Miglio, Gouri G. Sashital, Keller Thoma, PC, Peter E. Boivin, Honigman, Miller, Bruce L. Sendek, William B. Slowey, Butzel Long, Detroit, MI, Mark T. Nelson, Butzel Long, Ann Arbor, MI, Sheldon H. Klein, Butzel Long, Bloomfield Hills, MI, Cathrine F. Wenger, Trinity Health, Novi, MI, Corey M. Shapiro, SNR Denton U.S. LLP, Chicago, IL, David B. Gunsberg, Birmingham, MI, Margo Weinstein, Miller Shakman & Beem LLP, Chicago, IL, Sandra D. Hauser, Dentons U.S. LLP, New York, NY, for Defendants.

OPINION AND ORDER DENYING DEFENDANTS' MOTION TO EXCLUDE THE EXPERT TESTIMONY OF ORLEY ASHENFELTER

GERALD E. ROSEN, Chief Judge.

I. *INTRODUCTION*

***1** Through the present motion, certain of the Defendants seek to exclude the testimony of Plaintiffs' expert, Orley Ashenfelter, Ph.D., on the grounds that his testimony fails to meet the admissibility standards set out in Fed.R.Evid. 702 and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993).[FN1] Although Defendants have advanced a number of challenges to Dr. Ashenfelter's proposed expert testimony as summarized in his expert and rebuttal reports, they argue principally that Dr. Ashenfelter's "benchmark" analysis rests upon an unreliable methodology and is fatally undermined by unwarranted assumptions, oversimplifications, and leaps in logic. In response, Plaintiffs contend that the benchmark analysis employed by Dr. Ashenfelter has been widely used and accepted in antitrust suits, and that Defendants' various challenges to Dr. Ashenfelter's implementation of this methodology and his use and interpretation of data in the record are matters to be explored through cross-examination at trial.

FN1. Specifically, the present motion was brought by Defendants Detroit Medical Center, Henry Ford Health System, Mount Clemens General Hospital, Inc., William Beaumont Hospital, and Trinity Health Corp. Since this motion was filed, Plaintiffs have reached settlements with Defendants Mount Clemens General Hospital and William Beaumont Hospital, and the Court has granted its preliminary approval of these settlements. In addition, Plaintiffs have more recently reached settlements with Defendants Henry Ford Health System and Trinity Health Corp., subject to the Court's preliminary approval of these settlements.

Against this backdrop of settlement negotiations, Defendant Detroit Medical Center evidently is the sole remaining party against which Plaintiffs are

> pursuing their claims in this case. Nonetheless, because certain of these settlements are awaiting preliminary approval, the Court will refer to the moving party as "Defendants" throughout the remainder of this opinion.

Defendants' motion has been fully briefed by the parties. Having reviewed the parties' briefs and accompanying exhibits, the Court finds that the pertinent facts and legal arguments are sufficiently presented in these written submissions, and that oral argument would not aid the decisional process. Accordingly, the Court will decide Defendants' motion "on the briefs." *See* Local Rule 7.1(f) (2), U.S. District Court, Eastern District of Michigan. This opinion sets forth the Court's rulings on this motion.

II. *SUMMARY OF DR. ASHENFELTER'S PROPOSED EXPERT TESTIMONY*

The underlying facts of this case have been thoroughly set forth in the Court's ruling on Defendants' summary judgment motion, *see Cason–Merenda v. Detroit Medical Center,* 862 F.Supp.2d 603, 606–23 (E.D.Mich.2012), and need not be repeated here. Briefly, the two Plaintiff registered nurses ("RNs"), Pat Cason–Merenda and Jeffrey A. Suhre, allege that the Defendant health care institutions operating in the Detroit metropolitan area have violated § 1 of the federal Sherman Act, 15 U.S.C. § 1, by agreeing to regularly exchange compensation-related information among themselves in a manner that has reduced competition among Detroit-area hospitals in the wages paid to RNs.[FN2] In pursuing this federal antitrust claim, Plaintiffs seek to recover on behalf of themselves and a class of RNs employed by the eight Defendant hospitals.

> FN2. Plaintiffs further allege that the Defendant health care providers have violated § 1 of the Sherman Act by conspiring among themselves and with other local hospitals to hold down the wages of RNs employed by these institutions. In a March 22, 2012 opinion and order, however, the Court found that Defendants were entitled to summary judgment in their favor as to this claim, *see Cason–Merenda,* 862 F.Supp.2d at 628–41, leaving Plaintiffs' "rule of reason" claim in Count II of their complaint as the sole antitrust claim going forward in this litigation.

A. Dr. Ashenfelter's Qualifications

As stated in his expert report, Dr. Orley Ashenfelter is the Joseph Douglas Green Professor of Economics at Princeton University. He received his Ph.D. in economics from Princeton in 1970, and he has received a number of awards and honors and authored or edited many books, journals, and articles in the course of his academic career. Dr. Ashenfelter has proffered expert reports or given expert testimony in several antitrust cases and proceedings, including a similar nurse wage suit brought in the Northern District of New York. *See Fleischman v. Albany Medical Center,* 728 F.Supp.2d 130, 145–50 (N.D.N.Y.2010) (rejecting a defense challenge to Dr. Ashenfelter's proposed expert testimony in that case). In light of this extensive background, Defendants do not question Dr. Ashenfelter's qualifications to give expert testimony on economic issues of relevance to this litigation.

B. Dr. Ashenfelter's Initial Expert Report

***2** Dr. Ashenfelter begins his expert report by summarizing the allegations of Plaintiffs' complaint, and by assuming, as requested by Plaintiffs' counsel, that Plaintiffs can prove their allegations of (i) a conspiracy among the Defendant hospitals to depress the compensation of their RNs,[FN3] and (ii) an agreement among the Defendant health care institutions to regularly exchange RN compensation data in a manner that resulted in reduced competition among Defendants in the market for RNs and a corresponding restraint in RN wages below competitive levels. Against this backdrop, Dr. Ashenfelter provides his opinions on

three questions posed by Plaintiffs and their counsel:

> FN3. As noted above, the Court has determined as a matter of law that the record developed during discovery fails to meet the evidentiary threshold for permitting a trier of fact to decide whether this alleged conspiracy existed. *See Cason–Merenda*, 862 F.Supp.2d at 641.

> • Whether it can be shown by common evidence that all or almost all of the members of the [plaintiff] class were harmed by the conspiracy?
>
> • What is the aggregate total lost compensation suffered by members of the class and how can this aggregate sum be allocated across class members to reflect each class member's individual losses?
>
> • Did the conspiracy lead to market power and anticompetitive outcomes in the market for jobs as RNs in hospitals in the Detroit [Metropolitan Statistical Area ("MSA")]?
>
> (Defendants' Motion, Ex. A, Ashenfelter Report at ¶ 4.)

As to the first of these questions, Dr. Ashenfelter concludes that "all or almost all of the class was harmed by the alleged conspiracy," and that "this can be shown using evidence that is common to the class." (*Id.* at ¶ 11.) He gives three reasons for arriving at this conclusion. First, Dr. Ashenfelter observes that at each Defendant hospital, the "class members' wages, and most other elements of compensation, were determined in a common administered compensation system," and he reasons that "[e]xplicit or implicit cooperation among the defendants" in setting RN wages or sharing wage-related information "would have caused adjustments to the compensation systems." (*Id.* at ¶ 7.) The adjustments to these compensation systems, in turn, "would have affected the compensation of all or almost all individual class members." (*Id.*) FN4

> FN4. As noted in Plaintiffs' response to Defendants' motion, Defendants seemingly do not challenge this aspect of Dr. Ashenfelter's opinion.

Next, Dr. Ashenfelter uses econometric analysis to "show[ ] that relative labor supply to the various jobs in the [plaintiff RN] class is very elastic." (*Id.* at ¶ 8.) FN5 From this he infers that "even if the alleged conspiracy directly affected a subgroup of the class, such as a plausible benchmark group, pay for all jobs held by members of the class would have been depressed." (*Id.* at ¶ 8.)

> FN5. Later in his report, Dr. Ashenfelter explains that "[e]conomists say that the relative supply of workers to different jobs is 'highly elastic' if a small proportional change in relative compensation levels for the jobs will result in a large proportional change in the relative supply of workers to the jobs." (*Id.* at ¶ 98.)

Third, Dr. Ashenfelter employs a benchmark analysis as a class-wide method for both identifying and quantifying the impact of the alleged conspiracy upon members of the plaintiff class. As he explains:

> ... [E]ach of the defendants makes extensive use of nurses supplied by temporary agencies ("agency nurses") to do work that would otherwise be performed by members of the class. In a competitive labor market an employer will pay each employee the amount that the employee adds to the firm's revenue. It is reasonable to infer that the value to the defendant hospitals of the work performed by agency nurses is at least as high as the fee paid by the hospital to the agency (otherwise it would not be profitable for the hospital to employ the agency nurses). As a result, the fee paid to the agency for an agency nurse is less than or equal to the marginal

revenue product of that RN in that job. Therefore, the fee provides a conservative benchmark for the cost to a hospital of employing an RN in that job in a competitive market.

***3** (*Id.* at ¶ 9 (footnote with citation omitted).)

This benchmark analysis, resting upon the Defendant hospitals' use of agency nurses, forms much of the basis for Defendants' various challenges to Dr. Ashenfelter's expert testimony. Dr. Ashenfelter explains that he has used this agency nurse benchmark "to calculate what each member of the class would have earned in the absence of the alleged conspiracy," and that this calculation "show[s] that almost all of the members of the class actually earned less than they would have in the 'but-for' world." (*Id.* at ¶ 10.) Accordingly, this analysis not only demonstrates, in Dr. Ashenfelter's view, that "all or almost all of the class was harmed by the alleged conspiracy and [that] this can be shown using evidence that is common to the class," but it also "provides a measure of each class member's lost earnings." (*Id.* at ¶¶ 11–12.) Dr. Ashenfelter, therefore, relies on this benchmark to answer both the first and second questions posed by Plaintiffs' counsel, as this analysis makes it "possible both to calculate the aggregate amount of damages and allocate the total among individual class members in a reasonable way." (*Id.* at ¶ 12.)

As Dr. Ashenfelter recognizes in his report, the benefits and services received by a Defendant hospital through the use of an agency nurse are not precisely the same as those provided by a regular hospital-employed RN, so that it is necessary to adjust the rates paid for agency nurses to account for these differences. (*See id.* at ¶ 112.) Broadly speaking, he makes two such adjustments in his initial report. First, he subtracts from his agency fee benchmark certain human resources costs—including the cost of fringe benefits and the cost of payroll taxes and worker's compensation contributions—that the hospital would have to pay for its own RNs, but that agencies pay on behalf of their agency nurse employees who are brought in to perform RN work at the hospital. (*See id.* at ¶¶ 112–14.) Next, he attempts to quantify the value to a hospital of using an agency nurse to fill an RN vacancy on short notice, by looking to an instance in which Defendant Oakwood Healthcare Inc. set up an "internal agency" that "employed RNs to work at various Oakwood facilities as if they were working for an external agency." (*Id.* at ¶ 115.) Using data from this "internal agency" experience, Dr. Ashenfelter computes a 11.2 percent "premium" as representing the additional value provided by agency nurses performing more temporary or flexible RN services. (*Id.*)

Finally, turning to the third question posed by Plaintiffs' counsel, Dr. Ashenfelter "conclude[s] that the alleged conspiracy would have provided the defendants with market power and that this market power would have led to anticompetitive effects in the market." (*Id.* at ¶ 13.) In support of this opinion, Dr. Ashenfelter points to data which, in his view, establish two anticompetitive effects in the relevant market, sub-competitive compensation and sub-competitive levels of RN employment. (*See id.* at ¶¶ 13, 127–28.) Based on the principle that "evidence of anticompetitive effects is also evidence of market power because the anticompetitive effects could not exist in the absence of market power," he concludes that the Defendant hospitals must have exercised market power in order to produce the anticompetitive outcomes he has observed. (*Id.* at ¶¶ 13, 126–27.) In addition, Dr. Ashenfelter analyzes the Defendant institutions' collective market share in the relevant market—RN jobs at hospitals in the Detroit MSA—and opines that "if the defendants were to act cooperatively they would have sufficient market share to depress earnings and employment in the market." (*Id.* at ¶¶ 14, 129.)

C. Dr. Ashenfelter's Rebuttal Report

***4** In his rebuttal report, Dr. Ashenfelter seeks to address the various challenges raised by Defendants' several experts—Professor Daniel L.

Rubinfeld, Dean Edward A. Snyder, Professor Daniel S. Hamermesh, and Joseph Caracci, RN FN6 —to the analysis and conclusions set forth in his initial report. Most notably, Dr. Ashenfelter's rebuttal report reflects two changes to his agency benchmark analysis and figures to account for the points made by Defendants' experts. First, Dr. Ashenfelter makes a further downward adjustment to his agency nurse benchmark—in an amount less than $0.10 per hour of nurse employment—to reflect additional human resources costs that the Defendant hospitals incur in employing class members but do not pay for agency nurses. (*See* Defendants' Motion, Ex. B, Ashenfelter Rebuttal Report at ¶¶ 4, 39–40.) Next, he increases his "flexibility premium"—a figure which, as noted earlier, is intended to quantify the value to a hospital of employing agency nurses who are willing to work "where and when they are needed," (*id.* at ¶ 3)—to 18 percent (from its initial value of 11.2 percent), to account for the observation in Professor Rubinfeld's expert report that not all of the RNs in Oakwood's "internal agency" were equally comparable to true agency nurses. (*See id.* at ¶¶ 7, 64–67.) In light of these adjustments, Dr. Ashenfelter has computed "total lost earnings for the class of $720.5 million as compared with $847.6 million in [his] first analysis of this question." (*Id.* at ¶ 7.)

FN6. In separate motions that remain pending before the Court, Plaintiffs seek to exclude certain of the opinions offered by defense experts Rubinfeld and Snyder. In addition, in an opinion and order dated October 18, 2010, the Court granted Plaintiffs' motion to exclude the testimony of defense expert Caracci.

Roughly a month after his rebuttal report, Dr. Ashenfelter produced an errata sheet that corrects some of the figures found in his rebuttal report. (*See* Defendants' Motion, Ex. F, Rebuttal Errata.) For example, Dr. Ashenfelter has further increased his "flexibility premium" to 21.5 percent. (*See id.* at 1.) He has also lowered his overall calculation of class damages from $720.5 million to $596.2 million. (*See id.* at 2.) FN7

FN7. In their motion, Defendants point to a sur-rebuttal report prepared by one of their experts, Professor Rubinfeld, as purportedly showing that Dr. Ashenfelter's errata sheet makes "not merely corrections in arithmetic, but wholesale changes in his methodology." (Defendants' Motion, Br. in Support at 8, 15–16.) In an order dated March 31, 2010, however, the Court denied Defendants' request for leave to file the Rubinfeld sur-rebuttal report upon which they seek to rely in challenging Dr. Ashenfelter's errata, finding that this proposed report was not timely produced. In addition, Plaintiffs strenuously object to the notion that Dr. Ashenfelter's errata sheet incorporates any changes in methodology, and instead assert that this addendum merely reflects some technical mathematical recalculations to correct an "inadvertent omission" of a variable and a "computational error" in the results reported in the rebuttal report. (Plaintiffs' Response Br. at 8–9 & n. 10 (characterizing Defendants' claim of a change in methodology as an "outrageous" and "demonstrably baseless allegation").) While the Court finds it unnecessary to stray too far into this thicket, it would certainly appear that Dr. Ashenfelter's two-page errata, with its handful of changes to specific figures from his rebuttal report, would be a poor candidate for a Trojan horse of methodological changes to his underlying analytical approach.

III. *ANALYSIS*

A. The Standards Governing Defendants' Motion

In resolving Defendants' challenge to the proposed testimony of Plaintiffs' expert, Dr. Orley

Ashenfelter, the Court necessarily begins with the language of the pertinent Federal Rule of Evidence, which provides:

> If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

Fed.R.Evid. 702.[FN8] This Rule imposes upon the federal district courts a "basic gatekeeping obligation" to ensure that an expert's proffered testimony is both relevant and reliable. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 147, 119 S.Ct. 1167, 1174, 143 L.Ed.2d 238 (1999).

> FN8. Since Defendants filed their motion, the language of this Rule has been amended, but the advisory committee notes for these amendments state that "[t]hese changes are intended to be stylistic only," and that "[t]here is no intent to change any result in any ruling on evidence admissibility." Fed.R.Evid. 702, advisory committee notes to 2011 amendments.

***5** The Sixth Circuit has described a court's inquiry under Rule 702 as governed by three mandatory requirements and a non-exclusive list of additional considerations:

> Parsing the language of the Rule, it is evident that a proposed expert's opinion is admissible, at the discretion of the trial court, if the opinion satisfies three requirements. First, the witness must be qualified by "knowledge, skill, experience, training, or education." Fed.R.Evid. 702. Second, the testimony must be relevant, meaning that it "will assist the trier of fact to understand the evidence or to determine a fact in issue." *Id.* Third, the testimony must be reliable. *Id.* Rule 702 guides the trial court by providing general standards to assess reliability: whether the testimony is based upon "sufficient facts or data," whether the testimony is the "product of reliable principles and methods," and whether the expert "has applied the principles and methods reliably to the facts of the case." *Id.* In addition, *Daubert* provides a non-exclusive checklist for trial courts to consult in evaluating the reliability of expert testimony. These factors include: testing, peer review, publication, error rates, the existence and maintenance of standards controlling the technique's operation, and general acceptance in the relevant scientific community.

In re Scrap Metal Antitrust Litigation, 527 F.3d 517, 528–29 (6th Cir.2008) (internal quotation marks and citations omitted). The Supreme Court has cautioned, however, that the factors cited in *Daubert* "do *not* constitute a definitive checklist or test," and that they "may or may not be pertinent in assessing reliability, depending on the nature of the issue, the expert's particular expertise, and the subject of his testimony." *Kumho Tire*, 526 U.S. at 150, 119 S.Ct. at 1175 (internal quotation marks and citations omitted); *see also In re Scrap Metal*, 527 F.3d at 529 (recognizing that "the *Daubert* factors are not dispositive in every case and should be applied only where they are reasonable measures of the reliability of expert testimony" (internal quotation marks and citation omitted)). "[W]hether *Daubert'* s specific factors are, or are not, reasonable measures of reliability in a particular case is a matter that the law grants the trial judge broad latitude to determine." *Kumho Tire*, 526 U.S. at 153, 119 S.Ct. at 1176.

As this Court observed in an earlier antitrust suit, a court "must remain mindful of its limited gatekeeping role" under Rule 702. *In re Northwest Airlines Corp. Antitrust Litigation*, 197 F.Supp.2d 908, 914 (E.D.Mich.2002). In particular, the "rejection of expert testimony is the exception

rather than the rule, and the trial court's role as gatekeeper is not intended to serve as a replacement for the adversary system." *In re Northwest Airlines,* 197 F.Supp.2d at 913 (internal quotation marks and citation omitted). Thus, *Daubert* emphasizes that "[v]igorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence," and that "[t]hese conventional devices, rather than wholesale exclusion ..., are the appropriate safeguards where the basis of [expert] testimony meets the standards of Rule 702." *Daubert,* 509 U.S. at 596, 113 S.Ct. at 2798.

B. Defendants' Challenges to Dr. Ashenfelter's Benchmark Analysis Go Only to the Weight, and Not the Admissibility, of His Proposed Testimony, and Therefore Must Be Left for the Trier of Fact to Resolve.

***6** As observed earlier, the lion's share of Defendants' challenges to Dr. Ashenfelter's proposed expert testimony focus on his benchmark analysis, through which he looks to the Defendant hospitals' use of nurses supplied by outside agencies to both demonstrate the impact of the alleged antitrust conspiracy upon the members of the plaintiff RN class and calculate the damages incurred by the plaintiff class. Accordingly, the Court turns first to Defendants' various critiques of Dr. Ashenfelter's benchmark analysis, and then addresses the handful of remaining issues raised in Defendants' motion.

As a threshold matter, Defendants do not dispute that the "benchmark" or "yardstick" approach adopted by Dr. Ashenfelter in formulating his expert opinion is a "well accepted" method of proving antitrust damages. *Fishman v. Estate of Wirtz,* 807 F.2d 520, 551 (7th Cir.1986); *see also Conwood Co. v. United States Tobacco Co.,* 290 F.3d 768, 793 (6th Cir.2002); *Home Placement Service, Inc. v. Providence Journal Co.,* 819 F.2d 1199, 1205–06 (1st Cir.1987). Indeed, this Court held in a prior antitrust suit that an economic expert produced by the plaintiff air travelers would be permitted to present his benchmark analysis to the trier of fact, both as a means of showing that the defendant airlines had engaged in monopolistic pricing and as a measure of the damages purportedly suffered by the plaintiff class as a result of the defendants' allegedly anticompetitive conduct. *See In re Northwest Airlines,* 197 F.Supp.2d at 922–30. Under this benchmark approach, "the plaintiff's experience in a hypothetical free market" that would exist in the absence of the defendant's antitrust violation is determined by reference to "the experience of a comparable [participant] in an actual free market." *Fishman,* 807 F.2d at 551.

As this Court has recognized, the benchmark chosen by Plaintiffs and their expert "must be sufficiently comparable to the market under consideration to permit the conclusion that price differences are the product of antitrust violations, and not other factors." *In re Northwest Airlines,* 197 F.Supp.2d at 922; *see also Home Placement Service,* 819 F.2d at 1206 ("Central to this so-called 'yardstick' approach ... is the requirement [that] the plaintiff identify a sufficiently comparable firm (the 'yardstick') against which it can measure its quantum of damages."). This requirement of sufficient comparability, however, does not demand strict identity between the benchmark and the hypothetical free market that Plaintiffs and their expert seek to describe, because "[t]he vagaries of the marketplace usually deny us sure knowledge of what plaintiff's situation would have been in the absence of the defendant's antitrust violation." *J. Truett Payne Co. v. Chrysler Motors Corp.,* 451 U.S. 557, 566–67, 101 S.Ct. 1923, 1929, 68 L.Ed.2d 442 (1981). "Markets need not be wholly identical to serve useful and reliable purposes ... in determining what a market would do in the absence of an antitrust violation," *In re Northwest Airlines,* 197 F.Supp.2d at 929, and Plaintiffs and their expert need only produce sufficient evidence of comparability "as to permit a legitimate comparison by the trier of fact," *Home Placement Service,* 819

F.2d at 1206.

***7** Against this backdrop, the admissibility of Dr. Ashenfelter's benchmark approach turns on two questions: (i) whether the fees paid by the Defendant hospitals for agency nurses are sufficiently comparable to the wages paid to RNs employed by those hospitals, such that the former may be used as a benchmark for what the latter would be in the absence of Defendants' alleged antitrust violation, and (ii) whether Dr. Ashenfelter's analysis sufficiently accounts for the ways in which agency fees differ from in-house RN wages. The first of these questions need not be addressed at any length, because Defendants have largely failed to suggest any reason why agency nurse fees should be categorically ineligible for consideration as a benchmark for competitive RN wages. Defendants' only apparent argument on this point is that Dr. Ashenfelter's reliance on agency nurse fees is methodologically unsound "because he failed to investigate the temporary nurse agency industry that is the source of his benchmark." (Defendants' Motion, Br. in Support at 10.) Yet, as the Court explained in an earlier ruling in this case, "the internal operations of and costs incurred by a nurse staffing agency play no role in Dr. Ashenfelter's analysis." *Cason–Merenda v. Detroit Medical Center*, No. 06–15601, 2010 WL 8583308, at *4 (E.D.Mich. Oct.18, 2010). Rather, nurse agencies are merely a "black box" in this analysis, into which Defendants pay sums of money in exchange for workers who "have the same qualifications as [the RNs employed by the Defendant hospitals] and work side-by-side with their employee nurses providing the same essential care-giving services to their patients." (Plaintiffs' Response Br. at 14.) Accordingly, Defendants have failed to explain the need for Dr. Ashenfelter to investigate the temporary nurse agency industry, much less suggest how this lack of investigation undermines his benchmark analysis.

Turning to the second question, Defendants contend as a general matter that Dr. Ashenfelter has failed to make the "substantial adjustments" that purportedly are necessary to ensure that his agency fee benchmark is "reasonably comparable" to the wages that RNs would receive in the absence of Defendants' allegedly anticompetitive conduct. (Defendants' Motion, Br. in Support at 10–11.) In advancing this argument, Defendants begin with the broad assertion that Dr. Ashenfelter failed to "consider the differences between the fee to an agency and a wage to a nurse," but instead merely "equated the two, ignoring the fact ... that a fee to any agency, like a price paid to any company, covers more than the wages of the nurse employed by the agency." (*Id.* at 11.) To the extent, however, that Defendants suggest that Dr. Ashenfelter made no adjustments whatsoever in determining how an agency fee should compare to RN wages, Plaintiffs correctly observe that this assertion "is, quite simply, untrue." (Plaintiff's Response Br. at 15.) As noted above, Dr. Ashenfelter explicitly acknowledges in his initial expert report that "in hiring members of the class, the defendants incur costs in addition to the class members' monetary compensation that they do not incur when contracting to hire a nurse from an agency," and he recognizes that it therefore is necessary to "adjust these agency rates to arrive at a corresponding figure for hourly earnings of members of the class." (Defendants' Motion, Ex. A, Ashenfelter Report at ¶ 112.)

***8** Nonetheless, Defendants maintain that the adjustments made by Dr. Ashenfelter are inadequate in a number of respects. First, they contend that Dr. Ashenfelter failed to thoroughly review the records of the Defendant hospitals in order to fully account for the human resources costs these hospitals avoided by using agency nurses. As explained above, however, Defendants' argument on this point ignores the adjustments outlined in Dr. Ashenfelter's initial report to account for these costs, (*see* Ashenfelter Report at ¶¶ 113–14), as well as the further adjustment made in his rebuttal report to reflect additional human resources costs identified by Defendants and their expert, Professor

Rubinfeld, (*see* Defendants' Motion, Ex. B, Ashenfelter Rebuttal Report at ¶¶ 36–40, 67 n. 50). FN9 While Defendants point to Professor Rubinfeld's sur-rebuttal report as describing still more costs that Dr. Ashenfelter should have deducted in arriving at his estimate of the "but-for" wages that would have been paid to Plaintiffs in the absence of Defendants' alleged antitrust violations, the Court has determined that this sur-rebuttal report was untimely produced and cannot be considered. In any event, Dr. Ashenfelter's efforts to account for the Defendant hospitals' human resources costs are "based upon facts in the record," and Defendants' challenges to the completeness of Dr. Ashenfelter's review of this record and the accuracy of his resulting adjustments do not warrant the wholesale exclusion of Dr. Ashenfelter's testimony as unreliable, but instead are matters to be "tested on cross-examination and subjected to further scrutiny and criticism by Defendants' own expert" at trial. *In re Scrap Metal,* 527 F.3d at 530–31; *see also In re Northwest Airlines,* 197 F.Supp.2d at 927 ("[T]o the extent that Defendants and their experts have applied a similar methodology and merely reached a different conclusion, such a 'battle of the experts' must be resolved by the trier of fact.").

> FN9. At various points in their motion, Defendants suggest that it was somehow "improper" for Dr. Ashenfelter to use his rebuttal report as an opportunity to correct inaccuracies or infirmities that Defendants and their experts had identified in his initial report. (*See, e.g.,* Defendants' Motion, Br. in Support at 12–13 & n. 6, 15–16 (characterizing the rebuttal report as an impermissible "do-over").) Yet, as Plaintiffs observe, "it would be odd indeed if the law prevented an expert from taking on board the suggestions for refinements put forward by another expert commenting on his opinion." (Plaintiffs' Response Br. at 27.) Indeed, the Federal Rule governing initial and supplemental discovery disclosures—including the disclosure of expert testimony—expressly requires a party to "supplement or correct" such a disclosure "if the party learns that in some material respect the disclosure ... is incomplete or incorrect," Fed.R.Civ.P. 26(e)(1), and Defendants do not contend that Plaintiffs and their expert failed to make the necessary supplementation or correction within the established time limit for doing so.
>
> To be sure, there can come a point that an expert's supplemental submission amounts to such a "dramatic, pointed variation" from his initial report as to exceed the permissible purpose of supplementation or correction under Rule 26(e)(1). *Keener v. United States,* 181 F.R.D. 639, 641 (D.Mont.1998); *see also In re Ready–Mixed Concrete Antitrust Litigation,* 261 F.R.D. 154, 159–60 (S.D.Ind.2009) (striking an expert submission that was "not 'supplemental,' as contemplated by Rule 26," but instead "employ[ed] a host of new detailed analyses ...., none of which was developed in the original [expert] report"). Under these circumstances, the courts have recognized that overbroad "supplementation" under the guise of Rule 26(e)(1) would undermine the purposes of the expert disclosure provisions set forth in subsection (a)(2) of the Rule, which are intended to "prevent unfair surprise at trial" and "prevent[ ] experts from 'lying in wait' to express new opinions at the last minute, thereby denying the opposing party the opportunity to depose the expert on the new information or closely examine the expert's new testimony." *Minebea Co. v. Papst,* 231 F.R.D. 3, 5–6 (D.D.C.2005).

> Dr. Ashenfelter's rebuttal report does not trigger these concerns. It does not alter the fundamental benchmark approach adopted in Dr. Ashenfelter's initial report, nor does it advance any new theories as to impact or damages. Rather, Dr. Ashenfelter has merely refined his analysis and corrected or augmented some of his calculations in response to certain of the points raised by Defendants' experts upon their review of his initial report. The courts have explained that the filing of such a supplemental report "that fully informs the recipient of the anticipated testimony of the expert" without "belatedly send[ing] the case on a wholly different tack" accomplishes the "very purpose" of Rule 26(e), which is "to prevent surprise at trial." *Talbert v. City of Chicago*, 236 F.R.D. 415, 421, 424 (N.D.Ill.2006); *see also Crowley v. Chait*, 322 F.Supp.2d 530, 540 (D.N.J.2004) (observing that "*Daubert* does not require that an expert's testimony be excluded simply because he admitted and corrected his own mistakes," but that, to the contrary, such error correction "strengthens the quality of the expert report"). Nor can Defendants claim any prejudice from any "last minute" disclosures in Dr. Ashenfelter's rebuttal report, where they had the opportunity to depose him after the production of this report. Thus, the Court rejects Defendants' characterization of this rebuttal report as an improper "do-over."

Similarly, Defendants' challenge to the accuracy of Dr. Ashenfelter's "flexibility premium"—an adjustment to the agency fee that is intended to account for the additional value provided by agency nurses who perform more temporary or flexible RN services, (*see* Ashenfelter Report at ¶ 115)—does not provide a basis for excluding Dr. Ashenfelter's proposed testimony as unreliable. As noted earlier, Dr. Ashenfelter's initial report estimated this flexibility premium as 11.2 percent, (*id.* at ¶ 115), but he revised this figure to 18 percent in his rebuttal report, (*see* Ashenfelter Rebuttal Report at ¶ 67), and then to 21.5 percent in the errata to his rebuttal report, (*see* Defendants' Motion, Ex. F, Errata Sheet at 1). Notably, this 21.5 percent figure exceeds the 19.5 percent flexibility premium estimated by Defendant's expert, Professor Rubinfeld, (*see* Defendants' Motion, Ex. H, Rubinfeld Report at ¶ 137 n. 175), and incorporates the sole substantive critique offered by Professor Rubinfeld to Dr. Ashenfelter's calculation of this premium.

***9** To be sure, Defendants point to errors in the statistical analysis through which Dr. Ashenfelter sought to address Professor Rubinfeld's critique—errors that Dr. Ashenfelter acknowledged and attempted to correct in the errata to his rebuttal report—and they further maintain that Dr. Ashenfelter's estimated flexibility premium, even as revised and increased in his rebuttal report and errata, still remains an "inadequate deduction" that fails to adequate capture all of the differences between wages paid to RN employees and fees paid for agency nurses. (Defendants' Motion, Br. in Support at 16.) Yet, as stated by Defendants' own expert, Professor Rubinfeld, these are "data and implementation flaws" that reflect Dr. Ashenfelter's purported "fail[ure] to account appropriately for deductions from the agency bill rate" paid by the Defendant hospitals "for items such as agency margins or actual premium[s] earned by agency nurses relative to internal pool nurses or permanent employees." (Rubinfeld Report at ¶ 133 & n. 163.) Along the same lines, Defendants assert in their motion that these purported flaws in Dr. Ashenfelter's expert analysis have led him to "overstate[ ]" the damages allegedly suffered by the plaintiff class. (Defendants' Motion, Br. in Support at 16.) These quarrels with the accuracy of Dr. Ashenfelter's calculations, as opposed to his

underlying benchmark approach to estimating RN wages in the absence of Defendants' alleged antitrust violations, must be left for the trier of fact to resolve, and do not provide a basis for the exclusion of Dr. Ashenfelter's testimony under Rule 702. *See Conwood Co.*, 290 F.3d at 794 (holding that an expert's failure to consider additional variables identified as important by an opposing party's expert normally affects only the probative value of the expert's testimony, and not its admissibility).

Moving beyond the issue of the specific adjustments that Dr. Ashenfelter made (or failed to make) to his agency fee benchmark, Defendants next contend that the "one size fits all" nature of this benchmark disqualifies it as a reliable measure of RN wages in a market free from Defendants' alleged antitrust conspiracy. As Defendants observe, Dr. Ashenfelter's benchmark approach generates a single "but-for" wage figure encompassing all nurses who worked at a given Defendant hospital in a given year. In reality, however—and as Dr. Ashenfelter acknowledged at his deposition, (*see* Defendants' Motion, Ex. D, Ashenfelter 3/31/2009 Dep. at 342–43)—RN wages vary widely within a hospital, or even a single department, and this presumably would remain true in the "but-for" world in which the Defendant hospitals had not engaged in an alleged antitrust conspiracy. In Defendants' view, this disjunction between Dr. Ashenfelter's benchmark and the real world disqualifies Dr. Ashenfelter's analysis as a reliable account of the antitrust injury allegedly suffered by the plaintiff class, where this analysis would "lead[ ] to bizarre and arbitrary results" such as, for example, the most experienced nurses having the smallest damages. (Defendants' Motion, Br. in Support at 18.)

***10** Plaintiffs correctly point out, however, that this critique of Dr. Ashenfelter's benchmark analysis derives from its nature as an admittedly conservative estimate of "but-for" RN wages. Because Dr. Ashenfelter's benchmark rests upon the fees paid by the Defendant hospitals for agency nurses, it measures only the value of "generic" nursing services provided by these agency nurses, and Dr. Ashenfelter has acknowledged that this may result in "understat[ing] the losses of experienced nurses" as compared to the losses suffered by their less experienced counterparts. (Ashenfelter Rebuttal Report at ¶ 72; *see also* Ashenfelter 3/31/2009 Dep. at 345–48.) As Plaintiffs observe, so long as Dr. Ashenfelter is able to persuade the trier of fact that his benchmark provides a truly conservative estimate of but-for RN wages—an assertion that Defendants, of course, are free to challenge, both through cross-examination and through the testimony of their own experts—this will suffice to establish that Defendants' alleged antitrust violations had a common impact on the members of the plaintiff class, even if this benchmark might not accurately measure the precise harm suffered by each individual class members. It follows that Dr. Ashenfelter's testimony is admissible as to this issue of common impact.

Moreover, the Court agrees with Plaintiffs that this acknowledged imprecision in Dr. Ashenfelter's approach does not preclude him from testifying with sufficient reliability as to the damages suffered by the plaintiff class. When questioned on this subject at his deposition, Dr. Ashenfelter recognized that it was "certainly possible" to construct a benchmark that attempted to more precisely measure the variance in "but-for" wages paid to nurses with differing levels of experience, skill, and training who work at the same Defendant hospital, but he opined that this approach would be less reliable due to the "potential ... arbitrariness of the assumptions" he would need to make and the resulting introduction of "potential error that [he] wouldn't be able to quantify." (Ashenfelter 3/31/2009 Dep. at 344–45.) Again, if the trier of fact accepts this testimony, as well as Dr. Ashenfelter's more general characterization of his approach as providing a "lower bound estimate" of the losses suffered by the members of the plaintiff

class, (*id.* at 345), the Defendant hospitals will not be called upon to pay damages in excess of the harm inflicted on the plaintiff class as a result of their alleged antitrust violations. As Plaintiffs aptly observe, Defendants' stated concern over this purportedly "arbitrary" feature of Dr. Ashenfelter's analysis surely does not arise from any notions of "unfairness" to some class members, such as highly experienced nurses, who "may receive damages that underestimate their 'true' losses," but instead seeks to ensure, through the wholesale exclusion of Dr. Ashenfelter's testimony, that the members of the plaintiff class "can never recover anything for their injuries." (Plaintiffs' Response Br. at 31.) The Court finds nothing in Rule 702 or the case law that would mandate this result; to the contrary, in *In re Scrap Metal*, 527 F.3d at 534, the Sixth Circuit upheld an aggregate measure of damages in an antitrust suit that rested upon a "uniform-impact" theory similar to that advanced by Dr. Ashenfelter here.

***11** Next, Defendants challenge the reliability of Dr. Ashenfelter's benchmark analysis as purportedly dependent upon a theory of "collusive price discrimination" that is "completely unsupported by the facts." (Defendants' Motion, Br. in Support at 20.) As Plaintiffs point out in response, however, the phrase "collusive price discrimination" appears nowhere in Dr. Ashenfelter's initial or rebuttal reports, nor is it accurate to say that his benchmark analysis "relies" on any such theory of "collusive price discrimination." Rather, Dr. Ashenfelter merely mentions the economic behavior of price discrimination in his rebuttal report in response to a point raised by Defendants' experts—or, as Dr. Ashenfelter puts it, to explain "how it could be that the defendant hospitals are willing to pay so much more for agency nurses than they are willing to pay their regular RNs." (Ashenfelter Rebuttal Report at ¶ 31.) This discussion of price discrimination, then, is largely peripheral to Dr. Ashenfelter's benchmark analysis, and it should be left to the trier of fact to resolve this "battle of the experts" and determine the adequacy of Dr. Ashenfelter's explanation in response to the critique of Defendants' experts.

Defendants next contend that Dr. Ashenfelter's benchmark analysis rests on an unfounded assumption that the Defendant hospitals make "extensive" use of agency nurses, (Ashenfelter Report at ¶ 103), without any effort to confirm the validity of this assumption. Yet, in the very next paragraph of his expert report, Dr. Ashenfelter cites record evidence of the millions of dollars spent annually by the Defendant hospitals for agency nurses and the large numbers of hours worked by agency nurses at the Defendant hospitals during the relevant period. (*Id.* at ¶ 104.) While Defendants fault Dr. Ashenfelter for failing to compare the Defendant hospitals' use of agency nurses to the use rate of agency nurses at hospitals elsewhere in the country, Plaintiffs correctly observe that Dr. Ashenfelter's benchmark analysis does not require that the word "extensive" be construed as "more than in other cities." (Plaintiffs' Response Br. at 37.) Rather, the evidence of Defendants' significant use of agency nurses provides a sufficient basis in the record for allowing the trier of fact to consider Dr. Ashenfelter's benchmark analysis and determine the weight it should be given.

Finally, Defendants assert that Dr. Ashenfelter's admitted failure to test the methodology underlying his benchmark analysis renders this analysis unreliable and inadmissible. Yet, while the *Daubert* standard includes testing as one of the factors a court may consider in determining the admissibility of an expert's testimony, both the Supreme Court and the Sixth Circuit have emphasized that the factors cited in *Daubert* "do *not* constitute a definitive checklist or test," and that "the Rule 702 inquiry [i]s a flexible one." *Kumho Tire*, 526 U.S. at 150, 119 S.Ct. at 1175 (emphasis in original) (internal quotation marks and citations omitted); *see also In re Scrap Metal*, 527 F.3d at 529. More specifically, although a lack of testing may render an expert's opinion unreliable where the expert's theory "easily lends

itself to testing and substantiation," *Dhillon v. Crown Controls Corp.*, 269 F.3d 865, 870 (7th Cir.2001), the courts have recognized that this *Daubert* factor may not apply as well, if at all, to the social sciences, in which theories are less susceptible to "ideal experimental conditions and controls," *United States v. Simmons*, 470 F.3d 1115, 1123 (5th Cir.2006); *see also Isely v. Capuchin Province*, 877 F.Supp. 1055, 1065–66 (E.D.Mich.1995) (permitting a psychological expert to testify regarding repressed memory, despite the expert's acknowledgment that her theory of repressed memory "cannot be tested empirically"); *Voilas v. General Motors Corp.*, 73 F.Supp.2d 452, 461 (D.N.J.1999) (observing that outside the hard sciences, "theories are often not subject to testing or experimentation" (internal quotation marks and citation omitted)).

***12** In this case, Defendants evidently suggest that Dr. Ashenfelter could have tested his benchmark approach by examining agency fees and nurse wages paid by hospitals outside the Detroit metropolitan area. As Plaintiffs observe, however, Defendants' own expert, Professor Rubinfeld, attempted to perform such an analysis, and Dr. Ashenfelter has rejected this analysis as "unreliable" in light of the lack of credible data as to "what agencies charge in cities other than Detroit." (Ashenfelter Rebuttal Report at ¶ 58.) Although the trier of fact certainly need not credit Dr. Ashenfelter's view that such a test cannot be reliably conducted due to the limited available data as to agency fees paid by hospitals in other markets, this nonetheless is another "battle of the experts" that is not appropriate for resolution in the context of a Rule 702 motion to exclude an expert's testimony.

C. Defendants' Remaining Challenges to Dr. Ashenfelter's Economic Analysis Do Not Warrant the Exclusion of His Proposed Expert Testimony on These Subjects.

As observed earlier, the bulk of Defendants' challenges to Dr. Ashenfelter's proposed expert testimony are directed at the benchmark approach through which he proposes to demonstrate the common impact of Defendants' alleged antitrust violations upon the members of the plaintiff class and the damages suffered by the class. Beyond these critiques, however, Defendants also contend that other aspects of Dr. Ashenfelter's economic analysis are subject to exclusion under Rule 702 as unreliable. The Court disagrees, and instead finds, once again, that these remaining challenges must be left for resolution by the trier of fact.

As the first of these challenges, Defendants argue that Dr. Ashenfelter's analysis of the utilization rate of RNs in the Detroit metropolitan area should be excluded because of his purported failure to account for alternative explanations for the low utilization rate identified in his expert report. Dr. Ashenfelter opines in his report that this low utilization rate in the Detroit area, as compared to "mean RN utilization in other [U.S.] cities," supports the conclusion that "utilization of RNs is below the competitive level" in the Detroit metropolitan area, and thus "provides further confirmation that fewer RNs are working in hospital jobs [in the Detroit area] than would be expected in the absence of the alleged information exchange conspiracy." (Ashenfelter Report at ¶¶ 128, 130, 144.) In Defendants' view, however, Dr. Ashenfelter has failed to identify a reliable basis for the conclusion he draws from this utilization analysis, where the record reveals that at least thirty other cities encompassed within this analysis have RN utilization rates lower than Detroit's. This suggests, according to Defendants, that these low utilization rates in Detroit and several other cities might well be attributable to factors other than an alleged antitrust conspiracy—unless, of course, one is prepared to assume that the hospitals in these other cities have engaged in similar antitrust violations—yet Dr. Ashenfelter acknowledges that he did not look into the possible causes of the low utilization rates in other cities, and thus could not say whether factors apart from allegedly anticompetitive conduct might be responsible for

these low rates.

13** As Plaintiffs observe, however, this argument reads Dr. Ashenfelter's RN utilization study in isolation, rather than as part of a larger overall analysis in which Dr. Ashenfelter relies upon ***both Detroit's relatively low RN utilization rate ***and*** the purportedly depressed RN wages paid by the Defendant Detroit-area hospitals to conclude that the Detroit-area RN market suffers from each of "the two anticompetitive effects that can be expected to result from an exercise of market power in a labor market." (Ashenfelter Report at ¶¶ 125–28.) This addresses, at least indirectly, the only alternative explanation specifically identified by Defendants and their experts—namely, that low RN utilization may also be attributable to "higher than competitive wages." (Defendants' Motion, Br. in Support at 7.) Because Dr. Ashenfelter's finding of depressed RN wages rules out this alternative, his utilization analysis is not subject to exclusion on the ground that it fails to account for this alternative explanation for low RN utilization in the Detroit area. In any event, and as observed earlier, any such purported failure to address and rule out other possible causes of the injury allegedly suffered by the plaintiff class affects only the weight, and not the admissibility, of Dr. Ashenfelter's proposed expert testimony. *See Conwood Co.,* 290 F.3d at 794; *see also Jahn v. Equine Services, PSC,* 233 F.3d 382, 390 (6th Cir.2000) ("The fact that several possible causes might remain uneliminated only goes to the accuracy of the conclusion, not to the soundness of the methodology." (internal quotation marks, alteration, and citation omitted)).

Next, Defendants challenge Dr. Ashenfelter's analyses of the relevant geographic and product markets as based on insufficient investigation or data. Yet, as a threshold matter, Plaintiffs point out—and the Court likewise has recognized in an earlier ruling in this case—that "proof of actual detrimental effects ... can obviate the need for an inquiry into market power, which is but a surrogate for detrimental effects." *Cason–Merenda,* 862 F.Supp.2d at 648 (internal quotation marks and citation omitted). Because Dr. Ashenfelter's benchmark analysis, "if credited, serves as direct proof of a detrimental impact upon the wages paid to RNs by the Defendant hospitals," any purported weaknesses in Dr. Ashenfelter's analysis of the relevant market and of the Defendant hospitals' share of that market would not defeat Plaintiffs' remaining rule-of-reason claim. 862 F.Supp.2d at 648.

In any event, the Court finds that the purported weaknesses identified by Defendants in Dr. Ashenfelter's market analysis affect only the weight, and not the admissibility, of Dr. Ashenfelter's proposed testimony on this subject. Defendants do not dispute that the elasticity analysis upon which Dr. Ashenfelter primarily relies, (*see* Ashenfelter Report at ¶¶ 152–54), is an accepted method for defining a relevant geographic market.[FN10] While Defendants suggest additional factors Dr. Ashenfelter should have considered in his market analysis, this sort of challenge is amenable to exploration on cross-examination of Dr. Ashenfelter at trial. Similarly, to the extent that Defendants' experts have proffered a different analysis and definition of the relevant geographic market, Dr. Ashenfelter has in turn identified a number of purported flaws in this analysis, (*see* Ashenfelter Rebuttal Report at ¶¶ 127–39), and the resulting "battle of the experts" must be resolved by the trier of fact. Finally, as to Defendants' contention that Dr. Ashenfelter's definition of the relevant product market is undermined by his failure to properly consider whether this market should be narrower—*e.g.*, broken into subclasses of RNs in different hospital departments—or broader— *e.g.*, expanded to include RNs in non-hospital settings—Plaintiffs observe that the definition of a product market is driven by "economic realities and industry practice." *Spirit Airlines, Inc. v. Northwest Airlines, Inc.,* 431 F.3d 917, 933 (6th Cir.2005). As this Court has previously recognized, "to see that Dr. Ashenfelter's exclusion of non-hospital RNs [from

the relevant product market] was reasonable, one need look no further than the Defendant hospitals' own conduct in commissioning and conducting wage surveys" that nearly always sought "information only on what other *hospitals* [we]re paying their *hospital* nurses." *Cason–Merenda*, 862 F.Supp.2d at 648–49 (emphasis in original) (internal quotation marks and citation omitted).

FN10. Defendants do take issue, however, with Dr. Ashenfelter's failure to conduct an econometric study of the elasticity of the supply of nurses. Yet, Dr. Ashenfelter testified at his deposition that he chose not to do so because "there just wasn't enough data ... to do something that would be transparent and credible," (Ashenfelter 1/6/2009 Dep. at 149), and Plaintiffs point out that "none of Defendants' three economists have attempted any such analysis to support their discussion of market definition," (Plaintiffs' Response Br. at 42).

***14** Finally, Defendants challenge the admissibility of an "inverse elasticity" analysis performed by Dr. Ashenfelter, from which he concludes that collusion to depress the wages of a "substantial subgroup" within the RN class would result in lower wages for all jobs in the class. (*See* Ashenfelter Report at ¶¶ 95–102.) Again, however, this challenge rests in part on Dr. Ashenfelter's purported failure to include certain variables in his analysis, and such omissions affect only the probative value of this analysis. To the extent that Defendants fault Dr. Ashenfelter for failing to consider cross-elasticity of the supply of nurses among specific pairs of hospital departments—*e.g.*, between the medical-surgical and intensive care units, (*see* Defendants' Motion, Br. in Support at 30)—Plaintiffs correctly respond that it is irrelevant, for purposes of Dr. Ashenfelter's analysis, to know how many nurses would move from one specific department to another in response to changes in wages; rather, it only matters whether nurses would move generally among departments in response to this change.[FN11] Dr. Ashenfelter cites a basis in the record for his calculation of this "inverse elasticity" figure, (*see* Ashenfelter Report at ¶ 102), and Defendants remain free to cross-examine him as to other record evidence that would undermine this calculation. *See McLean v. 988011 Ontario, Ltd.*, 224 F.3d 797, 801 (6th Cir.2000) (emphasizing that "mere weaknesses in the factual basis of an expert witness' opinion bear on the weight of the evidence rather than on its admissibility" (internal quotation marks, alteration, and citation omitted)).

FN11. Plaintiffs further suggest that "it would require an unfathomable amount of data" to conduct the specific department-pair analysis proposed by Defendants. (Plaintiffs' Response Br. at 43.)

IV. *CONCLUSION*

For the reasons set forth above,

NOW, THEREFORE, IT IS HEREBY ORDERED that Defendants' April 24, 2009 motion to exclude the expert testimony of Orley Ashenfelter (docket # 349) is DENIED.

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Not Reported in F.Supp.2d, 2013 WL 1721651 (E.D.Mich.), 2013-1 Trade Cases P 78,350

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