

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 RESPONSE TO PLAINTIFFS’  
MOTION FOR CLASS CERTIFICATION AND APPOINTMENT OF  
CLASS COUNSEL [DKT. 139]**

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 Brief

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

This 20th day of April.

*/s/ Todd M. Stenerson*

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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.

*/s/ Todd M. Stenerson*

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# **EXHIBIT**

**1**

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v.	)	Judge Denise Page Hood
	)	Magistrate Judge Mona K. Majzoub
BLUE CROSS BLUE SHIELD	)	
OF MICHIGAN,	)	
	)	
Defendant.	)	

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**STATEMENT OF ISSUES PRESENTED**

- I. Should the Court certify the proposed class under Federal Rule of Civil Procedure 23 and appoint co-lead counsel for the proposed class?
  - a. Plaintiffs' Answer: Yes.
  - b. BCBSM's Answer: No.

**CONTROLLING AUTHORITY**

Federal Rule of Civil Procedure 23

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

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

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

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

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

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

Federal Rule of Evidence 702

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## INTRODUCTION

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

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

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<sup>1</sup> See Plaintiffs’ Brief In Support of Motion for Class Certification (“Pls. Br.”) [Doc. 133] at 4-5.

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

### **STATEMENT OF FACTS**

#### **I. Plaintiffs' Initial Class Definition.**

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

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

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

Healthcare Services *throughout* Michigan.”<sup>4</sup>

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

## II. Discovery.

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

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<sup>4</sup> Compl. ¶ 30 (emphasis added).

<sup>5</sup> *Id.* ¶ 26 (emphasis added). BCBSM was excluded from the class. *Id.*

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

<sup>7</sup> Hospital executives repeatedly testified that MFNs had no effect on their rate negotiations with other commercial payors, including the 13 hospitals in Plaintiffs’ revised class definition, discussed *infra*. See *e.g.*, Hughes (Bronson) Dep. at 304

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

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(App. 1) (testifying that she did not believe Bronson LakeView's renegotiation of the Aetna/PPOM contract was initiated because of the MFN or that the MFN clause affected the contractual rate of reimbursement); Andrews (Three Rivers Health) Dep. at 269 (App. 2) (testifying that Three Rivers Hospital would have sought increases from other commercial payors separate and apart from the MFN because of the hospital's financial condition); Vitale (Beaumont) Dep. at 65-66 (App. 3) and Matzick (Beaumont) Dep. at 141 (App. 4) (testifying that Beaumont never adjusted a commercial payor's reimbursement rate to comply with the MFN); McGuire (Ascension) Dep. at 186-187 (App. 5) (testifying that no commercial payor at Ascension Hospitals paid a higher reimbursement rate because of an MFN); Harning (Allegan) Dep. at 176-178, 230-231 (App. 6) (testifying that Allegan General Hospital would have sought reimbursement rate increases from commercial insurers who had rates below BCBSM's rate regardless of the MFN); Jackson (Charlevoix) Dep. at 193 (App. 7) (testifying that Charlevoix Area Hospital would have sought increases from other commercial payors separate and apart from any MFN); Leach (Munson) Dep. at 62 (App. 8) (testifying that reimbursement rate increases from Priority Health at Paul Oliver and Kalkaska were sought prior to MFNs being in place); Roeser (Sparrow Ionia) Dep. at 51-52 (App. 9) (testifying that Sparrow Ionia's decision to raise Priority Health's reimbursement rate was not related to BCBSM's contract).

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

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

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

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

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

<sup>10</sup> *See, e.g.*, Bjella (Alpena Regional) Dep. at 198-99 (App. 12) (testifying that a hospital's poor financial condition limits its willingness to accept discounts from payers).

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

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

<sup>13</sup> *See, e.g.*, ARMC00068-0068.001 (App. 13) (Alpena finances so bad it only had ten days cash on hand); Felbinger (Ascension) Dep. at 214-17 (App.14); Matzick

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

### III. Plaintiffs' Revised Class.

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

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(Beaumont) Dep. at 58-61 (App. 4); Marcellino (Botsford) Dep. at 150 (App. 15); Gronda (Covenant) Dep. at 138, 153-54 (App.16) & BC Ex. 1301 (App. 17) (citing government shortfalls and financial troubles brought on by the recession); BLUECROSSMI-E-0043304 (App. 18) & BLUECROSSMI-08-021004 (App. 19) (citing Dickinson financial difficulties); Worden (Marquette) Dep. at 152-53 (App. 20); BLUECROSSMI-08-010215 (App. 21) (hospital financially distressed and about to default on bond covenants); Susterich (Metro Health) Dep. at 48-53 (App. 22); BLUECROSSMI-99-02238941 (App. 23) (hospital in "serious financial trouble"); Gov't Ex. 19 (Rodgers) (App. 24) (MidMichigan seeking to carry out new construction); Leach (Munson) Dep. at 183 (App. 8); BLUECROSSMI-10-008253 (App. 25) (citing Sparrow financial difficulties).

<sup>14</sup> See, e.g., Fifer (Spectrum Health) Dep. at 187-92 (App. 26) (stating that Spectrum Health's Medicare and Medicaid shortfalls totaled \$80 million in 2012); Nelson (Memorial Medical Center) Dep. at 43 (App. 27) (stating that Medicare and Medicaid shortfalls "actually reduces our operating income"); Longbrake (Huron Medical Center) Dep. at 48-50 (App. 28) (stating that Medicare reimburses the hospital "about 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. 22) (stating that government reimbursement shortfalls is "a burden that we have to bear").

<sup>15</sup> See e.g., Gross (South Haven) Dep. at 39 (App. 40).

seek to certify a significantly narrower class.<sup>16</sup> Plaintiffs define the narrowed class as:

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

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

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

<sup>17</sup> Pls. Br. at 4. Plaintiffs’ Motion for Class Certification describes the class limitations as follows:

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

*Id.* at 5.

<sup>18</sup> Plaintiffs’ motion for class certification ignores the fact that BCBSM had contracts with all 144 hospitals in Michigan. See “Largest Network,” <http://www.bcbsm.com/index/about-us/why-choose-us/largest-network.html> (App. 29).

<sup>19</sup> Plaintiffs define these agreements as “affected provider agreements.” Pls. Br. at

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

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

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

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

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

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

b. Plaintiffs' Proposed Class Representatives.

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

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<sup>22</sup> See Pls. Mot. Add/Drop Named Pls.

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

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

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

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<sup>23</sup> See Pls. Mot. Add/Drop Named Pls. at 11.

#### IV. Plaintiffs' Expert Testimony.

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

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

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

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

Q: And how if at all does that economic evidence relating to Priority at Allegan affect your conclusion whether or not Aetna was affected at Three Rivers Hospital?

A: It doesn't. . . .

Q: How if at all does the economic evidence used to find impact to Priority at Charlevoix Hospital affect the ability to find impact to Aetna at Bronson LakeView?

A: It doesn't.

Q: And how if at all does the economic evidence for your conclusions that Priority was affected at the hospitals in your report assist you in determining whether or not for example HAP was impacted at any of the Beaumont facilities?

A: It doesn't. . . .

Q: How if at all, Doctor, does the economic evidence you found to conclude that Priority had impact at Allegan help you determine whether or not Priority has impact at Charlevoix?

A: It doesn't. . . .

*Id.* at 59-60.

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

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<sup>25</sup> Leitzinger’s opinions are neither reliable nor relevant, and therefore do not meet the standards for admissibility under FRE 702. Accordingly, BCBSM has

## V. BCBSM's Expert's Analysis.

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

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

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concurrently filed a motion to exclude his testimony.

<sup>26</sup> See Leitzinger Dep. at 21, 39, 119, 136 (App. 36).

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

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

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

### **STANDARD OF REVIEW**

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

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

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

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

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

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

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

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

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<sup>29</sup> See discussion in Section I(a) of the brief, *infra*.

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

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

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

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<sup>30</sup> See also *Sprague v. General Motors Corp.*, 133 F.3d 388, 397 (6th Cir. 1998).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Finally, Plaintiffs’ assertion that the “appropriate measure of damages” is a

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

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

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

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

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

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

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

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

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

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

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

potential causes of that change will need to be conducted on an individualized basis.<sup>40</sup>

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

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

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

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

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

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

<sup>43</sup> Dr. Sibley's report further demonstrates that the lack of MFNs at most Michigan

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

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

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

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

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

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

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

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

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

combination.” *Id.* at 62. Thus, proving the claims of named Plaintiffs will do little or nothing to prove the claims of absent class members.<sup>45</sup>

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

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

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

inappropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### CONCLUSION

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

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

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

Plaintiffs' Motion for Class Certification.

Respectfully submitted,

HUNTON & WILLIAMS LLP

By: /s/ Todd M. Stenerson

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tstenerson@hunton.com

*Attorney for Defendant*

February 3, 2014

**CERTIFICATE OF SERVICE**

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

**DEFENDANT'S MOTION TO EXCLUDE THE EXPERT TESTIMONY**

**OF DR. JEFFREY LEITZINGER** be served via electronic mail upon:

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

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HUNTON & WILLIAMS LLP

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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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CLASS CERTIFICATION AND APPOINTMENT OF CLASS COUNSEL**

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APPENDIX 1

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

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

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UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF MICHIGAN

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

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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:

1 A Say that again.

2 Q Sure. In fact, is there a reason why Bronson  
3 Methodist might actually want a higher rate from Aetna  
4 at the LakeView facility than it would want to receive  
5 at the main campus here in Kalamazoo? 16:52:38

6 A When the MFN was -- when we were aware of the  
7 MFN implications, we needed a higher rate, yes.

8 Q But it's also a Critical Access Hospital;  
9 correct?

10 A It's also a Critical Access Hospital. 16:52:52

11 Q And you said you don't recall whether or not  
12 the renegotiation that is in Plaintiff's Hughes Number  
13 11 was initiated by the MFN; is that right?

14 A I do not believe it was.

15 Q So you don't believe that Plaintiff's 11, the 16:53:05  
16 85 percent rate, was caused by the MFN?

17 A I do not believe it was.

18 Q Why?

19 A Because if it would have been in relationship  
20 to the MFN, I would have gone for 87. 16:53:15

21 Q And you went for 85?

22 A I went for 85.

23 Q Do you know how much business LakeView had  
24 from Aetna/Cofinity in or around January of 2008?

25 A Not much. 16:53:33

APPENDIX 2

STEVE ANDREWS

United States of America v. Blue Cross Blue Shield of Michigan

11/2/2011

Page 1

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.

STEVE ANDREWS

United States of America v. Blue Cross Blue Shield of Michigan

11/2/2011

Page 269

1 MR. SMALL: Object.

2 MR. GRINGER: Object.

3 THE WITNESS: No.

4 BY MR. STENERSON:

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

10 MR. GRINGER: Object to foundation.

11 MR. SMALL: Object to foundation.

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

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

18 (Off the record.)

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

22

APPENDIX 3

HIGHLY CONFIDENTIAL: Vitale, Nickolas 11-12-2012

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

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-----:
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   : Hon. Denise Page Hood
MICHIGAN,                    : Mag. Mona K. Majzoub
          Defendant.         :
-----:

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

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

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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:

1 A When it was made public in the press is my  
2 recollection of when I was made aware of that.

3 Q Okay. And I believe through some  
4 conversations with Mr. Matheson we determined that was  
5 around the October 2010 time frame? 12:41

6 A Right.

7 Q Okay. So I assume that prior to October of  
8 2010, the most favored nations provision in Beaumont's  
9 contract with Blue Cross didn't impact any business  
10 decision that you made on behalf of Beaumont? 12:41

11 A It did not.

12 Q During that time period prior to October of  
13 2010, say from 2006 to October of 2010, you didn't  
14 take (sic) any business decision on behalf of Beaumont  
15 as a result of the MFN provision in Beaumont's 12:41  
16 contract with Blue Cross?

17 A I did not. I would not have been in a  
18 position to have an impact on contracting, so --

19 Q Okay.

20 A -- it wasn't relevant. 12:41

21 Q To your knowledge, did Beaumont ever adjust a  
22 commercial insurer's reimbursement rate to comply with  
23 the most favored nations provision in its contract  
24 with Blue Cross/Blue Shield of Michigan?

25 MR. MATHESON: Objection to foundation. 12:42

1 THE WITNESS: To my knowledge, no.

2 BY MR. GOURLEY:

3 Q So, to your knowledge, Beaumont never  
4 adjusted Aetna's reimbursement rate in order to comply  
5 with the most favored nations provision in its 12:42  
6 contract with Blue Cross, correct?

7 MR. MATHESON: Objection, foundation.

8 THE WITNESS: Correct. Correct.

9 BY MR. GOURLEY:

10 Q I believe you testified earlier that you 12:43  
11 don't remember specifically bringing up removal of the  
12 most favored nations provision when you were  
13 negotiating with Blue Cross in the 2011 time frame; is  
14 that correct?

15 A No. What I recall is there was a brief 12:43  
16 discussion very early on in the negotiations and Blue  
17 Cross requested that we table that for now and go  
18 through all the business aspects of the discussion and  
19 that we would circle back to that at the end of the  
20 agreement. 12:43

21 Q Okay. So the most favored nations provision  
22 wasn't a sticking point in negotiations during that  
23 time period?

24 MR. MATHESON: Object to  
25 characterization. 12:43

APPENDIX 4

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 : Judge Denise Page Hood
   
MICHIGAN, :
   
:
   
Defendant. : Magistrate Judge
   
-----: Mona K. Majzoub

UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF MICHIGAN

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

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:

1 fact that the deponent is not identified as a recipient.

2 MR. TORZILLI: Okay. Noted. 11:24:17

3 BY MR. TORZILLI:

4 Q And, sir, on or about January 11, 2006, you  
5 were also an employee of Beaumont Hospital; correct?

6 A Yes.

7 Q Okay. Now, you were not a -- you are not 11:24:27  
8 indicated as a recipient of Mr. Johnson's e-mail that  
9 appears on the first page of Exhibit 4; correct?

10 A Correct.

11 Q Okay. Can you look at the second page of  
12 Exhibit Number 4. 11:24:46

13 Sir, what do you understand the second  
14 page of Exhibit Number 4 to be?

15 MR. GOURLEY: Objection, foundation.

16 THE WITNESS: Well, on the surface, it  
17 says "... Beaumont Hospitals Proposal to Blue Cross Blue 11:25:01  
18 Shield of Michigan...."

19 BY MR. TORZILLI:

20 Q Okay. And do you understand this to have been  
21 a proposal that you helped to deliver to Blue Cross on  
22 or about December 14th, 2005? 11:25:13

23 MR. GOURLEY: Objection, form,  
24 foundation.

25 THE WITNESS: The cover e-mail would

1 suggest that was the case.

2 BY MR. TORZILLI: 11:25:22

3 Q Okay. Do you remember the occasion of having  
4 delivered this proposal to Blue Cross Blue Shield of  
5 Michigan?

6 A In the e-mail, I assume Mike and Dan are Mike  
7 Schwartz and Dan Loepp of Blue Cross. 11:25:36

8 Q Okay.

9 A If that's the case, I did meet with Dan and  
10 Mike. It must have been this time frame, given the  
11 dates on the documents.

12 Q What do you remember about your meeting with 11:25:54  
13 Dan and Mike that occurred in the approximate December  
14 2005 time frame?

15 A I believe Mark Johnson and myself met with Dan  
16 and Mike at Blue Cross -- at Dan Loepp's office, in the  
17 Blue Cross headquarters. 11:26:18

18 Q What was the purpose of the meeting?

19 A Well, as the document reflects, we were  
20 proposing some payment changes to Beaumont to offset  
21 other issues that had occurred.

22 Q And are the payment changes that you were 11:26:43  
23 proposing embodied in the first four items at the top  
24 half of the second page of Exhibit Number 4?

25 A That may -- those were the main points. There

1 may have been other issues there that were going on, we  
2 discussed as well, but obviously these were four points  
3 we wanted to make with them. 11:27:08

4 Q Okay. I want to ask you about the bottom half  
5 of the page. And what do you understand the points on  
6 the bottom half of the page to represent?

7 MR. GOURLEY: Objection, form. 11:27:26

8 THE WITNESS: Well, it reflects  
9 Beaumont's commitment to do those things enumerated, or  
10 work toward those things enumerated, should Blue Cross  
11 make the payment changes that are identified in the top  
12 half of the document. 11:27:46

13 BY MR. TORZILLI:

14 Q I want to ask you about the first of the four  
15 items on the bottom half of the page. I'll read it into  
16 the record, first.

17 It says, "Adopt a most favored nation 11:27:56  
18 clause that will insure BCBSM discount is the highest of  
19 any payor; outside/independent review to be conducted  
20 every two years."

21 Do you see that?

22 A Yes. 11:28:10

23 Q Was that one of the things that Beaumont was  
24 willing to commit to in exchange for the payment changes  
25 that it was looking to get from Blue Cross?

1 A I think it was a throw-away for this document,  
2 in that it already existed in what we called the PHA 11:28:24  
3 document, the Participating Hospital Agreement.

4 Q Okay. So at least to the best of your  
5 knowledge and recollection, you thought you were already  
6 bound by a most favored nation provision?

7 A Yes. 11:28:39

8 Q Okay. What, if any, benefits do you know of  
9 to Beaumont of Beaumont having a most favored nation  
10 provision in its Participating Hospital Agreement with  
11 Blue Cross?

12 MR. GOURLEY: Objection, foundation. 11:29:07

13 THE WITNESS: Well, I guess it assured --  
14 in that it was integral to their contract, it was -- it  
15 assured us access to 60 percent of the market that they  
16 held as their client base.

17 BY MR. TORZILLI: 11:29:28

18 Q Do you mean assured access to Blue Cross  
19 subscribers?

20 A Yes.

21 Q Did -- at least as far as you know, did the  
22 most favored nation provision in the Blue Cross contract 11:29:42  
23 affect in any way the quality of care that Beaumont  
24 delivered to its patients?

25 A No.

1 Cross was independent of the fact that that MFN was  
2 already there and was going to stay there? 13:30:07

3 MR. TORZILLI: Object to the form.

4 THE WITNESS: Yes. PHA dealt with issues  
5 like that and the methodology of reimbursement, the  
6 formulas to determine payment, as opposed to individual  
7 negotiations with the hospitals that would address 13:30:22  
8 specific -- issues specific to those hospitals, excuse  
9 me.

10 BY MR. GOURLEY:

11 Q During your time at Beaumont, were you ever in  
12 a position to know whether or not Beaumont adjusted a 13:31:01  
13 non-governmental payer's reimbursement rate in order to  
14 comply with a Blue Cross MFN in its contract?

15 MR. TORZILLI: Objection to the  
16 foundation.

17 THE WITNESS: I'm not aware of that ever 13:31:16  
18 having occurred.

19 BY MR. GOURLEY:

20 Q So you don't think it ever occurred?

21 A No.

22 MR. MATHESON: Object to the form and 13:31:34  
23 foundation.

24 And, Jason, we do have an agreement that  
25 an objection by one Plaintiff's counsel is an objection

APPENDIX 5

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

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

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UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF MICHIGAN

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

1 the most favored nations provision?

2 A I can only speak to St. John Providence. We **14:28:48**  
3 do not coordinate any other contracts on a statewide  
4 basis other than Blue Cross. But for St. John  
5 Providence specifically, we have -- we have not made any  
6 changes to any contracts because of the MFN.

7 Q And when you -- thank you for that. But when **14:29:11**  
8 you say "St. John's Providence," does that include all  
9 the facilities in Detroit?

10 A Yes.

11 Q Okay. So I just want to be clear. When we're  
12 talking about St. John's Providence, you're talking **14:29:20**  
13 about the Providence Hospital and Medical Center in  
14 Southfield; correct?

15 A Providence Hospital in Southfield, Providence  
16 Novi, St. John Hospital, St. John Macomb, St. John  
17 Oakland, St. John River District. **14:29:32**

18 Q Okay. So I'd like to ask a series of  
19 questions about the St. John Hospitals --

20 A Okay.

21 Q -- using that definition; okay? Has St.  
22 John's hospitals raised the rate of Aetna because of the **14:29:44**  
23 Blue Cross MFN?

24 A We have not.

25 Q Has St. John Hospitals raised the rate of

1 United because of the Blue Cross MFN?

2 A We have not. **14:29:54**

3 Q Has St. John's raised the rate of HAP because  
4 of the Blue Cross MFN?

5 A We have not.

6 Q Has St. John Hospitals raised the rate of  
7 HealthPlus because of the Blue Cross MFN? **14:30:04**

8 A We have not.

9 Q Has St. John's Hospital raised the rate of any  
10 payer because of the Blue Cross MFN?

11 A No.

12 Q Has any single payer paid a penny more to St.  
13 John's Hospital because of the Blue Cross MFN? **14:30:12**

14 A No.

15 Q Has St. John's Hospital refused to lower any  
16 payer's rate because of the Blue Cross MFN?

17 MS. LEWIS: Object to the form. **14:30:28**

18 THE WITNESS: No.

19 BY MR. STENERSON:

20 Q Has Blue Cross [sic] refused to lower Aetna's  
21 rate because of the Blue Cross's MFN?

22 MS. LEWIS: Object to the form. **14:30:36**

23 THE WITNESS: I'm sorry?

24 BY MR. STENERSON:

25 Q I'm sorry. Has St. John's refused to lower

APPENDIX 6

RICHARD HARNING

United States of America v. Blue Cross Blue Shield of Michigan

11/7/2011

Page 1

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.

RICHARD HARNING

United States of America v. Blue Cross Blue Shield of Michigan

11/7/2011

Page 176

1 multifaceted-pronged approach that we hit on all  
2 cylinders. This was a major part of the hospital's  
3 turnaround without a doubt.

4 Q. When did the hospital have negative days  
5 cash on hand?

6 A. Spring of 2008.

7 Q. And that was right around the time when  
8 you were negotiating with Blue Cross; is that  
9 right?

10 A. Yeah.

11 Q. And you said as part of your  
12 multi-pronged approach, you said you targeted  
13 Priority Health and United, what did you mean by  
14 that?

15 A. Improvement in rates.

16 Q. And am I correct that even without a Blue  
17 Cross Most Favored Nation clause, the hospital  
18 would still have sought to increase the rates of  
19 Priority and United?

20 A. Yes.

21 Q. Why?

22 A. When you compare rates by competing

RICHARD HARNING

United States of America v. Blue Cross Blue Shield of Michigan

11/7/2011

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1 entities, you have to look at opportunities, and,  
2 if you looked at both of those payors, there would  
3 be an opportunity just from looking at the rate.

4 Q. And, from your perspective as a CFO, when  
5 you looked at the existing rates of Priority and  
6 United, what specifically did you look at to  
7 determine that there was an opportunity there for  
8 initial reimbursements?

9 A. They were less than Blue Cross's.

10 Q. And why when you saw that their rates  
11 were less than Blue Cross's rates did you determine  
12 there was an opportunity?

13 A. Because we have a Most Favored Discount  
14 clause with Blue Cross.

15 Q. My initial question, sir, was, if you  
16 hadn't had a Most Favored Nation clause with Blue  
17 Cross, would you have still seen an opportunity to  
18 raise the rates of United and Priority?

19 MR. GRINGER: Objection, asked and  
20 answered.

21 THE WITNESS: Yes.

22 BY MR. STENERSON:

RICHARD HARNING

United States of America v. Blue Cross Blue Shield of Michigan

11/7/2011

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1 Q. Why is that?

2 A. Because when you look at various payment  
3 rates by a like category of customers, there is  
4 disparity there.

5 Q. And that is separate and apart from the  
6 existence of any Most Favored Nation clause;  
7 correct?

8 A. Yes.

9 Q. Let me have you look at the first page of  
10 Blue Cross Exhibit 11. I want to talk to you a  
11 little bit about what are known as Blue Cross BIP  
12 payments, okay? What are Blue Cross BIP payments?

13 A. They are Blue Cross interim payments. We  
14 get a weekly allowance payment from Blue Cross that  
15 approximates the last 12-months average, claims  
16 incurred by Blue Cross patients at a given payment  
17 rate, it is an allowance.

18 Q. How do those Blue Cross BIP payments help  
19 the hospital operate?

20 A. They are imperative to stability and cash  
21 flow.

22 Q. Why is that?

RICHARD HARNING

United States of America v. Blue Cross Blue Shield of Michigan

11/7/2011

Page 230

1 THE WITNESS: Can you repeat the  
2 question?

3 BY MR. STENERSON:

4 Q. Sure. Are all the rate increases that  
5 you sought after you had an MFN with Blue Cross all  
6 the rate increases from United that you sought?

7 MR. GRINGER: The same objection.

8 MR. STENERSON: Let me start over.  
9 Withdraw.

10 BY MR. STENERSON:

11 Q. After you had an MFN -- well, strike  
12 that. Any increase you sought from United  
13 Healthcare in '08 and '09, were those increases you  
14 would have sought even if you did not have an MFN  
15 with Blue Cross?

16 A. Yes.

17 Q. Why is that?

18 A. Opportunities to improve the financial  
19 viability for Allegan General Hospital.

20 Q. If you could go to number 9, please.  
21 This is the group of documents related to  
22 negotiations with Priority; correct?

RICHARD HARNING

United States of America v. Blue Cross Blue Shield of Michigan

11/7/2011

Page 231

1 A. Yes.

2 Q. In this time frame in September of 2008,  
3 even if you had not had an MFN with -- well,  
4 strike that.

5 In September 2008 and forward, are  
6 all the increases you sought from Priority  
7 increases you would have sought even if there was  
8 no MFN with Blue Cross?

9 MR. GRINGER: Object to form.

10 THE WITNESS: Yes.

11 BY MR. STENERSON:

12 Q. Why is that?

13 A. Disparity in rates would lead one to  
14 conclude that you have an opportunity to increase  
15 your rate.

16 Q. Can you explain that to me.

17 A. The disparity in the rates of like  
18 commercial competitors would lead one to conclude  
19 that you have an opportunity to renegotiate a  
20 higher rate.

21 Q. So, when you recognize that Priority was  
22 lower than Blue Cross, that's what you are

APPENDIX 7

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

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

1 most favored nation or MFN agreements limit competition  
2 and push hospital costs higher." Quote, "'Did it have  
3 any impact on our ability to do business? No,' Jackson  
4 said."

5 Is that consistent with your memory?

6 A Yes.

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

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

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

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

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

17 A Yes. 15:01:25

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

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

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

25 BY MR. STENERSON:

APPENDIX 8

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

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

UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF MICHIGAN

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

Traverse City, Michigan  
Thursday, March 15, 2012

Confidential Video Deposition of:

STEVEN LEACH,

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

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

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

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

10 A Yes.

11 Q And what about Paul Oliver?

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

13 Q And Munson Medical Center, too?

14 A Correct.

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

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

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

1 favored nations clause?

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

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

6 BY MR. GRINGER:

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

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

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

15 A No.

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

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

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

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

1 BY MR. GRINGER:

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

4 A Yes.

5 Q So what changed?

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

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

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

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

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

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

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

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

6 MR. GRINGER: I'm not --

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

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

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

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

15 BY MR. GRINGER:

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

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

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

APPENDIX 9

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

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

1 access hospitals get higher reimbursement?

2 A I don't know.

3 Q Are you aware of how Sparrow Ionia's obligation  
4 to guarantee Blue Cross the best discount was  
5 established? 10:03

6 A No.

7 Q You mentioned earlier that Sparrow Ionia Hospital  
8 negotiated a new contract with Priority Health as  
9 a result of the most favored discount clause in  
10 the Blue Cross provider agreement; is that right? 10:03

11 MR. MARTIN: Object to the form.

12 MR. MANDEL: I will object to it  
13 mischaracterizes the testimony.

14 MR. MARTIN: That's what I meant too.

15 THE WITNESS: It wasn't related to 10:03  
16 the -- you know, the Blue Cross contract. It was  
17 related to we were getting way less reimbursement  
18 than we needed, and we basically went to Priority  
19 and said we have to have a competitive

20 reimbursement if we're going to survive. 10:04

21 BY MS. BHAT:

22 Q And when you say "competitive reimbursement",  
23 what do you mean?

24 A Well, I think at the time they were reimbursing  
25 us less than 40 percent of our charges, and the 10:04

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

10:04

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

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

10:05

12 Q Can you explain what you mean by that?

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

10:05

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

10:05

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

23 Q Is -- is Blue Cross/Blue Shield currently aware  
24 that Sparrow Ionia Hospital is in compliance with  
25 the most favored discount clause?

10:06

APPENDIX 10

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

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-----:
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   : Judge Denise Page Hood
MICHIGAN,                   :
                               :
                Defendant.    : Magistrate Judge
-----:                      : Mona K. Majzoub

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UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF MICHIGAN

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

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Lansing, Michigan  
Wednesday, August 8, 2012

Confidential Video Deposition of:

PAULA M. REICHLER,

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

P R O C E E D I N G S

VIDEOGRAPHER: We are now on the record. **09:15:27**

This is the videotaped deposition of Paula Reichle,  
being taken on Wednesday, August 8th, 2012. The time is  
now 9:14 a.m.

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

This matter is being held in the United States District  
Court, Eastern District of Michigan, Southern Division.

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

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

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

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

MR. DANKS: Ryan Danks for the United

1 States.

2 MR. SUKENIK: Michael Sukenik, Gibson 09:16:40

3 Dunn, on behalf of Aetna.

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

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

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

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

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

15 EXAMINATION

16 BY MR. DANKS:

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

18 A Good morning.

19 Q Have you ever been deposed before?

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

21 Q Okay. And in what context were you deposed?

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

24 Q Was that company Sparrow?

25 A It was not.

1 Q A few ground rules as we get started here. I  
2 am going to do my best to ask questions clearly and **09:17:33**  
3 concisely, but if I don't do so and you don't understand  
4 the question, please feel free to ask me to repeat it;  
5 is that okay?

6 A That's fine.

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

10 A Correct.

11 Q -- shaking or things like that?

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

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

18 A Sounds reasonable.

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

25 A Okay.

1 correct?

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

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

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

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

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

23 Q And what is the Critical Access definition?

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

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

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

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

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

11 A (Nodding head.)

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

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

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

1 Aetna.

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

5 A Yes.

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

8 (Government Exhibit Reichle 9 was  
9 marked.)

10 THE WITNESS: (Reviewing Government  
11 Exhibit Reichle 9.)

12 BY MR. DANKS: **12:12:25**

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

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

18 A Um-hum, yes.

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

22 A That's correct. **12:13:00**

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

1 A Correct.

2 Q And those contracts were contingent on the **16:15:48**  
3 sale of PHP to Blue Care Network; is that correct?

4 A Correct.

5 Q And during the course of those negotiations,  
6 did either -- did Miss Horn or Mr. Koziara from Priority  
7 ever ask you how the rates being offered compared to --**16:16:06**  
8 how the rate Sparrow was offering them compared to the  
9 rates that Blue Cross was receiving?

10 A I don't think so.

11 Q How about for Mr. Helms and HealthPlus?

12 A They didn't -- did not ask that question. **16:16:20**

13 Q Did they ask a similar question?

14 A They may have, you know, talked in general  
15 about being able to have rates that were competitive  
16 with Blue Cross. They never asked us what our rates  
17 were or for a specific number in relation to that; but **16:16:37**  
18 they did ask questions like "We need to be competitive  
19 with the Blues."

20 Q And did they ever describe to you a range that  
21 would put some actual numbers on what they --

22 A They may have. I don't specifically recall, **16:16:54**  
23 but they might have.

24 Q I think you testified earlier that you thought  
25 that Priority could well have expanded to meet the Tier

APPENDIX 11

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

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

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

**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.<sup>1</sup> 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");<sup>2</sup> (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.

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<sup>1</sup> 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").

<sup>2</sup> 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,<sup>3</sup> how prices hospitals set for insurance plans differ based on whether the hospital has a financial interest in the insurance plan,<sup>4</sup> or whether prices vary systematically by a hospital's location or local competitive environment.<sup>5</sup> 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.<sup>6</sup>

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.

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<sup>3</sup> 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.").

<sup>4</sup> Leitzinger Deposition at 121:21-122:4.

<sup>5</sup> Leitzinger Deposition at 39:4-22; 119:5-12.

<sup>6</sup> Leitzinger Deposition at 136:5-8.

13. Economists studying antitrust issues regularly consider institutional context, even parsing institutional details and records.<sup>7</sup> 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

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<sup>7</sup> 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.”<sup>8</sup>

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.<sup>9</sup>

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.<sup>10</sup> 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.<sup>11</sup> 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

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<sup>8</sup> 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).

<sup>9</sup> Leitzinger Deposition at 84:6-23; 153:9-14.

<sup>10</sup> Leitzinger Deposition at 36:19-22; 44:12-23; 46:4-6.

<sup>11</sup> 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 antitrust 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.<sup>12</sup>

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

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<sup>12</sup> 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.<sup>13</sup> Thus, he fails to address potentially complex data issues that relate to the calculation

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<sup>13</sup> 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.<sup>14</sup> 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.”<sup>15</sup> At each hospital, the class pertains only to certain “affected provider agreements”

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<sup>14</sup> CAC at ¶ 10.

<sup>15</sup> 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.”<sup>16</sup> By considering HAP’s two PPO networks at the three Beaumont hospitals separately, Dr. Leitzinger arrives at twenty-three “affected combinations.”<sup>17</sup>

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.<sup>18</sup>

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.”<sup>19</sup>

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.<sup>20</sup>

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<sup>16</sup> Plaintiffs’ Motion at 4-5, and also Leitzinger Report at ¶ 7, Table 1.

<sup>17</sup> Leitzinger Report at ¶ 7 and corrected Exhibits 8 and 9.

<sup>18</sup> Based on 2011 American Hospital Association data as provided in Dr. Leitzinger’s Exhibit 3.

<sup>19</sup> Plaintiffs’ Motion at 5.

<sup>20</sup> 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.<sup>21</sup> 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.<sup>22</sup> 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.”<sup>23</sup>

## **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.<sup>24</sup> 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.<sup>25</sup> To account for

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<sup>21</sup> Plaintiffs’ Motion at 3 (“BCBSM offered increased reimbursement rates to obtain MFN provisions,” calling such payments a “quid pro quo”).

<sup>22</sup> Plaintiffs’ Motion at 3 (“... the scheme ensured that [BCBSM’s] rival insurers’ costs were even higher...”).

<sup>23</sup> Plaintiffs’ Motion at 4.

<sup>24</sup> Leitzinger Report at ¶ 51.

<sup>25</sup> 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.”<sup>26</sup>

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.<sup>27</sup> 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.

<sup>26</sup> Leitzinger Report at ¶ 75- ¶ 76 and Exhibit 9.

<sup>27</sup> 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.<sup>28</sup>

### 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.<sup>29</sup> As shown in Table 1, during the 2005-2007 period, many of the “affected hospitals” had margins on net patient income that were negative.<sup>30</sup>

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

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<sup>28</sup> Leitzinger Report at ¶ 59.

<sup>29</sup> BLUECROSSMI-99-01584986 at BLUECROSSMI-99-01585007.

<sup>30</sup> 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.<sup>31</sup> 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]

[REDACTED]<sup>32</sup> [REDACTED]  
[REDACTED]

[REDACTED].<sup>33</sup> 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.<sup>34</sup> 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

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<sup>31</sup> For the complete chronology, see “Participating Hospital Agreement, Status Update Report,” BLUECROSSMI-E-0021634-81.

<sup>32</sup> BLUECROSSMI-EM-0211752-0211814 at BLUECROSSMI-EM-0211789. The [REDACTED] does not include [REDACTED].

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

<sup>34</sup> 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].<sup>35</sup>

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.<sup>36</sup> Through this omission, Dr. Leitzinger ignores the long economic tradition of examining bargaining power and its effect on

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<sup>35</sup> BLUECROSSMI-EM-0211752-0211814 at BLUECROSSMI-EM-0211801.

<sup>36</sup> See Leitzinger Report, Exhibit 3.

negotiated outcomes.<sup>37</sup> 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.<sup>38</sup> Likewise, hospitals that offer physician networks in addition to hospital services may leverage additional bargaining power.<sup>39</sup>

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<sup>40</sup>. Both the Beaumont and Ascension-Michigan systems perceived some of their hospitals to be important to insurers.<sup>41</sup>

While I do not opine on the veracity of this claim, such a perception clearly can be a source of

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

<sup>38</sup> 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.").

<sup>39</sup> 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.

<sup>40</sup> 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").

<sup>41</sup> 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.<sup>42</sup> Conversely, Allegan General Hospital (“Allegan”) did not regard itself as having significant bargaining power over BCBSM.<sup>43</sup>

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<sup>44</sup> 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.<sup>45</sup>

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<sup>42</sup> 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.”).

<sup>43</sup> 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.”).

<sup>44</sup> 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.

<sup>45</sup> 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.<sup>46</sup> Allegan described the potential loss of BCBSM as “catastrophic.”<sup>47</sup>

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.<sup>48</sup> 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.<sup>49</sup> For both of these reasons, insurers may agree to pay more. These factors can empower even small, financially-distressed hospitals to seek higher prices.<sup>50</sup>

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

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

<sup>47</sup> Deposition of Richard Harning (Allegan), 11/7/2011, at 85.

<sup>48</sup> 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).

<sup>49</sup> CAC at ¶ 58.

<sup>50</sup> 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,<sup>51</sup> a payer’s need for access for its members to a hospital’s services,<sup>52</sup> a hospital’s

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<sup>51</sup> 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,<sup>53</sup> the strategic goals of hospitals, payers, and Administrative Service Organizations (“ASOs”), including whether an entity is for-profit or non-profit,<sup>54</sup> and many other idiosyncratic factors. They also reflect individual relationships<sup>55</sup> and individual personalities<sup>56</sup> 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.<sup>57</sup> These carry contemporaneous changes in terms

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<sup>52</sup> 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.

<sup>53</sup> 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.”).

<sup>54</sup> 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”).

<sup>55</sup> 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.”).

<sup>56</sup> 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.”).

<sup>57</sup> 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.<sup>58</sup> 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?

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BLUECROSSMI-E-0008311-8315.

<sup>58</sup> 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.<sup>59</sup>

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.<sup>60</sup>

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?

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<sup>59</sup> Leitzinger Deposition at 62:19-25 (*objection omitted*).

<sup>60</sup> 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.<sup>61</sup>
- A contention that BCBSM leveraged that market power<sup>62</sup> to force a "statewide institution of MFNs."<sup>63</sup>
- A contention that that these MFN agreements, by their very nature, serve to increase the costs faced by BCBSM's rivals.<sup>64</sup>

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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<sup>61</sup> 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.").

<sup>62</sup> 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.*)

<sup>63</sup> Leitzinger Report at ¶ 111.

<sup>64</sup> 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.<sup>65</sup> 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.

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<sup>65</sup> 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 slob in contracting”<sup>66</sup> and to have “the [BCBSM] marketing people stop yelling at us” by demonstrating that BCBS obtained good prices from hospitals relative to its competitors.<sup>67</sup>

59. Antitrust economists have recognized that MFNs often reflect the business realities of rewarding and evaluating negotiators.<sup>68</sup> 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”<sup>69</sup> 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.”<sup>70</sup>

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.<sup>71</sup> For example, BCBSM’s

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<sup>66</sup> Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 77.

<sup>67</sup> 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...”).

<sup>68</sup> Jonathan B. Baker and Judith A. Chevalier (2013), “The Competitive Consequences of Most-Favored-Nation Provisions,” *Antitrust* 27(2), at 22.

<sup>69</sup> Jonathan B. Baker and Judith A. Chevalier (2013), “The Competitive Consequences of Most-Favored-Nation Provisions,” *Antitrust* 27(2), at 22.

<sup>70</sup> Stephen Smith (2013), “When Most-Favored is Disfavored: A Counselor’s Guide to MFNs,” *Antitrust* 27(2), at 12.

<sup>71</sup> 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.”<sup>72</sup> 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.<sup>73</sup> 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<sup>74</sup> and that no rates for any competing insurers were raised because of an MFN.<sup>75</sup> 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.<sup>76</sup> 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.<sup>77</sup> Three Rivers’ CFO stated that the MFN did not lead to higher payments from BCBSM.<sup>78</sup>

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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.”).

<sup>72</sup> Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 30.

<sup>73</sup> Deposition of Karmon Bjella (Alpena), December 13, 2011 at 264.

<sup>74</sup> Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 81.

<sup>75</sup> Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 186-189.

<sup>76</sup> 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.”).

<sup>77</sup> Deposition of Steve Andrews (Three Rivers), 11/2/2011, at 132-133.

<sup>78</sup> 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.”<sup>79</sup> Other hospitals also acknowledged that the MFN was irrelevant to the hospital but was seen as very important to BCBSM for bureaucratic reasons.<sup>80</sup>

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.”<sup>81</sup>

... 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.<sup>82</sup>

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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.”).

<sup>79</sup> 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.”).

<sup>80</sup> 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]”)

<sup>81</sup> 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.”).

<sup>82</sup> 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.<sup>83</sup>

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.<sup>84</sup>

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

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<sup>83</sup> 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.").

<sup>84</sup> 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.<sup>85</sup> At the very least, this uncertainty may involve costly delays as true motives are discovered.

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<sup>85</sup> 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.<sup>86</sup>

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.<sup>87</sup> 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

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<sup>86</sup> Stephen Smith (2013), “When Most-Favored is Disfavored: A Counselor’s Guide to MFNs,” *Antitrust* 27(2), at 13.

<sup>87</sup> 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).<sup>88</sup> 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,<sup>89</sup> and (ii) BCBSM's alleged expansion of that market power through its use of MFNs.<sup>90</sup> 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.<sup>91</sup>

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."<sup>92</sup> He then proceeds to cite estimates of BCBSM share of various segments of an alleged

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<sup>88</sup> See also Leitzinger Report, Exhibit 6.

<sup>89</sup> Plaintiffs' Motion at 7-8.

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

<sup>91</sup> 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.").

<sup>92</sup> Leitzinger Report at ¶ 101.

downstream market for commercial health insurance.<sup>93</sup> 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.<sup>94</sup>

73. Economists have recognized several reasons that an insurer's market share need not translate into market power over all hospitals.<sup>95</sup> 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.<sup>96</sup> 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

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<sup>93</sup> Leitzinger Report at ¶¶ 102-103.

<sup>94</sup> 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.").

<sup>95</sup> 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.

<sup>96</sup> 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.<sup>97</sup> 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.<sup>98</sup> 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

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<sup>97</sup> 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.").

<sup>98</sup> 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](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.<sup>99</sup>

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<sup>100</sup> but fails to recognize that BCBSM's commitment to including as many hospitals as possible may reduce its market power over some hospitals.<sup>101</sup> 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.<sup>102</sup>

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

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<sup>99</sup> 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.

<sup>100</sup> Leitzinger Report at ¶ 35.

<sup>101</sup> 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.

<sup>102</sup> Leitzinger Deposition at 76-80.

varies by market region and by plaintiff.<sup>103</sup> One payer may have alternative local trauma services through its contract with a rival hospital, for example, while another may not.<sup>104</sup> 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.<sup>105</sup>

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<sup>103</sup> 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.

<sup>104</sup> 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.").

<sup>105</sup> 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.”<sup>106</sup> Dr. Leitzinger’s analysis of BCBSM market power that ignores the countervailing (and individually variable) market power of hospitals is incomplete and incorrect.<sup>107</sup>

80. In analyzing market power, Dr. Leitzinger ignores that this crucially depends on each hospital’s market power, as well.<sup>108</sup> 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.<sup>109</sup> For some hospitals with few nearby alternatives, plaintiffs acknowledge that both business goals<sup>110</sup> and regulatory

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<sup>106</sup> 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.

<sup>107</sup> 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.”).

<sup>108</sup> 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.”).

<sup>109</sup> 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.”).

<sup>110</sup> “... 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<sup>111</sup> 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.<sup>112</sup> 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.<sup>113</sup> 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).

<sup>111</sup> “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).

<sup>112</sup> 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).

<sup>113</sup> 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,<sup>114</sup> hospital size,<sup>115</sup> the existence and range of special services,<sup>116</sup> affiliations with universities and physicians, and reputation.<sup>117</sup> 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.<sup>118</sup>

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

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<sup>114</sup> 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).

<sup>115</sup> 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 ...").

<sup>116</sup> 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.").

<sup>117</sup> 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).

<sup>118</sup> 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.<sup>119</sup> 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.<sup>120</sup>

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,<sup>121</sup> the financial health of a hospital, parties' negotiating skill, hospital utilization,<sup>122</sup> and the strategic goals of each hospital and

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<sup>119</sup> 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.").

<sup>120</sup> 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.").

<sup>121</sup> 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).

<sup>122</sup> 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."<sup>123</sup> For the financial health of hospitals, Dr. Leitzinger admits that he simply didn't consider it.<sup>124</sup> 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.<sup>125</sup> 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.”).

<sup>123</sup> Leitzinger Deposition at 39:21-22.

<sup>124</sup> Leitzinger Deposition at 136:5-8.

<sup>125</sup> Leitzinger Deposition at 21:5-10.

antitrust injury occurred for all class members.<sup>126</sup> 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.”<sup>127</sup> 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.<sup>128</sup> 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.<sup>129</sup> 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”<sup>130</sup> and that the entirety of his numerical analysis “does not relate to prices for

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<sup>126</sup> CAC at ¶ 46; Plaintiffs’ Motion at 29; Leitzinger Report at ¶ 11.

<sup>127</sup> 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.

<sup>128</sup> Leitzinger Report at ¶ 79-84.

<sup>129</sup> Leitzinger Report at ¶ 81 and Leitzinger Deposition at 44:12-23.

<sup>130</sup> Leitzinger Deposition at 46:4-6.

commercial health insurance.”<sup>131</sup> 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”).<sup>132</sup> 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<sup>133</sup> but does not specify what that evidence might be. For example, Dr. Leitzinger distinguishes between a “PPO market” and an “HMO market”<sup>134</sup> 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,<sup>135</sup> and admits generally that he does not know anything about the product designs of the companies.<sup>136</sup>

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<sup>131</sup> Leitzinger Deposition at 36:21-22.

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

<sup>133</sup> Leitzinger Report at ¶ 94.

<sup>134</sup> Leitzinger Report at ¶¶ 29, 31, 33.

<sup>135</sup> Leitzinger Deposition at 105:1-8.

<sup>136</sup> 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.<sup>137</sup> Although Dr. Leitzinger cites the *Guidelines* and the “small but significant, nontransitory increase in price” (SSNIP) test as his approach to market delineation,<sup>138</sup> he consistently contradicts the *Guidelines* in his analysis. First, he proposes to follow a political (rather than economic) boundary of the state of Michigan,<sup>139</sup> despite contradictory information presented in the CAC.<sup>140</sup> 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.”<sup>141</sup> 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.<sup>142</sup> 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).

<sup>137</sup> 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.”).

<sup>138</sup> Leitzinger Report ¶¶ 91-92.

<sup>139</sup> 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.

<sup>140</sup> 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.

<sup>141</sup> Leitzinger Report at ¶ 100.

<sup>142</sup> 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.<sup>143</sup> 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.<sup>144</sup>

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,<sup>145</sup> portion of hospitals/patients/beds covered by MFNs, and other factors,<sup>146</sup> 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.<sup>147</sup> Therefore, a finding that a group of consumers in one geographic market for

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<sup>143</sup> Leitzinger Report at ¶ 34 (“Employees and individuals demand access to health care near where they live and work.”).

<sup>144</sup> 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.).

<sup>145</sup> 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.”).

<sup>146</sup> 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.

<sup>147</sup> 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."<sup>148</sup>

*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."<sup>149</sup>

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"<sup>150</sup> and that his numerical analysis "does not relate to prices for commercial health insurance."<sup>151</sup>

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

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

<sup>149</sup> Leitzinger Report at ¶ 84.

<sup>150</sup> Leitzinger Deposition at 46:4-5.

<sup>151</sup> 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).<sup>152</sup> 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.”<sup>153</sup> Dr. Leitzinger describes these increases as economic evidence capable of showing the MFN agreements led to higher reimbursement rates for hospital healthcare services.<sup>154</sup>

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

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<sup>152</sup> In some cases, the insurer contract date is before the MFN effective date.

<sup>153</sup> Leitzinger Report at ¶ 47.

<sup>154</sup> 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;<sup>155</sup> and (iii) a test statistic used for

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<sup>155</sup> 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.<sup>156</sup>

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).<sup>157</sup> 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.”<sup>158</sup> 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

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<sup>156</sup> 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.

<sup>157</sup> The term “treatment” originates from medical experiments in which one group of patients receives a drug and a control group of patients does not.

<sup>158</sup> 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.”<sup>159</sup> 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,”<sup>160</sup> 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,<sup>161</sup> 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

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<sup>159</sup> Leitzinger Report at ¶ 53.

<sup>160</sup> Leitzinger Report at note 128.

<sup>161</sup> 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.<sup>162</sup> 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.<sup>163</sup> 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

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<sup>162</sup> 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).

<sup>163</sup> 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.”<sup>164</sup> 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.<sup>165</sup> Thus, his DID analysis provides no

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<sup>164</sup> 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.

<sup>165</sup> 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).<sup>166</sup> 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.<sup>167</sup> 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

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<sup>166</sup> Significance levels of ten percent are sometimes considered only marginally significant.

<sup>167</sup> 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.<sup>168</sup>

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<sup>168</sup> 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.<sup>169</sup> 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 Pointe 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.<sup>170</sup> Clearly, the feasibility of these reductions and their financial impact on Beaumont Hospital – Grosse Pointe 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."<sup>171</sup> During this period, the study concluded that

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

<sup>170</sup> 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).

<sup>171</sup> 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."<sup>172</sup> 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

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<sup>172</sup> 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.<sup>173</sup> 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

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<sup>173</sup> 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."<sup>174</sup> 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."<sup>175</sup> 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."<sup>176</sup> 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

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<sup>174</sup> Leitzinger Deposition at 128:9-13.

<sup>175</sup> Leitzinger Report at ¶ 55.

<sup>176</sup> 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.<sup>177</sup> Although Dr. Leitzinger asserts that hospital locations are largely irrelevant,<sup>178</sup> 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

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<sup>177</sup> See Leitzinger Report, Figures 1 and 2.

<sup>178</sup> 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 into 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.<sup>179</sup> He states, "I don't think the negotiating documents bear on the economic evidence that I have presented."<sup>180</sup>

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<sup>179</sup> 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.

<sup>180</sup> 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.”<sup>181</sup> 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.

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<sup>181</sup> 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.<sup>182</sup>

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.

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<sup>182</sup> Leitzinger Deposition at 59:2-60:22.

Beaumont considered itself to be very important to insurers,<sup>183</sup> and firmly believed that its value entitled it to get more reimbursement from BCBSM than it had been getting.<sup>184</sup> Its importance was acknowledged by BCBSM.<sup>185</sup> This provided Beaumont with considerable bargaining power, which was acknowledged by BCBSM: “Beaumont has a lot of leverage on their side.”<sup>186</sup> 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.<sup>187</sup>

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

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<sup>183</sup> 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.

<sup>184</sup> 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.

<sup>185</sup> Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 46.

<sup>186</sup> Deposition of Douglas Darland, Vol. 1, 11/14/2012, at 53.

<sup>187</sup> 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.<sup>188</sup> These hospitals believed that BCBSM was paying too little to Michigan hospitals, in general.<sup>189</sup> 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.”<sup>190</sup>

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.”<sup>191</sup> Mr. McGuire regarded departicipation—the non-renewal of contracts with payers—as a valid and valuable negotiating tool:<sup>192</sup>

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.<sup>193</sup>

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

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<sup>188</sup> Deposition of Laura Eory, 11/12/12, at 146:1-147:25.

<sup>189</sup> Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 78.

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

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

<sup>192</sup> 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”).

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

steep price increases across Ascension-Michigan's hospitals.<sup>194</sup> It was made clear to BCBSM that other hospitals could soon follow<sup>195</sup> and a prioritized list of hospitals that would also departicipate if needed was devised.<sup>196</sup> 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."<sup>197</sup> 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."<sup>198</sup>

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."<sup>199</sup>

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

<sup>195</sup> See Deposition of Patrick McGuire at 195:17-19.

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

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

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

<sup>199</sup> 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.<sup>200</sup> 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.<sup>201</sup>

137. The coordinated negotiating campaign was broadened to include the threatened departicipation of multiple hospitals in the Ascension-Michigan system.<sup>202</sup>

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.<sup>203</sup>

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.”<sup>204</sup>

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

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

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

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

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

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

PPO agreement is 2.9 percentage points<sup>205</sup> and is 13.6 percentage points for the BCBSM PPO agreement at Providence Park Hospital.<sup>206</sup> However, it is also important to note that, in the view of Mr. McGuire “the MFN was relatively ineffective.”<sup>207</sup> 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.”<sup>208</sup> He testified that no rates for any competing insurers were either raised or lowered because of an MFN.<sup>209</sup>

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

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<sup>205</sup> Leitzinger Report, Corrected Exhibit 9.

<sup>206</sup> Leitzinger Report , Corrected Exhibit 9.

<sup>207</sup> Deposition of Patrick McGuire (Ascension-Michigan), 8/14/2012, at 81.

<sup>208</sup> 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).

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

PHA and reimbursement mechanism.<sup>210</sup> 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.<sup>211</sup> 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.<sup>212</sup> Allegan unilaterally offered BCBSM an MFN provision.<sup>213</sup> 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."<sup>214</sup> Indeed, Allegan was able to negotiate rates with Priority and United that exceeded the levels necessary to comply with the MFN.<sup>215</sup>

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

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<sup>210</sup> Leitzinger Report Exhibit 9 (corrected). See also BLUECROSSMI-98-000551-00561.

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

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

<sup>213</sup> 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.").

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

<sup>215</sup> 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.<sup>216</sup> The CFO of Three Rivers Health stated that the hospital's financial condition was the "number one factor" in its negotiations with Aetna,<sup>217</sup> 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 ..."<sup>218</sup>

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

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

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

<sup>218</sup> 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.<sup>219</sup> Conversely, Three Rivers generally saw itself as in a poor bargaining position with respect to BCBSM.<sup>220</sup> Departicipation "didn't seem like a viable option."<sup>221</sup> 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.<sup>222</sup> Also both sides of the BCBSM-Beaumont negotiation thought the MFN of little importance.<sup>223</sup> 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

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

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

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

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

<sup>223</sup> 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.<sup>224</sup> 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."<sup>225</sup>

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<sup>224</sup> 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.

<sup>225</sup> 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,"<sup>226</sup> 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."<sup>227</sup>

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.").

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

<sup>227</sup> 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.<sup>228</sup>

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.<sup>229</sup>

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.<sup>230</sup> 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

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<sup>228</sup> 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")

<sup>229</sup> 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").

<sup>230</sup> 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.<sup>231</sup> Much like his omission in the case of Munson

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<sup>231</sup> 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.<sup>232</sup> On the same date, Bronson Healthcare Group acquired and took over operations at LakeView Community Hospital.<sup>233</sup> 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,

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<sup>232</sup> Leitzinger Report Table 1.

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

which had no MFN.<sup>234</sup> 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.<sup>235</sup>

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."<sup>236</sup> 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.<sup>237</sup>

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<sup>234</sup> 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.

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

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

<sup>237</sup> 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.<sup>238</sup> In his estimation, the hospital's financial jeopardy would have resulted in higher rates from Priority even without the MFN.<sup>239</sup> 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.

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

<sup>239</sup> 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.<sup>240</sup>

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.<sup>241</sup> 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

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<sup>240</sup> Leitzinger Deposition at 173:25-174:3.

<sup>241</sup> 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.<sup>242</sup>

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,<sup>243</sup> 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.<sup>244</sup> 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."<sup>245</sup> Notably, while these services are unprofitable mostly due to their utilization by

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<sup>242</sup> 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.

<sup>243</sup> 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.").

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

<sup>245</sup> 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.<sup>246</sup>

168. Service and quality cutbacks in response to financial challenges are rarely uniform, instead negatively impacting only some treatments and diagnoses.<sup>247</sup> 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.<sup>248</sup> 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.”<sup>249</sup> More broadly, even if the cost of a given service improvement does not vary across patients, their value of the service improvement (and thus a determination of whether the value is worth the increased cost) does. As patients vary in their medical needs and tradeoffs between price and service quality, determining the net impact

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<sup>246</sup> 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).

<sup>247</sup> 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.

<sup>248</sup> 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.”).

<sup>249</sup> 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.<sup>250</sup> 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.<sup>251</sup>

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.<sup>252</sup> 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.<sup>253</sup>

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.

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<sup>250</sup> 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.").

<sup>251</sup> Leitzinger Deposition, at 175:12-17.

<sup>252</sup> 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.

<sup>253</sup> 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.<sup>254</sup>

171. In addition, lack of revenue may force a hospital to cut back on special programs or services.<sup>255</sup> 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.<sup>256</sup>

Mr. Falatko went on to say:

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

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

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<sup>254</sup> Deposition of Jill Wehner (Harbor Beach), 1/11/2012, at 286:3-286:8.

<sup>255</sup> 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.

<sup>256</sup> Deposition of Michael Falatko (Hills and Dales), 12/16/2011, at 98:4-20.

<sup>257</sup> 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.<sup>258</sup>

In some cases, extra revenue is essential to the hospital's continued operation.<sup>259</sup> 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.<sup>260</sup>

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

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

<sup>259</sup> Deposition of Kevin J. Cawley (Sheridan Hospital), 4/19/2012, 162:11-163:22

<sup>260</sup> 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,"<sup>261</sup> leading to "reduced competition in the provision of health insurance and higher health care costs" and raising the price of health insurance.<sup>262</sup> 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.<sup>263</sup> 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 ...<sup>264</sup>

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<sup>261</sup> Leitzinger Report at ¶ 79.

<sup>262</sup> Leitzinger Report at ¶ 77.

<sup>263</sup> 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.").

<sup>264</sup> 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<sup>265</sup> 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.<sup>266</sup>

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<sup>265</sup> Leitzinger Deposition at 38:14-21.

<sup>266</sup> 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.<sup>267</sup> 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

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<sup>267</sup> 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.”<sup>268</sup>

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

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<sup>268</sup> 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.”<sup>269</sup> 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,<sup>270</sup> saving hospitals and payers on negotiating costs, reducing the chance of negotiating breakdown, and reducing uncertainty.<sup>271</sup> These very real benefits must be weighed against any potential alleged anticompetitive harm. The costs of renegotiating a contract can be quite large.<sup>272</sup> In several ways, MFNs can reduce the costs of negotiation. For example, sometimes hospitals may desire MFNs

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<sup>269</sup> Leitzinger Report at ¶ 111.

<sup>270</sup> 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.”).

<sup>271</sup> 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.

<sup>272</sup> 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.<sup>273</sup>

#### 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

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<sup>273</sup> 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.”<sup>274</sup> 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.<sup>275</sup> 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

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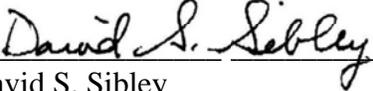
<sup>274</sup> Plaintiffs' Motion at 5.

<sup>275</sup> 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 ( $\$2,000 \times 0.10$ ) 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 ( $\$900 \times 0.10$ ) 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 ( $\$1,100 \times 0.10$ ). 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, 80<sup>TH</sup> 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, 234<sup>TH</sup> JUDICIAL DISTRICT  
Stealth, L.P. v. Aetna Health, Inc., *et al.*

Statement of Opinions (2011) and deposition testimony (2011).

THE DISTRICT COURT OF THE 22<sup>ND</sup> 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.

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APPENDIX II

LIST OF DOCUMENTS CONSIDERED

## **COURT DOCUMENTS**

Complaint, Civil Action No. 2:10-cv-14155-DPH-MKM (10/18/2010).  
Class Action Complaint, Civil Action No. 2:11-cv-10375-DPH-VMM (1/28/2011).  
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. Velturo (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. Velturo (with exhibits), Civil Action No. 2:11-cv-15346-DPH-MKM (6/7/2013).  
Reply Report of Dr. David Dranove Supporting Motion for Class Certification (redacted version for public file), Master Docket No. 07-CV-4446 (12/8/2009).

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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).  
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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).  
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#### **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 Velturo (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.threerivershealth.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  
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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

BLUECROSSMI-98-000533  
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BLUECROSSMI-EM-0240625  
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CIVLIT-00361349  
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PH-DOJ-0002204  
PH-DOJ-0002207  
PH-DOJ-0002437  
PH-DOJ-0002468  
PH-DOJ-0003526  
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SHER-09416-09433  
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SHS-001194  
SHS011937  
SHS-KMAT-000000661  
SHS-KMAT-000003625  
TRH-HC-0003185  
TRH-HC-0003870  
US-DOJ-003366  
WBH-61254  
WBH-61255  
WBH-61256

WBH-61282

**HCRIS DATA**

***HCRIS 2552-96:***

HCRIS\_DataDictionary.csv  
HCRIS\_DataModel.pdf  
HCRIS\_FACILITY\_NUMBERING.csv  
HCRIS\_STATE\_CODES.csv  
HCRIS\_TABLE\_DESCRIPTIONS \_AND\_SQL.txt  
hosp\_2003\_ALPHA.CSV  
hosp\_2003\_NMRC.CSV  
hosp\_2003\_ROLLUP.CSV  
hosp\_2003\_RPT.CSV  
hosp\_2004\_ALPHA.CSV  
hosp\_2004\_NMRC.CSV  
hosp\_2004\_ROLLUP.CSV  
hosp\_2004\_RPT.CSV  
hosp\_2005\_ALPHA.CSV  
hosp\_2005\_NMRC.CSV  
hosp\_2005\_ROLLUP.CSV  
hosp\_2005\_RPT.CSV  
hosp\_2006\_ALPHA.CSV  
hosp\_2006\_NMRC.CSV  
hosp\_2006\_ROLLUP.CSV  
hosp\_2006\_RPT.CSV  
hosp\_2007\_ALPHA.CSV  
hosp\_2007\_NMRC.CSV  
hosp\_2007\_ROLLUP.CSV  
hosp\_2007\_RPT.CSV  
hosp\_2008\_ALPHA.CSV  
hosp\_2008\_NMRC.CSV  
hosp\_2008\_ROLLUP.CSV  
hosp\_2008\_RPT.CSV  
hosp\_2009\_ALPHA.CSV  
hosp\_2009\_NMRC.CSV  
hosp\_2009\_ROLLUP.CSV  
hosp\_2009\_RPT.CSV  
hosp\_2010\_ALPHA.CSV  
hosp\_2010\_NMRC.CSV  
hosp\_2010\_ROLLUP.CSV  
hosp\_2010\_RPT.CSV  
hosp\_2011\_ALPHA.CSV  
hosp\_2011\_NMRC.CSV  
hosp\_2011\_ROLLUP.CSV  
hosp\_2011\_RPT.CSV  
HOSPITAL96\_ROLLUP\_REQUIREMENTS.csv  
Hospital96\_RollupReadme.pdf  
HOSPITAL96CostCenterCodes.pdf  
HOSPITAL96FileDataElements.xls  
HOSPITAL96FileDataElements508version.pdf  
Hospital96IMEDSHEExplanation.pdf  
HOSPITAL96README.txt  
HOSPITAL96WORKSHEET\_CODES.pdf

***HCRIS 2552-10:***

HCRIS\_DataDictionary.csv  
HCRIS\_DataModel.pdf  
HCRIS\_FACILITY\_NUMBERING.csv  
HCRIS\_STATE\_CODES.csv  
HCRIS\_TABLE\_DESCRIPTIONS \_AND\_SQL.txt  
hosp10\_2010\_ALPHA.CSV  
hosp10\_2010\_NMRC.CSV  
hosp10\_2010\_RPT.CSV  
hosp10\_2011\_ALPHA.CSV  
hosp10\_2011\_NMRC.CSV  
hosp10\_2011\_RPT.CSV  
hosp10\_2012\_ALPHA.CSV  
hosp10\_2012\_NMRC.CSV  
hosp10\_2012\_RPT.CSV  
HOSP2010\_CROSSWALK.pdf  
HOSP2010\_CROSSWALK.xlsx  
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 <sup>3</sup>	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 <sup>4,5</sup>								
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 <sup>4</sup>								
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 <sup>3</sup>	2005	2006	2007	2008	2009	2010	2011	2012
Charlevoix Area Hospital <sup>4</sup>								
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 <sup>2,4</sup>								
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 <sup>2,4</sup>								
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 <sup>2,4</sup>								
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 <sup>1,2,4</sup>								
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 <sup>3</sup>	2005	2006	2007	2008	2009	2010	2011	2012
Sparrow Ionia Hospital <sup>4</sup>								
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 <sup>2, 4</sup>								
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
<p>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, &lt;<a href="https://www.beaumont.edu/press/news-stories/2007/10/beaumont-hospitals-acquires-bon-secours/">https://www.beaumont.edu/press/news-stories/2007/10/beaumont-hospitals-acquires-bon-secours/</a>&gt; (January 17, 2014).</p>								

TABLE 2  
SUMMARY OF ALTERNATIVE DID ANALYSES

Hospital Name	Insurer	Network	DID (MFN*Post Period) <sup>1</sup>		
			Leitzinger Report <sup>2</sup> Quarterly	Alternative Model 1 <sup>3</sup> Aggregated	Alternative Model 2 <sup>4</sup> 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 <sup>/1, 4</sup> (\$)	Actual Net Operating Margin <sup>/5</sup> (%)	But-For Net Operating Margin <sup>/6</sup> (%)
Beaumont Hospital - Grosse Pointe <sup>/2</sup>	BCBSM	PPO	36,017,576	-12,659,275	-2.65	-11.56 <sup>/7</sup>
	HAP	AHL	1,158,977			
	HAP	PHP	907,994			
	<i>Total</i>		38,084,547			
Beaumont Hospital - Royal Oak <sup>/3</sup>	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			
	<i>Total</i>		74,101,228			
Beaumont Hospital - Troy <sup>/3</sup>	BCBSM	PPO	33,621,329	124,663,209	4.45	2.91
	HAP	AHL	3,574,952			
	HAP	PHP	7,053,896			
	<i>Total</i>		44,250,176			
<p>Notes:</p> <p>/1 Financial data from HCRIS.</p> <p>/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.</p> <p>/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).</p> <p>/4 Equals Net Patient Revenues less Total Operating Expenses.</p> <p>/5 Equals Net Patient Income divided by Net Patient Revenues.</p> <p>/6 Equals Net Patient Income less Reduction in Payments divided by Net Patient Revenues less Reduction in Payments.</p> <p>/7 But-For Net Operating Margin for reduction in BCBSM PPO payments only is -11.04%.</p>						

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) <sup>1</sup>	p-value <sup>1</sup>
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

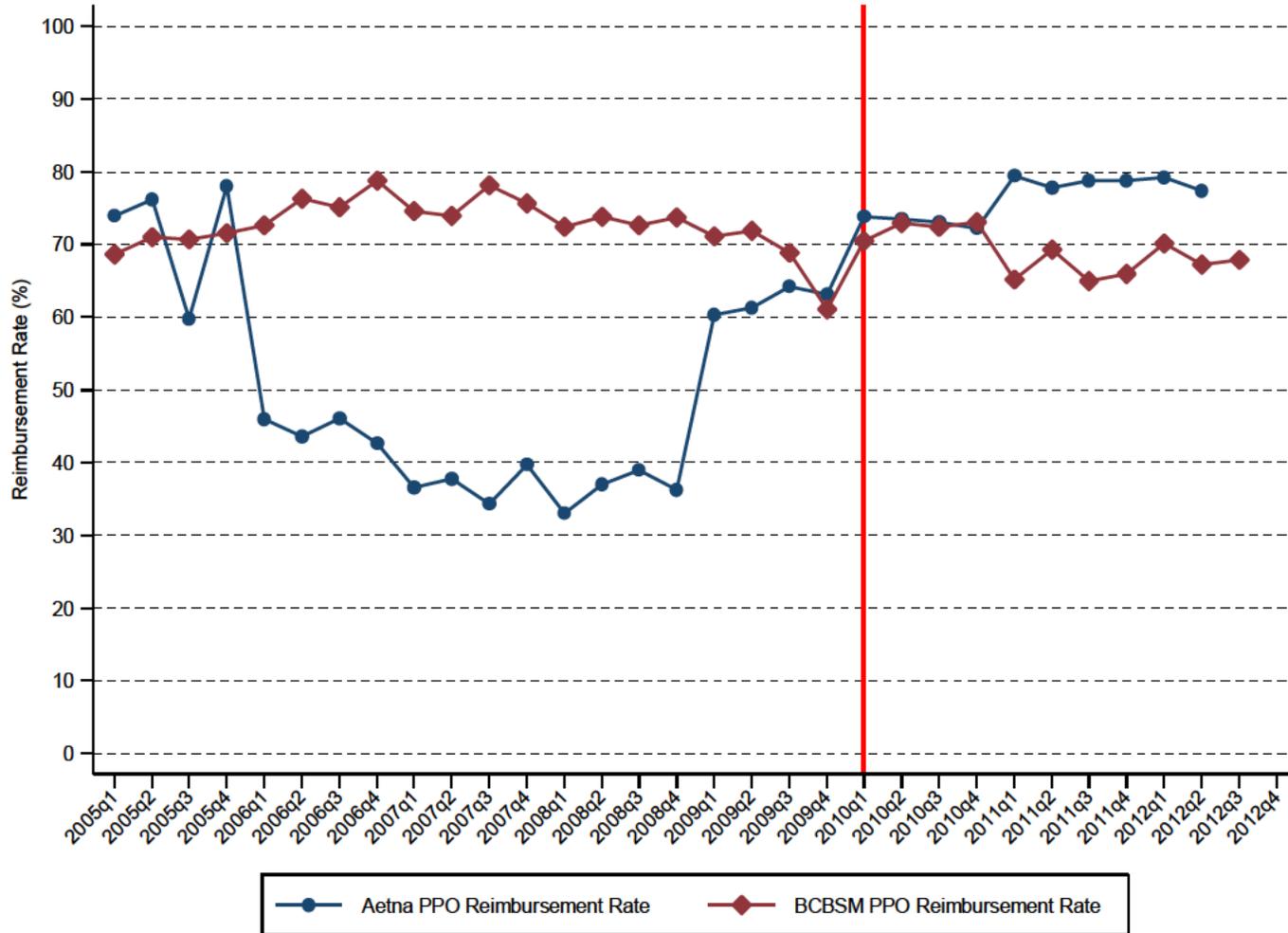
Hospital Name	Excluded Control Hospital	Hospital Peer Group	Control Peer Group	DID (MFN*Post Period) <sup>/1</sup>	p-value <sup>/1</sup>
Beaumont Hospital - Grosse Pointe	Lakeland Regional Medical Center-St. Joseph	2	2	3.18%	0.157
Beaumont Hospital - Grosse Pointe	McLaren Bay Regional	2	2	1.94%	0.427
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) <sup>1</sup>	p-value <sup>1</sup>
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

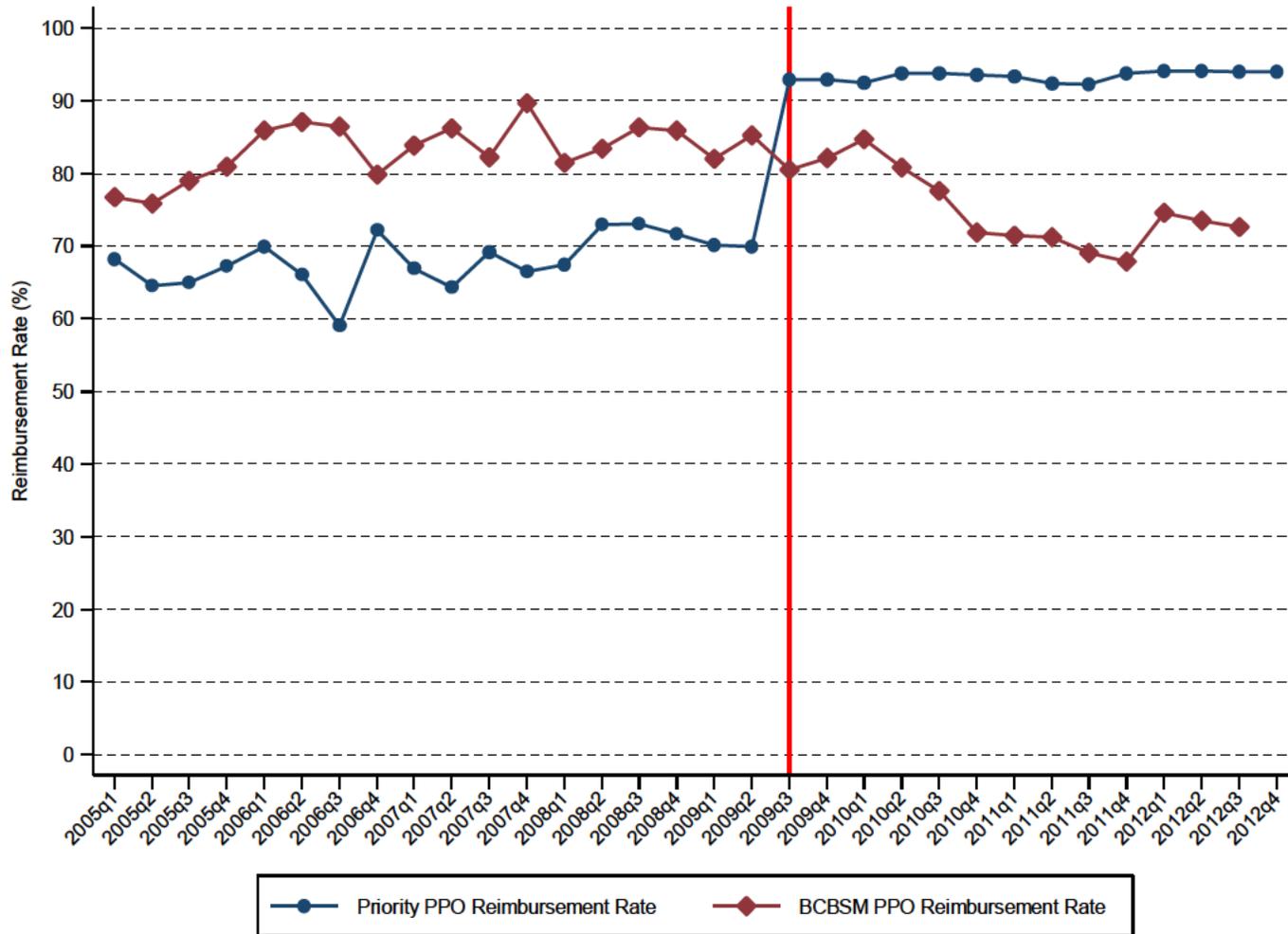
Note:  
<sup>1</sup> Regression using insurer claims data obtained from Dr. Leitzinger’s backup material and SAS regression code. Regression analysis based on post period used in Dr. Leitzinger’s DID regression for the “affected” combination Beaumont Hospital - Royal Oak HAP HMO.

FIGURE 1  
AETNA PPO & BCBSM PPO - THREE RIVERS HEALTH - REIMBURSEMENT RATES



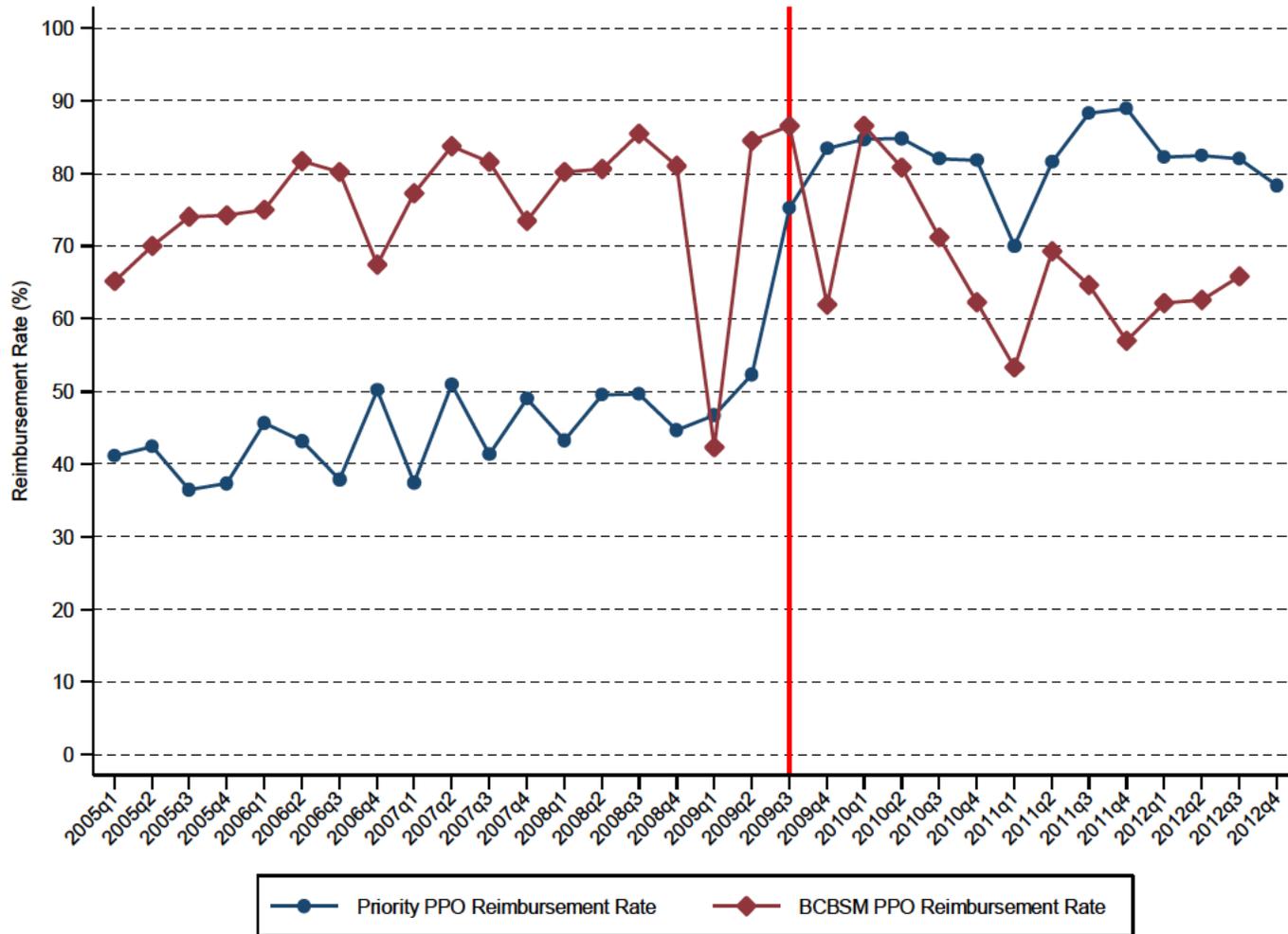
Source: Insurer claims data provided in Dr. Leitzinger's backup material.  
Note: Vertical line corresponds to MFN effective date.

FIGURE 2  
 PRIORITY PPO & BCBSM PPO - CHARLEVOIX AREA HOSPITAL - REIMBURSEMENT RATES

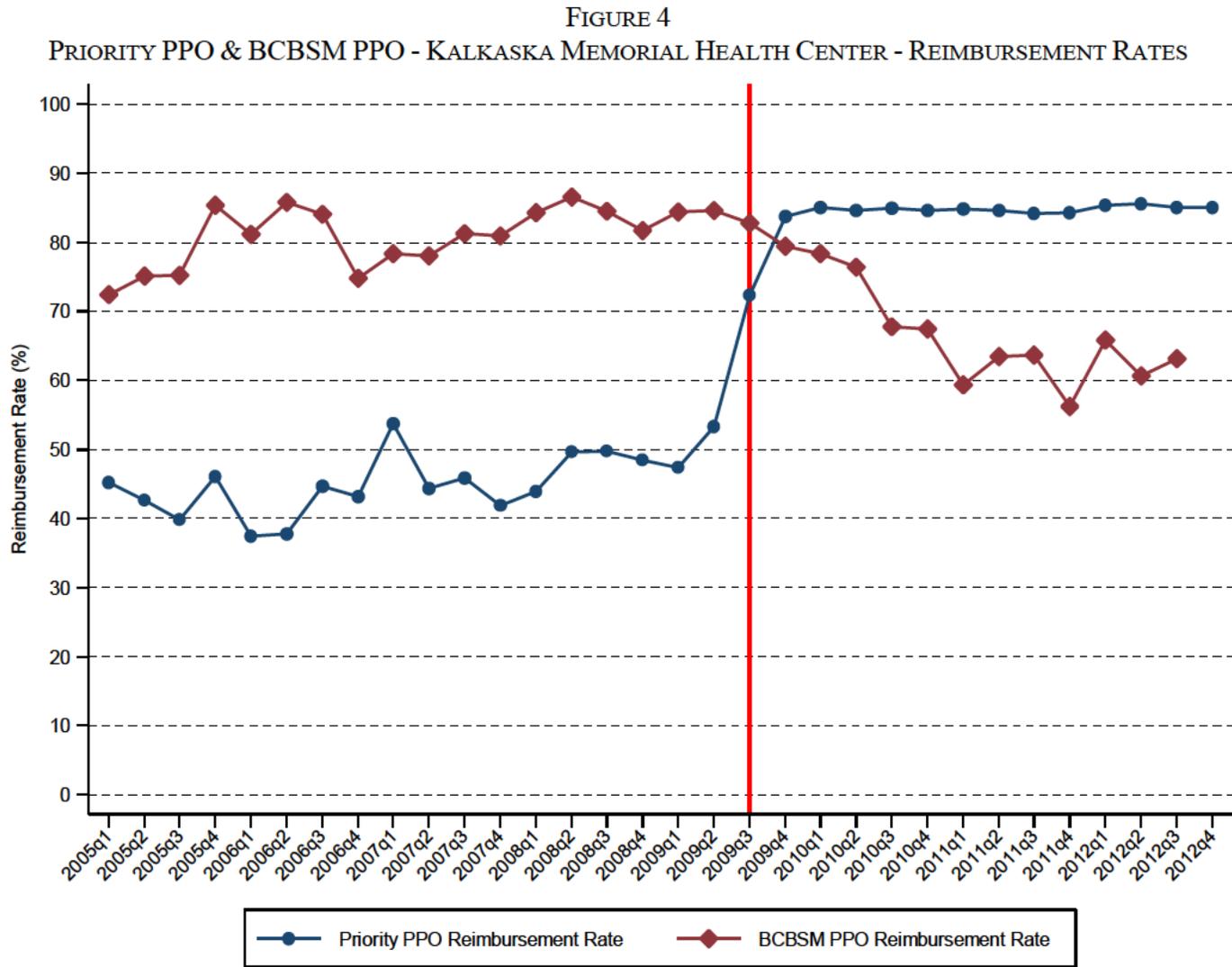


Source: Insurer claims data provided in Dr. Leitzinger’s backup material.  
 Note: Vertical line corresponds to MFN effective date.

FIGURE 3  
 PRIORITY PPO & BCBSM PPO - PAUL OLIVER MEMORIAL HOSPITAL - REIMBURSEMENT RATES

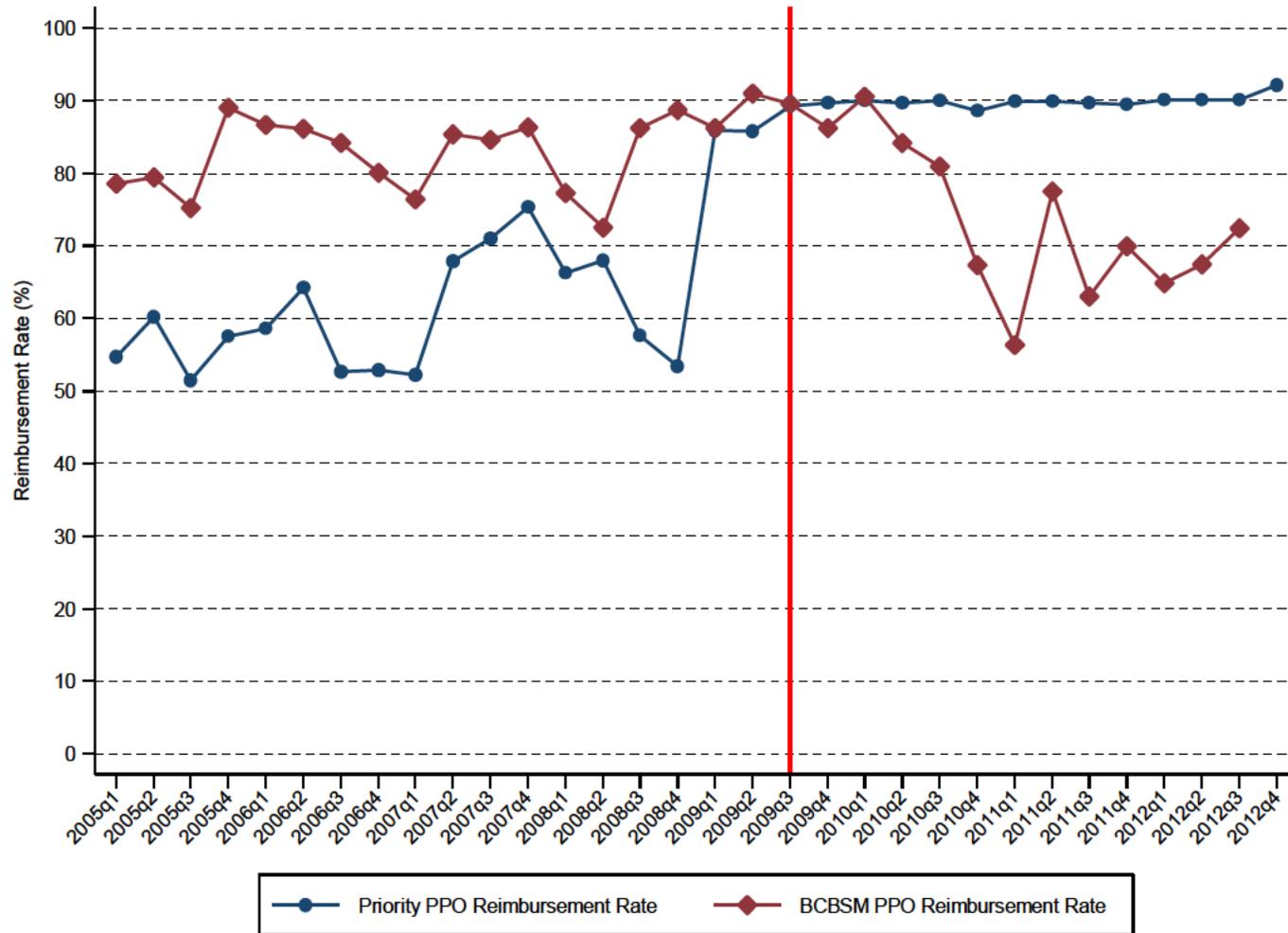


Source: Insurer claims data provided in Dr. Leitzinger’s backup material.  
 Note: Vertical line corresponds to MFN effective date.



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 12

KARMON BJELLA

United States of America v. Blue Cross Blue Shield of Michigan

12/13/2011

Page 1

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

UNITED STATES OF AMERICA, et al,

Plaintiffs,

vs.

Case No.2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD

OF MICHIGAN,

Defendant.

---

The Videotaped Deposition of KARMON BJELLA,  
Taken at 39577 Woodward Avenue, Suite 300,  
Bloomfield Hills, Michigan,  
Commencing at 9:35 a.m.,  
Tuesday, December 13, 2011,  
Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

KARMON BJELLA

United States of America v. Blue Cross Blue Shield of Michigan

12/13/2011

Page 198

1 the last paragraph, it says: In the spirit of  
2 cooperation, ARMC will agree to maintain its current  
3 discount rates with other payers and not decrease them  
4 below current contractual levels.

5 Do you see that?

6 A. Yes.

7 Q. Am I correct in understanding that that's an offer  
8 that Alpena made to Blue Cross because it had already  
9 decided that it was going to maintain and seek  
10 increases from other payers anyway?

11 MR. GRINGER: Objection, misstates the  
12 record, and foundation as well.

13 A. I wouldn't know who made the proposal first, but the  
14 statement at least as I signed the piece of paper was  
15 intended to say we worked it out.

16 BY MR. STENERSON:

17 Q. In or around December of 2009, given the financial  
18 condition of the hospital, was the hospital  
19 considering giving new and increased discounts to any  
20 commercial payers?

21 A. No.

22 Q. Why not?

KARMON BJELLA

United States of America v. Blue Cross Blue Shield of Michigan

12/13/2011

Page 199

1 A. Because we were already losing money. We couldn't do  
2 that.

3 Q. You couldn't do what?

4 A. Give more discounts.

5 Q. So irrespective of any MFN clause or MFN with any  
6 agreement, it's your testimony, sir, that in December  
7 of 2009, Alpena Medical Center was not in a position  
8 to give any additional discounts to any commercial  
9 payer; is that right?

10 MR. GRINGER: Objection, form.

11 A. Our firm statement for everyone in the organization is  
12 all expenses would go down and all revenues would go  
13 up.

14 MR. STENERSON: We'll take a short break.

15 VIDEO TECHNICIAN: The time is now 2:54  
16 p.m. We are off the record.

17 (Recess taken at 2:54 p.m.)

18 (Back on the record at 3:05 p.m.)

19 VIDEO TECHNICIAN: We are back on the  
20 record. The time is 3:05 p.m.

21 BY MR. STENERSON:

22 Q. Mr. Bjella, if you could please take for me out of

APPENDIX 13

# 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 addition 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.

Northeast Michigan's Leading Provider of Specialty Services

1501 West Chisholm St. • Alpena, Michigan 49707-1498 • (989) 356-7000

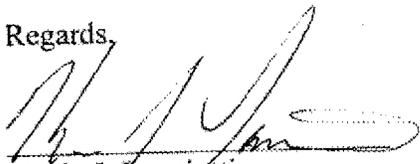
With our current cash on hand less that 10 days, we are finding this an upward hill to climb.

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 14

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

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

```

UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF MICHIGAN

```

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

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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:

1 Q And have Blue Cross negotiators conveyed that  
2 sentiment to you?

15:07:31

3 A Yes.

4 Q And, hypothetically -- we were talking about  
5 Medicare and Medicaid -- if Congress passed a law  
6 tomorrow that said effective immediately Medicare will  
7 pay cost plus 5 percent, and Michigan Ascension  
8 facilities started getting a 5 percent margin on its  
9 Medicare business, what would that do to Blue Cross's  
10 leverage at Michigan Ascension hospitals --

15:07:48

11 MR. LIPTON: Object to the form.

12 MR. JOYCE: Object --

15:08:04

13 BY MR. STENERSON:

14 Q -- in your view?

15 A Their leverage wouldn't change because they're  
16 still a dominant player in Michigan. What might change  
17 was the need for the Michigan Ascension Health hospitals  
18 to push Blue Cross into significantly higher rates,  
19 because we would have received them from the Federal  
20 Government at that point in time.

15:08:21

21 For us, it really is trying to hit an  
22 overall operating margin given the constraints that we  
23 have. Medicare and Medicaid, we cannot negotiate those  
24 rates. For others we can easier than Blue Cross. But  
25 Blue Cross is such a big payer, we have to talk with

15:08:36

1 them to help us meet our goals so that we can stay in  
2 business.

15:08:57

3           The last thing Blue Cross would need --  
4 would like is for Borgess Health to shut down and have a  
5 one-hospital town. Wouldn't be able to deal with all  
6 the business and they would be at a total negotiating  
7 disadvantage at that point in time. So it's in  
8 everybody's best interest to make sure that everybody  
9 kind of pays their fair share. In the absence of that,  
10 we have no alternative.

15:09:10

11           Q     Right. It's not in Blue Cross's business to  
12 force your rates down so low that you can't operate;  
13 correct?

15:09:20

14           A     That's correct.

15           Q     So let's talk about that. Let's talk about  
16 that a little bit in the negotiation of trying to find  
17 that right price. I think you mentioned that Blue  
18 Cross's leverage wouldn't change if Medicare started  
19 paying cost plus 5 percent, but the hospital could  
20 approach negotiations in a different manner; correct?

15:09:30

21                   MR. LIPTON: Object to the form.

22                   THE WITNESS: That's correct.

15:09:49

23           BY MR. STENERSON:

24           Q     So is it true that negotiations depend on both  
25 sides of the table?

1 MR. LIPTON: Object to the form.

2 THE WITNESS: Could you rephrase that 15:09:55

3 question?

4 BY MR. STENERSON:

5 Q Sure. When you entered into the negotiations  
6 that resulted in Plaintiff's 9, the LOU with the  
7 effective date of July 1, 2008, did you tell Blue Cross 15:10:07  
8 Blue Shield of Michigan negotiators what your bottom  
9 line price was?

10 A Yes.

11 Q Did the negotiation ultimately reach that  
12 price? 15:10:25

13 A No.

14 Q Well, then, was it really your bottom line?

15 A Yes.

16 Q Can you explain?

17 A As I indicated before in one of the other 15:10:31  
18 exhibits where I made that quote at the end, you know,  
19 "Great deal," we were overruled. And, therefore, we had  
20 to accept what -- you know, what we received. That was  
21 not our goal. We did not achieve a 5 percent operating  
22 margin. We did not spend the capital that we needed to 15:10:51  
23 spend. So it's -- you know, sometimes you win in the  
24 game, sometimes you lose.

25 Our goal and our bottom line was to hit a

1 5 percent operating margin, and we needed to get certain  
2 rates from Blue Cross in that negotiation, amongst doing **15:11:06**  
3 all kinds of other things with other payers and other  
4 costs, to get to where we need to go.

5 Q In your view, is there a difference in your  
6 mind between your goal amount and your bottom line in a  
7 negotiation? **15:11:20**

8 A No. I happened to be overruled by someone  
9 higher than me.

10 Q Well, somebody within Ascension Health  
11 accepted an amount lower than what you personally would  
12 have accepted? **15:11:32**

13 A That is correct. I still have to try to get  
14 my 5 percent operating margin some other way, though.

15 Q At the time the negotiations that resulted in  
16 Plaintiff's 9 began, do you recall what, converted to a  
17 percent of charge, the Blue Cross reimbursement rate was **15:11:53**  
18 at Borgess Medical?

19 A I believe it was 37 to 39 percent of charges.

20 Q And do you know what it is under the -- well,  
21 strike that.

22 Is Plaintiff's 9 still in effect? **15:12:12**

23 A It is until 2013, yes.

24 Q Do you know what Blue Cross's rate is today at  
25 Borgess Medical?

APPENDIX 15

DAVID MARCELLINO  
September 6, 2012

Page 1

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

UNITED STATES OF AMERICA, et al,

Plaintiffs,

vs.

Case No. 2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD

OF MICHIGAN,

Defendant.

---

The 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.

DAVID MARCELLINO  
September 6, 2012

Page 150

1 A. I am -- you know, I do remember, you know -- we must  
2 have had -- I don't remember the meeting specifically.

3 Q. Do you know if at or around the time of March, 2007,  
4 Botsford was looking for a, a rate increase to support  
5 cost plus 3%?

6 A. Yeah, that's based upon the Blue Cross model.

7 Q. Okay, and do you know in this approximate timeframe  
8 what Blue Cross's position was as to what  
9 reimbursement rate they were willing to provide to  
10 Botsford?

11 MR. STENERSON: Object to the form.

12 A. Well, because we were negotiating, it was obvious that  
13 it was their recognition of what our cost was, and  
14 they felt -- they came up with a different number than  
15 what we did. So it was part of the negotiation, was  
16 to try to get to the point, and that really relates  
17 back to the rebasing discussion in terms of what your  
18 starting point for cost.

19 BY MR. TORZILLI:

20 Q. Okay, and at this point in time, how -- could you  
21 describe how close Botsford and Blue Cross were to a  
22 final agreement?

23 A. I think we were getting fairly close, if I remember  
24 the meeting correctly. I think it was -- when Kim  
25 Sorget got involved, I think we were getting close to

APPENDIX 16

MARK GRONDA  
December 13, 2012

1 UNITED STATES DISTRICT COURT  
2 EASTERN DISTRICT OF MICHIGAN  
3 SOUTHERN DIVISION  
4  
5 UNITED STATES OF AMERICA, et al,  
6 Plaintiffs,  
7 vs. Case No. 2:10-cv-14155-DPH-MKM  
8  
9 BLUE CROSS BLUE SHIELD  
10 OF MICHIGAN,  
11 Defendant.

12 \_\_\_\_\_

13  
14  
15 The Confidential Videotaped Deposition of  
16 MARK GRONDA,  
17 Taken at 4960 Towne Centre Road,  
18 Saginaw, Michigan,  
19 Commencing at 10:08 a.m.,  
20 Thursday, December 13, 2012,  
21 Before Rebecca L. Russo, CSR-2759, RMR, CRR.

22  
23  
24  
25

MARK GRONDA  
December 13, 2012

1 Medicare and Medicaid losses trended?

2 A. Well, the volumes have gone up, both Medicare and  
3 Medicaid, and the losses have gotten more significant  
4 with Medicaid, because we're either getting no price  
5 increases, or in a couple cases we actually had  
6 takeaways, as the states manage their budget problems.

7 Q. So, if I understand correctly, in the past five years  
8 at Covenant, the Medicare and Medicaid shortfalls have  
9 increased both in terms of increased volume of  
10 patients and downward trending rates?

11 A. Rates that have not kept up with inflation, and with  
12 the example with Medicaid, I think they're actually  
13 downward, you know, less reimbursement, let alone  
14 inflation.

15 Q. Have Medicare rates in the past five years kept pace  
16 with inflation?

17 A. No.

18 Q. So in the past five years, Medicare rates at Covenant,  
19 as compared to inflation, have been trending downward?

20 A. They've eroded.

21 Q. And what are Covenant's options to make up for those  
22 sins of Medicare and Medicaid?

23 MR. ALLEN: Objection, form.

24 A. The only option we have is to look to the commercial  
25 payers, including Blue Cross.

MARK GRONDA  
December 13, 2012

Page 153

- 1 A. I do.
- 2 Q. Why did you think it important to tell Blue Cross that  
3 even after a rate increase, they would have a  
4 reimbursement advantage of at least 13 percentage  
5 points?
- 6 A. It's a negotiating position, just to reinforce what a  
7 large advantage they had.
- 8 Q. Did anyone from Blue Cross express to you in the past  
9 the concern that because of Blue Cross' size, that  
10 hospitals might seek a larger portion of government  
11 shortfalls from Blue Cross?
- 12 A. Could you repeat that?
- 13 Q. Sure. Did anyone from Blue Cross express to you in  
14 the past that because of Blue Cross' size, hospitals  
15 like Covenant might seek to only seek increases from  
16 Blue Cross and not other commercial payers?
- 17 A. No.
- 18 Q. In the -- do you know whose handwriting is on this  
19 document?
- 20 A. Yeah, it's mine.
- 21 Q. I'd like to direct your attention to the handwriting  
22 on the top of page 2. Could you read that for us?
- 23 A. High 'caid/uncompensated care, services, economy.
- 24 Q. Do you know what you were writing a note about there?
- 25 A. Just some of the factors that we felt compelled us to

MARK GRONDA  
December 13, 2012

1 need higher reimbursement from Blue Cross because of  
2 the high Medicaid uncompensated care, and the fact  
3 that we were just going into a recession at that  
4 point.

5 Q. I was going to say, I know the economy has been less  
6 than ideal recently, but do you recall at this time,  
7 in or around November of '08, what the economic  
8 conditions in and around Saginaw were like?

9 A. Not specifically, but we've been in a downturn for two  
10 decades because of the downsizing of GM before this  
11 most recent recession, so it's -- we've had higher  
12 unemployment rates than the state and in the nation,  
13 as a rule. I couldn't tell you the exact unemployment  
14 rate unless I said it here. I don't see it.

15 Q. If you could go to page 3, in the paragraph that  
16 starts C, it says:

17 We believe that other hospitals in our area  
18 are benefitting from higher Blue Cross rates due to  
19 their having higher costs, not due to any superiority  
20 in terms of efficiency or quality.

21 Do you see that?

22 A. I do.

23 Q. It says:

24 As you are aware, one of the largest  
25 factors affecting operating costs is wages, yet the

APPENDIX 17

Covenant HealthCare  
1447 North Harrison  
Saginaw, MI 48602  
989.583.0000 Tel



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 1<sup>st</sup>, 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

Δ π EXHIBIT 1301  
Deponent BCB  
Date 12-15-12 Rptr. KR  
WWW.DEPOBOOK.COM

*A High Cost / Uncompensated care  
services → economy*

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%).

*B  
LOW  
COST*

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.

*☆*

*OP  
shift*

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**

*7/1/08*

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.

*☆*

*Hurley*

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.

decrease non-reimb costs in side agreement

to we go 1/5 of new model w/ side agreement

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

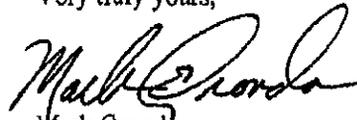
shifts from inpatient to outpatient. We believe that this shift should be estimated and taken into account in developing rates under the market pricing initiative.

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

*Negotiate  
Blue  
Cross  
PPO  
then*



APPENDIX 18

**From:** Milewski, Robert <RMilewski@bcbsm.com>  
**Sent:** Saturday, October 6, 2007 12:01 AM  
**To:** Parris, Bernadette <BParris@bcbsm.com>  
**Subject:** FW: Meeting

---

Bernie, FYI

---

**From:** Connolly, Jeffrey  
**Sent:** Fri 10/5/2007 8:28 AM  
**To:** Milewski, Robert; Sorget, Kim; Darland, Doug; Noxon, Gerald  
**Subject:** Re: Meeting

Melissa, can you set up a meeting through Bob's office on this. I would like Ken D there as well.

Thanks

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----- 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 opportunity.

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

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----- 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

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----- 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.

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----- 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

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Dickinson County Healthcare System, 1721 S. Stephenson Ave. Iron Mountain, MI 49801, [www.dchs.org](http://www.dchs.org)

APPENDIX 19

# Discussions With BCBSM

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**DCH  
SYSTEM**

---

*Participants From BCBSM:*

- o Ron Crowfoot
- o Doug Darland

*Participants From DCHS:*

- o John Schon, Administrator and CEO
- o John Lee, CFO
- o 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.

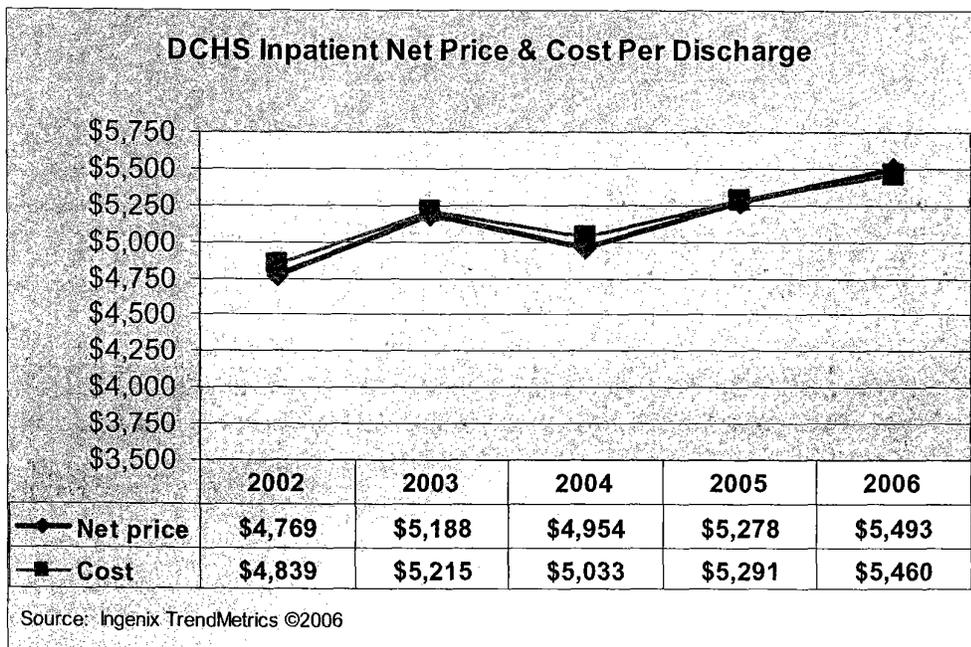


# DCHS Financial Challenges

---

- 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



- 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*
<b>Present and historical Payer Mix:</b>						
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.						
<b>Gross revenue in \$000's:</b>						
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 intervals			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*
<b>Net revenue and allowances in \$000s:</b>						
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: 1997 net 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.

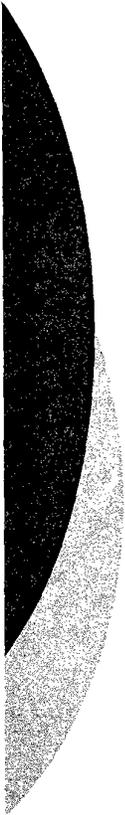


# DCHS

## 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.



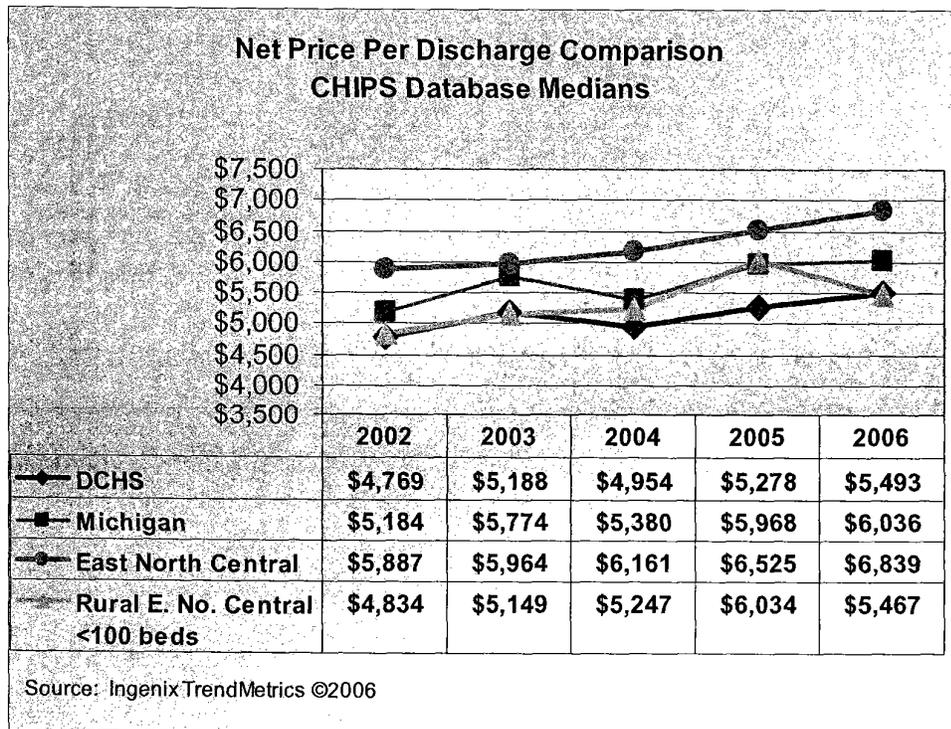
# DCHS

## Productivity and Staffing

	Eight Months Ended 8/31:		At three year intervals:			
	2007	2006	2006	2003	2000	1997*
<b>Productivity and efficiency:</b>						
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%
<b>Staffing level - total employment:</b>						
Total paid full-time equivalent employees	632.3	627.3	629.0	615.6	580.2	545.5
Paid hours / adjusted discharge <small>(IP discharges / ratio of IP revenue to Total)</small>	104.33	107.98	107.64	108.56	110.18	117.94
<b>% increase in employment:</b>						
Eight month periods	1%					
Three-year intervals			2%	6%	6%	
<b>% improvement:</b>						
<b>Staff level relative to patient volumes</b>						
Eight month periods	3%					
Three-year intervals			1%	1%	7%	

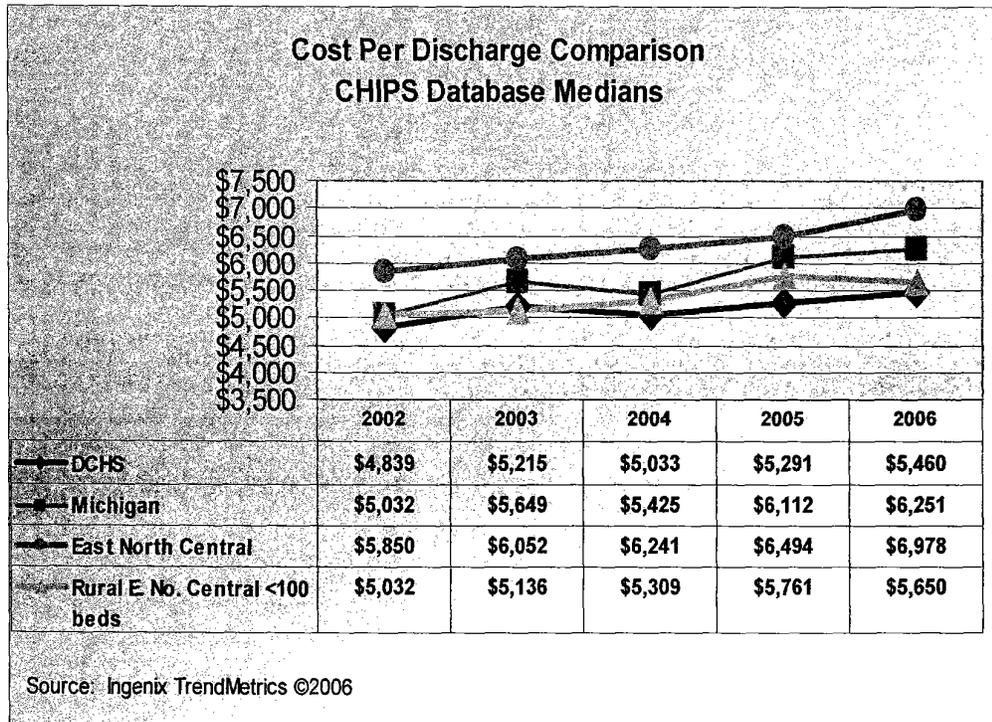
- Staffing is controlled relative to patient volumes.
- DCHS is the largest employer in Dickinson County and has provided steady employment with good job growth.
- As a tactic, could leverage these facts in efforts to win support from community.

# DCHS Price Comparison



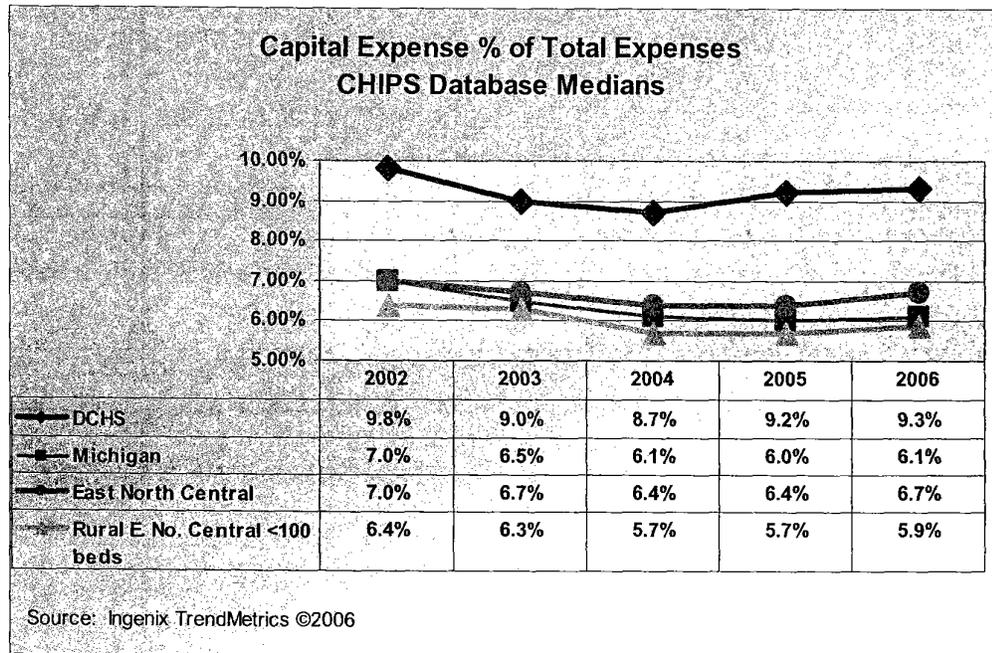
- Compares favorably except to small hospitals.
- BCBSM Peer 5 hospitals receive better reimbursement and can set prices lower.
- Wisconsin hospitals receive better reimbursement and can set prices lower.
- Unfavorable competitive situation.

# DCHS Cost Comparison



- Cost per discharge 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



- 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 orthopedist 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

<b>Specialty</b>	<b>Average Revenue Generated</b>	<b>Average Starting Salary*</b>
Cardiology ( <i>invasive</i> )	\$2,662,600	\$342,000
Orthopedic Surgery	\$2,312,168	\$370,000
Cardiology ( <i>non-invasive</i> )	\$2,240,286	\$342,000
Neurosurgery	\$2,100,000	\$489,000
Internal Medicine	\$1,987,253	\$162,000
General Surgery	\$1,947,934	\$272,000
Hematology/Oncology	\$1,624,246	\$275,000
Family Practice	\$1,615,828	\$145,000
Obstetrics & Gynecology	\$1,413,426	\$234,000
Gastroenterology	\$1,336,133	\$315,000
Pulmonology	\$1,332,534	\$248,000
Urology	\$1,272,563	\$320,000
Psychiatry	\$888,911	\$174,000
Nephrology	\$865,214	\$225,000
Pediatrics	\$697,516	\$151,000
Ophthalmology	\$584,310	N/A
Neurology	\$557,916	\$210,000

*\*2006 Merritt, Hawkins & Associates' Recruitment Incentives Survey.*

# DCHS

## Physician Practice Losses & Recruiting Activity

---

Practice specialty	YTD: 9/30/2007	FYE: 12/31/2006
Orthopedics	\$ (130,000)	\$ (238,000)
Pediatrics	\$ (89,000)	\$ (229,000)
Internist	\$ (214,000)	\$ (326,000)
Obstetrics	\$ (18,000)	N/A
Overall, including outlying clinics	\$ (1,032,000)	\$ (1,498,000)

**Special note: The hospitalist program is projected to add \$250,000 to \$400,000 to annual losses.**

### **Physician Recruiting Activities:**

- Current recruiting report shows active status of candidates, including internal medicine, pulmonology and obstetrics.
- Recruiting successes include 2 pediatricians and an ENT.
- Present Internist/Nephrologists plus recruiting candidates in Internal Medicine and Pulmonology could also form the core for a Hospitalist Program.
- Planning discussions with present general surgeons about recruiting a gastroenterologist are ongoing.

APPENDIX 20

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

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

```

UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF MICHIGAN

```

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

```

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:

1 THE WITNESS: Would you repeat that.

2 BY MR. SANDBERG: 13:32:34

3 Q I posited 60 percent.

4 A You started at 60 percent.

5 Q So, therefore, a 40 percent discount?

6 A Yes.

7 MR. SANDBERG: Okay. Thank you very 13:32:42

8 much.

9 MR. GRINGER: Scott, Mr. Warheit,

10 anything?

11 MR. WARHEIT: I have no questions for

12 him. 13:32:48

13 MR. GRINGER: Mr. Stenerson.

14 MR. STENERSON: One second, please.

15 EXAMINATION

16 BY MR. STENERSON:

17 Q Good afternoon. Mr. Worden. My name is Todd 13:33:05

18 Stenerson. I represent Blue Cross.

19 When you joined Marquette General in the

20 spring of 2008, what was the hospital's financial

21 condition?

22 A They were just about to report a \$10 million 13:33:18

23 operating loss. They had had Wellspring, which was a

24 nationally known turn-around firm, that was here. They

25 had just gone through an early retirement program. They

1 had gone through some management reorganization, and  
2 they were extremely financial -- financially distressed.13:33:39  
3 And their day's cash I believe was just a little bit  
4 over 50 days cash, and they were about to default on  
5 several bond covenants.

6 Q Do you know how close Marquette was in  
7 defaulting on their bond covenants? 13:33:53

8 A We did default on it.

9 Q You did default?

10 A We did.

11 Q Do you know how many covenants were defaulted?

12 A Three. I know it very well. 13:34:00

13 Q And this is in the spring of 2008?

14 A It actually -- our fiscal year ends June 30,  
15 and so when we issued the financial statements in  
16 September, we would have had to issue default notices on  
17 the covenants that we defaulted on. 13:34:15

18 Q And while the agreement that's reflected in  
19 Worden Number 3 had yet to be signed when you joined,  
20 did you understand why -- or, strike that.

21 Did you come to learn why Marquette  
22 General was seeking additional reimbursements from Blue13:34:34  
23 Cross that ultimately resulted in the agreement that's  
24 Worden Number 3?

25 A Yes.

APPENDIX 21

**Darland, Doug**

---

**From:** Seitz, Kevin  
**Sent:** Tuesday, May 22, 2007 5:41 PM  
**To:** Sorget, Kim; Milewski, Robert; Connolly, Jeffrey  
**Cc:** Darland, Doug; Noxon, Gerald; Crofoot, Ron; Carlson, Jeanne; Klobucar, Kevin  
**Subject:** RE: Marquette General Hospital

agree with your option 3. We can also offer to split upside risk on the HMO(not necessarily 50/50).

Please keep in mind Kevin Klobucar's advice. BCN would like to go into the U.P., but BCBSM should not sacrifice for this to happen.

would like to bring this to closure quickly. Can we give them a deal/no deal deadline of June 30<sup>th</sup>? 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

5/24/2007

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
- no Model picking + choosing  
(over model by \$10M)
- May consider funding opportunity  
when your plans are ready to  
"support partnership" etc. be shared
- BCW open to gain/sharing
- Separate gain share program w/ BC

5/24/2007

APPENDIX 22

TIMOTHY SUSTERICH  
November 20, 2012

1 UNITED STATES DISTRICT COURT  
2 EASTERN DISTRICT OF MICHIGAN  
3 SOUTHERN DIVISION  
4  
5 UNITED STATES OF AMERICA, et al,  
6 Plaintiffs,  
7 vs. Case No. 2:10-cv-14155-DPH-MKM  
8  
9 BLUE CROSS BLUE SHIELD  
10 OF MICHIGAN,  
11 Defendant.

12 \_\_\_\_\_

13  
14  
15 The Confidential Videotaped Deposition of  
16 TIMOTHY SUSTERICH,  
17 Taken at 5900 Byron Center Avenue,  
18 Wyoming, Michigan,  
19 Commencing at 9:17 a.m.,  
20 Tuesday, November 20, 2012,  
21 Before Rebecca L. Russo, CSR-2759, RMR, CRR.

22  
23  
24  
25

TIMOTHY SUSTERICH  
November 20, 2012

Page 26

1 Q. And how has that mix changed, if at all, say in the  
2 past five years?

3 A. I wouldn't say it's changed significantly.

4 Q. Been fairly constant?

5 A. Yeah, pretty much.

6 Q. Do the government payers cover cost of providing  
7 service to government patients?

8 A. They do not.

9 Q. Do you know why not?

10 A. No, I don't.

11 Q. Do you -- why don't you go and negotiate a higher rate  
12 with Medicare?

13 A. It's a government program.

14 Q. They don't let you negotiate?

15 A. No, we do not negotiate with the government.

16 Q. Why don't you go negotiate higher rates with Medicaid?

17 A. It's a government agency, as well.

18 Q. So Medicaid won't negotiate with you?

19 A. No.

20 Q. Do you know approximately, in the current year, how  
21 much money in government underpayment -- well, strike  
22 that.

23 We can give a little background for folks  
24 who aren't in the hospital industry. When you say  
25 that government payers don't pay costs, how does that

TIMOTHY SUSTERICH  
November 20, 2012

Page 27

1 affect Metro Health's financial position?

2 A. Well, obviously, it's a burden that we have to bear.

3 Q. So do you know, in rough estimates, what percentage of  
4 cost Medicare reimburses Metro Health for services  
5 provided to Medicare patients?

6 A. I don't know exactly.

7 Q. Do you have a combined number for Medicare and  
8 Medicaid as to how much under cost those programs  
9 reimburse Metro Health for providing care to their  
10 patients?

11 A. We calculate it annually. I just don't remember the  
12 exact number.

13 Q. Do you know the dollar range of the -- well, strike  
14 that.

15 So do I understand correctly that if the  
16 hospital provides service to a patient and it costs a  
17 hundred dollars to provide the service, and it's only  
18 reimbursed, say, \$80, it has a \$20 loss on that  
19 service?

20 A. That'd be accurate.

21 Q. And if you add those individual patient losses up over  
22 the course of the year, is there a label that you give  
23 that bucket of money?

24 A. Community benefit.

25 Q. And when you use the phrase community benefit, what is

TIMOTHY SUSTERICH  
November 20, 2012

Page 48

1 MARKED FOR IDENTIFICATION:

2 BLUE CROSS EXHIBIT 1057

3 10:35 a.m.

4 A. It is.

5 BY MR. STENERSON:

6 Q. Thank you. Let me hand you what I'm marking as Blue  
7 Cross 1058 --

8 MARKED FOR IDENTIFICATION:

9 BLUE CROSS EXHIBIT 1058

10 10:35 a.m.

11 BY MR. STENERSON:

12 Q. -- and ask you to review it.

13 A. Okay.

14 Q. Is 1058, Blue Cross 1058 an email correspondence you  
15 had with Mr. Darland at Blue Cross?

16 A. Apparently, yes.

17 Q. Does this document refresh your memory about any of  
18 the discussions you had with Blue Cross in or around  
19 2008?

20 A. I'm aware that we were negotiating, yes.

21 Q. And is this document in or around the time when you,  
22 on behalf of Metro Health, had approached Blue Cross  
23 to seek an increase in reimbursement rate?

24 A. It would have been, yes.

25 Q. Do you know how -- do you recall how long the --

TIMOTHY SUSTERICH  
November 20, 2012

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1 excuse me. Do you recall how long the negotiations  
2 lasted?

3 A. I do not recall.

4 Q. Is it -- suffice it to say you had more than one  
5 conversation regarding the request for an increased  
6 rate?

7 A. Yes.

8 Q. Now, Mr. Darland's email is asking, in the first  
9 bullet, how do our rates come to the rates Priority  
10 pays to your hospital.

11 Do you see that?

12 A. I do.

13 Q. And to other commercial payers, do you see that?

14 A. I do.

15 Q. Do you recall earlier today when you mentioned that  
16 you thought it was a relevant fact for Metro Health to  
17 understand what its competitors were being paid by  
18 Blue Cross?

19 A. I do.

20 Q. Did you find anything wrong with the fact that  
21 Mr. Darland was concerned with where Priority's rates  
22 were?

23 MS. BHAT: Objection to form.

24 A. I was.

25 BY MR. STENERSON:

TIMOTHY SUSTERICH  
November 20, 2012

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1 Q. I'm sorry?  
2 A. I was.  
3 Q. You were what?  
4 A. I was concerned with him asking that question.  
5 Q. Okay. And did you respond to Mr. Darland's question?  
6 A. That we had a confidentiality agreement in all of our  
7 contracts, that we don't discuss rates.  
8 Q. And Mr. Darland, in his third bullet, asks whether or  
9 not Priority's been approached, do you see that?  
10 A. I do.  
11 Q. Do you recall if you responded to that?  
12 A. I don't recall.  
13 Q. At the time that Mr. Darland was asking this, do I  
14 understand correctly that you were already in  
15 discussions with Priority?  
16 A. I don't know if we were already, but we did have  
17 discussions with Priority, yes.  
18 Q. Let me ask it this way. Prior to Mr. Darland's email  
19 in Blue Cross 1058, had Metro Health already made the  
20 decision to approach Priority for an increase in  
21 rates?  
22 A. We had.  
23 Q. Am I correct in understanding that nothing that  
24 Mr. Darland asked you in this email caused you to seek  
25 additional reimbursement rates from Priority?

TIMOTHY SUSTERICH  
November 20, 2012

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1 MS. BHAT: Objection to form.

2 A. No, we were already in -- we already made a decision  
3 that we needed to approach all payers -- not all  
4 payers, but the significant payers, relative to rates.

5 BY MR. STENERSON:

6 Q. In your discussions with Priority, did they seek to  
7 determine what your reimbursement rate was with Blue  
8 Cross?

9 A. Don't recall.

10 Q. In your negotiations with Blue Cross, did you seek to  
11 determine what Blue Cross' reimbursement rate was to  
12 other hospitals in Grand Rapids?

13 A. I did not.

14 Q. How did you learn what you believe to be the rates  
15 that Blue Cross was paying other hospitals in Grand  
16 Rapids?

17 A. Well, Blue Cross or Blue Care Network is our TPA for  
18 our employees, so we obviously have claims that are  
19 paid to the other institutions.

20 Q. So you were able to roughly reverse-engineer those  
21 issues?

22 A. Correct.

23 Q. Would you describe Mr. Darland as a hard negotiator?

24 A. I would.

25 MS. BHAT: Objection to form.

TIMOTHY SUSTERICH  
November 20, 2012

Page 52

1 BY MR. STENERSON:

2 Q. And what do you mean by hard negotiator?

3 A. Unwilling to -- well, unwilling to get to where I  
4 would like it to be.

5 Q. Do you think Mr. Darland is in the practice of paying  
6 hospitals like Metro Health higher reimbursement than  
7 he needs to?

8 A. No.

9 MS. BHAT: Objection to form.

10 MR. MATHESON: Objection to form.

11 MS. BHAT: And foundation.

12 BY MR. STENERSON:

13 Q. At the same time, did you find that Mr. Darland would  
14 listen to your actual financial needs in determining  
15 whether or not to agree to an increase?

16 MR. MATHESON: Objection to the form and to  
17 the leading.

18 A. He was -- he did listen, yes.

19 BY MR. STENERSON:

20 Q. Let me ask it this way. In your negotiations with  
21 Mr. Darland, what did you find to be an effective way  
22 to get Mr. Darland to consider a potential increased  
23 reimbursement?

24 MR. MATHESON: Objection, based on earlier  
25 leading.

TIMOTHY SUSTERICH  
November 20, 2012

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1 A. The cost structure of the organization had changed.

2 MR. STENERSON: That's a new one.

3 MR. MATHESON: It's worked before.

4 BY MR. STENERSON:

5 Q. Any other factors that you found -- what if any other  
6 factors did you find effective in negotiating for  
7 higher reimbursements with Mr. Darland?

8 A. That was the basis for going forward with it at that  
9 time.

10 Q. Let me show you what I'm gonna mark as Blue Cross  
11 1059.

12 MARKED FOR IDENTIFICATION:

13 BLUE CROSS EXHIBIT 1059

14 10:42 a.m.

15 A. Just stick this here?

16 BY MR. STENERSON:

17 Q. Yes, sir. If you would take a moment and review Blue  
18 Cross 1059 --

19 A. The whole document?

20 Q. -- just to familiarize yourself with it.

21 A. I'm familiar with it.

22 Q. Do you recognize Blue Cross 1059?

23 A. I do.

24 Q. And what is it?

25 A. It's a letter of understanding between Blue Cross and

APPENDIX 23

---

**From:** Sorget, Kim  
**Sent:** Friday, January 25, 2008 1:49 PM  
**To:** Milewski, Robert; Connolly, Jeffrey  
**Cc:** Dallafior, Ken; Darland, Doug  
**Subject:** RE: Metro

We will do some research on this but it may take a month or more. Doug and team have some very tight timelines on the Market Based Outpatient Pricing Initiative with the hospital industry and the MHA, as well as the PG5 deployment in addition to us opening up negotiations with Marquette General. KIM

-----Original Message-----

From: Milewski, Robert  
Sent: Wednesday, January 23, 2008 9:10 AM  
To: Connolly, Jeffrey  
Cc: Sorget, Kim; Dallafior, Ken  
Subject: RE: Metro

I don't know how much work it is, but I am good with this being the next step, if Kim is OK. I suspected that we would receive a request from Metro eventually because of their new facility.  
Bob

Robert Milewski  
Senior Vice President, Contracting and Hospital Relations  
Blue Cross Blue Shield of Michigan  
27300 W. 11 Mile Road, B792  
Southfield, MI 48034-6147

Bernie Parris, Executive Assistant  
Phone: 248-448-6903

-----Original Message-----

From: Connolly, Jeffrey  
Sent: Wednesday, January 23, 2008 9:08 AM  
To: Milewski, Robert; Sorget, Kim  
Cc: Dallafior, Ken  
Subject: Re: Metro

Very very well said...I completely agree with you. Tim Susterich (their CFO) expects a response. Is the next step to have Doug assess the dollars?

Thanks

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----- 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

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----- 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

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----- 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

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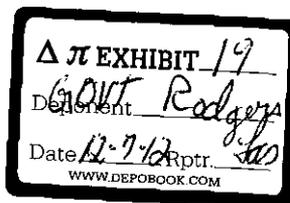
APPENDIX 24

**MidMichigan Health / Blue Cross Blue Shield Agreement  
CONFIDENTIAL**

On September 5, 2008 MidMichigan Health and Blue Cross Blue Shield of Michigan reached a verbal agreement on contract terms after nearly nine months of negotiations. The contract terms are summarized as follows:

- The initial contract term is 3 years (fiscal year 2009, 2010 and 2011) it then becomes evergreen (automatically renews each year) with either party able to open it for negotiations with 120 days notice.
- Initially and annually thereafter, rates will increase by the market basket (NIPI) plus 0.3% at Midland and Gratiot and by the market basket at Clare and Gladwin. After the initial year, rate increases will be capped by the Standard Model Participating Hospital Agreement rate increase. Under these terms, Midland receives approximately \$5.5 million per year of enhanced payments relative to the standard Blue Cross agreement. 55
- 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. 22
- <sup>MHA</sup> 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. 7 11
- 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 AVAIL



**1954**

APPENDIX 25

Jerry Noxon

Dear Jerry:

I appreciate you and Kim Sorget spending time with me on the phone on December 13, 2007 to clarify your proposal letter dated November 28, 2007.

I understand BCBSM's desire to have all hospitals on the revised PHA payment methodology and am supportive of this concept. However, your proposed increase of 1.8% does not cover the BCBSM pro rata share of new capital and operating costs that Sparrow will incur as a result of opening our new West Wing next month not to mention just general cost inflation. After our discussion I rolled forward our costs from the last rebasing using our actual annual increases in our costs per adjusted discharge. That analysis suggested that our current BCBSM rates are about \$2 million higher than the PHA methodology would support, not the \$9 million you reference in your letter. The following proposal would move us to the standard PHA agreement in year 2 and provide Sparrow with slightly lower annual rate increases to offset this estimated \$2 million difference.

- Year 1- Sparrow to receive an update of 2.6% for hospital inpatient and outpatient charge based services with an application of the incentive program to all services consistent with the standard PHA agreement. In addition, Sparrow will be allowed to retain the \$560,000 "PHA signing bonus" to partially offset the incremental costs in 2008 associated with opening the new West Wing.
- Year 2- Sparrow to receive the full PHA update factor less 1% plus the application of all provisions of your standard PHA agreement.
- Year 3- Sparrow to receive the full PHA update factor.

You have indicated that since 2010 is the beginning of a new base year cycle that rebasing will occur using 2007 data. As noted earlier Sparrow is opening its new West Wing in 2008 and 2007 will not be totally reflective of the increased costs to serve BCBSM beneficiaries and members. We would propose that 2007 costs be adjusted to include the new capital and operating costs in the rebasing process.

Thank you for your time to review our counterproposal. We stand prepared to meet with you as soon as practicable to conclude these payment discussions.

APPENDIX 26

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

----- :  
 :  
 UNITED STATES OF AMERICA and the :  
 :  
 STATE OF MICHIGAN, :  
 :  
 Plaintiffs, :  
 :  
 vs. : Case No.  
 :  
 BLUE CROSS BLUE SHIELD OF : 2:10-CV-14155  
 :  
 MICHIGAN, : DPH-MKM  
 :  
 Defendant. :  
 :  
 ----- :

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

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

VIDEOTAPED DEPOSITION OF JOSEPH FIFER  
HIGHLY CONFIDENTIAL

1 rendering care to Medicare and Medicaid patients.

2 Q. I still don't understand. Can you explain  
3 further?

4 A. When we get paid from Medicare and Medicaid  
5 reimbursement, that's less than providing the care **14:35:12**  
6 to the patients; so we lose money on those patients.

7 Q. How -- Well, strike that.

8 At the time you left in 2012, were you  
9 losing money at the Spectrum Health facilities for  
10 providing care to Medicare patients? **14:35:26**

11 A. Yes.

12 Q. At the time you left Spectrum in 2012,  
13 were you losing money on providing care to Medicaid  
14 patients?

15 A. Yes. **14:35:36**

16 Q. Is that the same answer for the three  
17 smaller facilities?

18 A. It is definitely the same for Medicaid.  
19 I'm not a hundred percent sure on Medicare for all  
20 three. **14:35:56**

21 Q. Do you know what your annual, in dollars,  
22 Medicare and Medicaid shortfall was at the Spectrum  
23 Health facilities at the time you left?

24 MR. LIPTON: Objection to form.

1 BY THE WITNESS:

2 A. It was approximately a hundred million  
3 dollar loss -- Strike that.

4 Just Medicare and Medicaid was probably  
5 around \$80 million. **14:36:22**

6 Q. And if I'm understanding you correctly,  
7 that means if you take all the costs of providing  
8 patient care to a year's worth of Medicare and  
9 Medicaid patients, the payments you receive from  
10 those government programs add up to \$80 million less **14:36:39**  
11 than it costs you to provide the care?

12 A. That's correct.

13 Q. And what are some of the ways that a  
14 hospital like Spectrum Health can make up for those  
15 tens of millions of dollars of shortfalls? **14:36:55**

16 A. There's only one other way, and that is to  
17 be paid by the commercial payors in rates adequate  
18 enough to make up for that.

19 Q. Did I hear you correctly that there's only  
20 one way to make up for the government shortfalls, **14:37:10**  
21 and that is to get it from the non-government  
22 payors?

23 A. That's my opinion. And actually, that's by  
24 fact. I don't know how else it would happen.

1 Q. You mentioned in your answer an additional  
2 source of losses that the hospitals incurred --  
3 sorry. Your answer of a hundred million intimated  
4 there may be another source of potential losses?

5 A. No. My first hundred-million-dollar  
6 number, I was remembering the community benefit  
7 calculation that we used to do. That includes other  
8 things where that hospital supports the community  
9 above and beyonds losses on Medicare and Medicaid.  
10 It's got nothing to do with Medicare and Medicaid.

14:37:40

14:37:58

11 Q. Are you referring MHAs, community benefit  
12 reports?

13 A. There's several calculations, but that's  
14 one of them.

15 Q. What is the annual community benefits  
16 report the hospital fills out as part of the MHA?

14:38:09

17 A. What is it?

18 Q. Yes.

19 A. What is the report? Again, MHA has a  
20 definition of community benefit that they recommend  
21 that hospitals complete, and MHA gathers that data  
22 from hospitals. And that definition of community  
23 benefit includes things like losses on Medicare and  
24 Medicaid as well as community programs.

14:38:18

1 Q. Does it include charity care?

2 A. Yes.

3 Q. What is charity care?

4 A. Charity care is care that's provided for  
5 patients that don't have the resources to and don't  
6 have insurance and don't have the money to pay for  
7 it.

**14:38:45**

8 Q. Does it include bad debt?

9 A. I don't remember. I don't remember if  
10 that's in the MHA calculation or not.

**14:39:03**

11 Q. And so shifting back to the methods in  
12 which a hospital -- Strike that.

13 Shifting back to the only method you  
14 believe a hospital can use to make up for the  
15 failures of Medicare and Medicaid payments, who is  
16 your largest payor, commercial payor at Spectrum  
17 Health facilities?

**14:39:22**

18 MR. LIPTON: Objection to form.

19 BY THE WITNESS:

20 A. Blue Cross.

**14:39:36**

21 Q. And do you know who your second largest  
22 payor is at Spectrum Health?

23 A. That would be Priority Health.

24 Q. And do you know how their annual revenues

1 compare at Spectrum?

2 A. About when I was there, yes.

3 Q. And how do they compare?

4 A. Well, actually the number I can remember  
5 more distinctly would be the percent of our revenue. **14:39:56**

6 Blue Cross was somewhere around 17 percent of our  
7 revenue, and Priority Health was somewhere around  
8 13 percent of our revenue.

9 Q. And the Medicare and Medicaid losses of  
10 approximately \$80 million annually at the time you **14:40:17**  
11 left, has that number been relatively constant in  
12 the past 5 years?

13 A. It's grown.

14 Q. And where has it grown from, if you  
15 recall? **14:40:29**

16 MR. LIPTON: Objection. Form.

17 BY THE WITNESS:

18 A. I don't recall the number 5 years ago. But  
19 10 years ago, between the two programs it was zero.

20 Q. Really? So in 2002, Spectrum Health **14:40:40**  
21 facilities did not have any government shortfall for  
22 Medicare and Medicaid patients?

23 A. If you combine the programs together,  
24 correct.

1 Q. What has happened in the past 10 years  
2 that has caused government payors to go from  
3 covering cost to creating upwards of an \$80 million  
4 loss to Spectrum?

5 MR. LIPTON: Objection to form. Foundation. **14:41:06**

6 BY THE WITNESS:

7 A. The rising cost of healthcare, and  
8 increases from those payors that were either  
9 nonexistent or at a lesser rate than the cost  
10 increases. **14:41:24**

11 Q. I'm sorry. I didn't follow your answer.

12 A. The percent payment increase from those  
13 payors has been significantly less than the percent  
14 increase in the cost of delivering that care.

15 Q. Just let me understand. So the actual **14:41:39**  
16 cost at Spectrum Health facilities in the past  
17 10 years has significantly outpaced the payment  
18 increases from Medicare and Medicaid?

19 A. Yes.

20 Q. Do you know what -- Well, strike that. **14:41:54**

21 Did the Blue Cross MFN provision have  
22 anything to do with Spectrum Health facilities  
23 increased cost in the past decade?

24 MR. LIPTON: Objection to form.

APPENDIX 27

KERRI NELSON  
March 22, 2012

Page 1

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

UNITED STATES OF AMERICA, et al,  
Plaintiffs,

vs. Case No. 2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD  
OF MICHIGAN,  
Defendant.

---

The 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.

KERRI NELSON  
March 22, 2012

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1 A. Unpaid costs for government program patients.

2 Q. What is that?

3 A. That would be our Medicare and Medicaid shortfalls.

4 Q. Okay. And what are Medicare and Medicaid shortfalls?

5 A. It's the difference between the cost of providing  
6 service to those patients that have Medicare and  
7 Medicaid versus what we get paid in reimbursement.

8 Q. Okay. We'll circle back to this in a few minutes,  
9 but, in your opinion, what is the impact of Medicare  
10 and Medicaid shortfalls on the hospital's financials?

11 MS. ARIAS: Objection to form.

12 A. It actually reduces our operating income.

13 BY MR. LASKEN:

14 Q. Is that positive for the hospital?

15 A. Not -- no.

16 Q. Does it help the hospital stay in business?

17 MS. ARIAS: Objection to form, foundation.

18 A. No.

19 BY MR. LASKEN:

20 Q. Does it help the hospital provide better care?

21 MS. ARIAS: Objection to form, foundation.

22 A. No.

23 BY MR. LASKEN:

24 Q. Does it help the hospital buy new equipment?

25 A. No.

APPENDIX 28

JEFFERY LONGBRAKE  
August 29, 2012

Page 1

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

UNITED STATES OF AMERICA, et al,

Plaintiffs,

vs.

Case No. 2:10-cv-14155-DPH-MKM

BLUE CROSS BLUE SHIELD

OF MICHIGAN,

Defendant.

\_\_\_\_\_ /

The 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.

JEFFERY LONGBRAKE  
August 29, 2012

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1 It's near 20% in some cases. So that's what I was  
2 referring to in terms of people in our market, so...

3 Q. Can you explain to me what you mean by payer mix?

4 A. Yeah, payer mix is the different types of payers that  
5 pay the hospital for services, Medicare being one.

6 Q. And you said Medicare makes up approximately 50% of  
7 Huron Medical Center's payer mix?

8 A. Approximately.

9 Q. And Medicaid can be anywhere from an additional 10 to  
10 20.

11 A. 8 to 10 in the general population, higher in OB, but  
12 yes, 8 to 10 is accurate.

13 MR. GOURLEY: I'll hand you what we'll mark  
14 as Exhibit 658.

15 MARKED FOR IDENTIFICATION:

16 BLUE CROSS LONGBRAKE EXHIBIT 658

17 10:40 a.m.

18 BY MR. GOURLEY:

19 Q. Mr. Longbrake, do you recognize this document?

20 A. Yes.

21 Q. And what is it?

22 A. It was provided as part of the information request.  
23 It's a description of our payer mix for fiscal year  
24 2006.

25 Q. And at least for fiscal year 2006, Medicare was 46.7%

JEFFERY LONGBRAKE  
August 29, 2012

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1 of Huron Medical Center's payer mix, correct?

2 A. That's correct.

3 Q. And Medicaid was 10.62%?

4 A. That's correct.

5 Q. Okay. Does Medicare cover the actual costs of medical  
6 services that Huron Medical Center provides?

7 A. Not typically.

8 Q. And what is the current Medicare reimbursement rate  
9 that Huron Medical Center receives?

10 A. About 48 cents on the dollar, somewhere in that  
11 neighborhood, depending on the services.

12 Q. And what is the current Medicaid reimbursement rate  
13 that Huron Medical Center receives?

14 A. Somewhere between 20 and 30 cents on the dollar,  
15 again, depending on the services.

16 Q. So is Huron Medical Center losing money on its  
17 Medicare and Medicaid patients?

18 A. In some cases.

19 Q. When you're receiving 48 cents on a dollar of Medicare  
20 and 20 --

21 A. Of charges.

22 Q. Of charges, correct. So you're not covering your  
23 costs, correct?

24 A. In some cases we don't.

25 Q. And what impact does that have on the financial

JEFFERY LONGBRAKE  
August 29, 2012

Page 50

1 condition of Huron Medical Center?

2 A. It just makes it challenging at times. I mean,  
3 typically Medicare, as you know, is settled by cost  
4 report, so you get some of those costs back, but it's  
5 out four or five years in the future in many cases.  
6 So typically we don't cover the total charge, the  
7 total cost.

8 Q. How does Huron Medical Center make up for the fact  
9 that it doesn't receive or that Medicare reimbursement  
10 doesn't cover the actual cost?

11 A. Well, we provide services to the payer mixes that are  
12 listed here. In some cases we get reimbursed better  
13 by some other payers. We try to, of course, do as  
14 much Medicare volume as we can and as much volume as  
15 we can with all payers, and also, we as one of the  
16 documents referred about operating -- operating income  
17 is one thing, but net income is the bottom line that  
18 most people look at, and that's influenced by other  
19 activities such as investment income.

20 Q. I think you mentioned one area where you were able to  
21 recoup some of that, some of the money lost to  
22 Medicare patients, is from getting greater  
23 reimbursement from other payers; is that correct?

24 A. That's correct.

25 Q. And that would be from the other commercial payers?

APPENDIX 29

## Largest Network

Our network is the largest in the state. Nearly 30,000 doctors and 158 hospitals work with Blue Cross Blue Shield of Michigan and Blue Care Network.

**Our PPO network:** As a Blue Cross Blue Shield of Michigan member, you have access to all of the hospitals and more than 95 percent of the doctors in Michigan.

**Our HMO network:** As a Blue Care Network member, you have access to more than 5,000 primary care physicians, including family doctors, internists and pediatricians. You also have access to more than 15,000 specialists and most of the state's leading hospitals.



PPO or HMO, members can use our online search to easily find:

- A doctor, hospital or health care professional
- A dentist
- A vision care professional

[FIND A DOCTOR >](#)

Our pharmacy network is also extensive. Members can use a [walk-in pharmacy](#) or conveniently mail order medications.

### Worldwide coverage

When you leave Michigan, your benefits travel with you.

Your enrollee ID card gives you access to more than 80 percent of the doctors and 90 percent of the hospitals in the United States.

The Bluecard Worldwide program gives you access to a network of over 900 hospitals in more than 130 countries when you're living or traveling abroad.

Visit the [Blue Cross Blue Shield Association website](#) to find health care professionals outside Michigan.

### Blue Distinction® Centers

[The Blue Distinction Specialty Care Program](#) is a [Blue Cross and Blue Shield Association](#) program that recognizes hospitals that meet strict quality and cost-efficiency standards.

Blue Distinction Centers are available for:

- Bariatric surgery
- Cardiac care
- Complex and rare cancers
- Knee and hip replacement
- Spine surgery
- Transplants

The program has two designations for hospitals: Blue Distinction Centers and Blue Distinction Centers+.

- Blue Distinction Centers are hospitals that meet the program's quality standards for specialty care.
- Blue Distinction Centers+ are hospitals that meet the program's quality and cost-efficiency standards for specialty care.

You can use the [Blue Distinction Center Finder](#) to look for a center near you.

*Designation as Blue Distinction Centers means these facilities' overall experience and aggregate data met objective criteria established in collaboration with expert clinicians' and leading professional organizations' recommendations. Individual outcomes may vary. To find out which services are covered under your policy at any facilities, please call the customer service number on the back of your Blue Cross Blue Shield of Michigan or Blue Care Network identification card; and call your provider before making an appointment, to verify the most current information on their network participation status. Neither the Blue Cross and Blue Shield Association nor any of its licensees, including Blue Cross Blue Shield of Michigan and Blue Care Network, are responsible for any damages, losses or noncovered charges that may result from using this website or receiving care from a provider listed on this website.*

APPENDIX 30

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



# **SECOND AMENDED AND RESTATED PARTICIPATING HOSPITAL AGREEMENT**

Revised – July 1, 2007

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

## Exhibit B

### REIMBURSEMENT

#### I. Implementation

Unless otherwise indicated, the following inpatient and outpatient reimbursement methodologies will be effective with the start of Hospital's fiscal year beginning on or after July 1, 2006.

#### II. Peer Groups

Hospitals will be categorized into one of the following peer groups:

PEER GROUP	HOSPITAL CHARACTERISTICS
1	Meet two of the following: <ul style="list-style-type: none"> <li>- 50 or more full time equivalent (FTE) interns and residents</li> <li>- 325 or more licensed beds</li> </ul>
2	Meet one of the following criteria: <ul style="list-style-type: none"> <li>- Fewer than 50 FTE interns and residents</li> <li>- 325 or more licensed beds</li> </ul>
3	Meet one of the following two groups of criteria: <ul style="list-style-type: none"> <li>- Group one - meet both criteria               <ul style="list-style-type: none"> <li>· Non-rural * hospital</li> <li>· Fewer than 325 licensed beds</li> </ul> </li> <li>- Group two - meet both criteria               <ul style="list-style-type: none"> <li>· Rural* hospital</li> <li>· More than 150 licensed beds</li> </ul> </li> </ul>
4	Meet all of the following criteria: <ul style="list-style-type: none"> <li>- Rural * hospital</li> <li>- 150 or fewer licensed beds</li> <li>- Not in Peer Group 5</li> </ul>
5	Meet all of the following criteria: <ul style="list-style-type: none"> <li>- Rural * hospital</li> <li>- 100 or fewer licensed beds</li> <li>- Total annual equivalent inpatient admissions of less than 6000**</li> <li>- Hospital is not a specialty or limited service hospital without emergency room services.</li> </ul>

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

6	Meet one of the following criteria: - Licensed as a psychiatric hospital - Received psychiatric exempt unit status from Medicare
7	Meet the following criteria: - Received rehabilitation exempt hospital or unit status from Medicare

\* United States Census Bureau definition of rural  
 \*\* Total acute care, psychiatric and rehabilitation inpatient admissions plus outpatient admissions calculated as follows: Outpatient charges / (inpatient acute care charges per inpatient acute care admissions)

### III. Model Reimbursement Methodology for Peer Group 1-4 Hospitals

#### A. Reimbursement Principles

Hospitals' inpatient and outpatient rates and the reimbursement policies that guide the development of these rates will be based on the following principles:

1. [REDACTED]
2. [REDACTED] (Exhibit B, Section III, G)
3. [REDACTED]
4. [REDACTED] (Exhibit B, Section IV).
5. Hospitals' reimbursement and cost levels will be assessed [REDACTED]

APPENDIX 31

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

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

**THE SHANE GROUP, INC., et al.,**

**Plaintiffs, on behalf of  
themselves and all others  
similarly situated,**

**v.**

**BLUE CROSS BLUE SHIELD OF  
MICHIGAN,**

**Defendant.**

**No. 2:10-cv-14360-DPH-  
MKM**

**EXPERT REPORT OF JEFFREY LEITZINGER, PH.D.  
IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION**

**Econ ONE Research, Inc.**

**October 21, 2013**

550 South Hope Street, Suite 800  
Los Angeles, California 90071

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## **I. Experience and Qualifications**

1. My name is Jeffrey J. Leitzinger. I am an economist and President of Econ One Research, Inc., an economic research and consulting firm with offices in Los Angeles, Sacramento, Houston, Washington D.C., and Philadelphia. I have masters and doctoral degrees in economics from the University of California at Los Angeles and a bachelor's degree in economics from Santa Clara University. My doctoral work concentrated on the field within economics known as industrial organization, which involves the study of markets, competition, antitrust, and other forms of regulation, among other things.
2. During the past 33 years of my professional career, industrial organization has remained the principal focus of much of my work. I have worked on numerous projects relating to antitrust economics, including analyzing issues involving market power, market definition, and the competitive effects of firm behavior. I also have frequently assessed damages resulting from alleged anticompetitive conduct and have substantial experience in the calculation of damages in Class action litigation. Additionally, I have significant experience with economic issues related to Class certification in antitrust contexts.
3. I have testified as an expert in state and federal courts, and before a number of regulatory commissions. A summary of my training, past experience, and prior testimony is set forth in Exhibit 1.
4. Econ One is being compensated for the time I spend on this matter at my normal and customary rate of \$675 per hour. Econ One also is being compensated for time spent by research staff on this project at their normal and customary rates.

## **II. Introduction, Assignment, and Materials Reviewed**

5. In 2010, the U.S. Department of Justice ("US DOJ" or "DOJ") and the State of Michigan filed a civil antitrust action against Blue Cross Blue Shield of Michigan (BCBSM) "to enjoin [BCBSM] from including 'most' favored nation' clauses ("MFNs") in its contracts with hospitals in Michigan, to enjoin the enforcement of

such clauses by BCBSM, and to remove those clauses from existing contracts.”<sup>1</sup> The DOJ complaint contended that the MFN agreements<sup>2</sup> reduced competition in the sale of health insurance throughout Michigan “by inhibiting hospitals from negotiating competitive contracts with Blue Cross’ competitors.”<sup>3</sup> 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.<sup>4</sup>

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”),<sup>5</sup> against BCBSM.<sup>6</sup> 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.

---

<sup>1</sup> *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.

<sup>2</sup> 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.

<sup>3</sup> DOJ Complaint at p. 1.

<sup>4</sup> DOJ Complaint at p. 4.

<sup>5</sup> The Class is fully defined below in ¶7.

<sup>6</sup> *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”<sup>7</sup> 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

<sup>7</sup> 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 BCBSM's 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.<sup>8</sup> Other highly populated areas include

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<sup>8</sup> 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,<sup>9</sup> Flint - northwest of Detroit,<sup>10</sup> Lansing in the south-central region,<sup>11</sup> 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.<sup>12</sup> The “Upper Peninsula” has about three percent of the population; Marquette, the largest city on the Upper Peninsula, has about 20,000 people.<sup>13</sup>

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.<sup>14</sup> The hospitals listed in Table 1 are acute care hospitals. Exhibit 3 presents descriptive

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<sup>9</sup> Grand Rapids-Wyoming, MI Metro - Kent County.

<sup>10</sup> Near Detroit Metro in Genesee County.

<sup>11</sup> Lansing-East Lansing MSA.

<sup>12</sup> 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.

<sup>13</sup> 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”).

<sup>14</sup> 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<sup>15</sup> and MFN status.

15. Michigan acute care hospitals are located in 118 cities, with anywhere from one to six per city (in Detroit).<sup>16</sup> Most (106, or 78 percent) are located in 34 urban core-based statistical areas (“CBSA”) which each have a population greater than 10,000.<sup>17</sup> 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.<sup>18</sup> 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.<sup>19</sup> In Michigan, the average charge for a hospital stay in 2011 was \$25,347; the median was \$14,985.<sup>20</sup> Given these costs, most consumers or their

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<sup>15</sup> 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.

<sup>16</sup> AHA ANNUAL SURVEY DATABASE, FY2011. Chicago: Health Forum LLC, an American Hospital Association company, 2012 (“AHA Survey Database, 2011”).

<sup>17</sup> 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/>.

<sup>18</sup> AHA Survey Database, 2011.

<sup>19</sup> 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=H4sIAAAAAAAAAAEuxSCxOLEz09TQ0TMtKSwtOSk3K CXAMSUxOTEIKSU5JScxMy0wEwjQwMEpM8rW0zDDIMMwwyjDOMMkwS0tLBABIG7aiQwAAAAD054CA17115D6AF7F43458EC7BABD4E4857C6CB6&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.

<sup>20</sup> 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.<sup>21</sup> Payment for hospital health care services therefore may involve multiple parties, including the patient, a health insurance provider and (often) the patient's employer.<sup>22</sup>

## 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.<sup>23</sup> The U.S. Census Bureau reports that about 87 percent of Michiganders with private insurance are covered by an employer-sponsored health plan.<sup>24</sup> Employers may cover all, some, or none of the

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<http://hcupnet.ahrq.gov/HCUPnet.jsp?Parms=H4sIAAAAAAAAAAEuxSCxOLEz09TQ0TMtKSwtOSk3KCXAMSUxOTEIKSU5JScxMy0wEwjQwMEpM8rW0zDDIMMwvyjDOMMkwS0tLBABIG7aiQwAAAAD054CA17115D6AF7F43458EC7BABD4E4857C6CB6&JS=Y>.

<sup>21</sup> 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=H4sIAAAAAAAAAAEuxSCxOLEz09TQ0TMtKSwtOSk3KCXAMSUxOTEIKSU5JScxMy0wEwjQwMEpM8rW0zDDIMMwvyjDOMMkwS0tLBABIG7aiQwAAAAD054CA17115D6AF7F43458EC7BABD4E4857C6CB6&JS=Y>).

<sup>22</sup> Michael A. Morrissey, "Health Insurance" Health Administration Press, Chicago, Illinois AUPHA Press, Washington, DC, 2008 ("Morrissey") 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.

<sup>23</sup> 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).

<sup>24</sup> 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.<sup>25</sup> With self insurance, the employer underwrites the cost of its employees' health care needs.<sup>26</sup> 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.<sup>27</sup>

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<sup>25</sup> 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")

<sup>26</sup> [https://www.michigan.gov/lara/0,4601,7-154-35299\\_10555\\_12902\\_35510-263297--,00.html](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.")

<sup>27</sup> 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.<sup>28</sup> 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.<sup>29</sup>
21. Health plans also vary according to the nature of the provider network available to the patient.<sup>30</sup> 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.<sup>31</sup> 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.<sup>32</sup>
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”).<sup>33</sup> The MFNs at issue in this case

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<sup>28</sup> 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.

<sup>29</sup> Dunn Deposition at 165:16-19.

<sup>30</sup> Ho (2006) at 1042.

<sup>31</sup> Glossary of Health Care Terms and Health Terms.

<sup>32</sup> 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.

<sup>33</sup> 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.<sup>34</sup>
- **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

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<sup>34</sup> 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).<sup>35</sup>

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.<sup>36</sup> It is the largest of the 38 independently-licensed members of the Blue Cross Blue Shield Association,<sup>37</sup> With \$19.3 billion in revenue in 2010<sup>38</sup> (and \$6.1 billion in premiums earned from fully-insured plans in 2011),<sup>39</sup>

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<sup>35</sup> See Health Terms.

<sup>36</sup> 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).

<sup>37</sup> 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.

<sup>38</sup> BLUECROSS-MI-99-01577870 at BLUECROSS-MI-99-01577882.

<sup>39</sup> This excludes government-sponsored plans and workers compensation.

BCBSM is also the largest health insurer in Michigan.<sup>40</sup> It has the most members and the largest network of hospitals and physicians in the state.<sup>41</sup> 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.<sup>42</sup> 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.<sup>43</sup> ASCs comprise about 47 percent of BCBSM's total enrollees. BCBSM administers health care plans for employees/retirees of Ford, Chrysler, General Motors and the State of Michigan.<sup>44</sup> BCN, a BCBSM subsidiary since 1998, offers BCBSM's HMO plans for groups and individuals and also manages some ASCs.<sup>45</sup> About 18 percent of BCBSM enrollees are in HMO plans.

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<sup>40</sup> 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.

<sup>41</sup> 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.

<sup>42</sup> BCBSM OFIR Annual Statement 2011 at p. 4.

<sup>43</sup> 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](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>.

<sup>44</sup> 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](http://www.michigan.gov/difs/0,5269,7-303-12902_35510-262303--,00.html)

<sup>45</sup> 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.<sup>46</sup> Priority predominantly sells fully-funded HMO health benefit plans to Michigan-based employers in 65 Michigan Counties in the Lower Peninsula.<sup>47</sup> Priority also sells fully- and share-funded<sup>48</sup> 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.<sup>49</sup>
29. Priority earned \$1.6 billion in premiums from fully-insured plans in 2011,<sup>50</sup> with 99 percent of premiums earned from commercial group plans and the remaining \$19 million from individuals.<sup>51</sup> 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.yourlifefecure.com/>.

<sup>46</sup> 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.

<sup>47</sup> 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](http://www.priorityhealth.com/about-us/profile/~media/Images/05_240w_content/Pages/05-priority-health-service-area-map.jpg).

<sup>48</sup> 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>

<sup>49</sup> 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.

<sup>50</sup> Excludes government-sponsored plans and workers compensation.

<sup>51</sup> 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.<sup>52</sup> 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).<sup>53</sup> 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).<sup>54</sup> CuraNet’s PPO network is available to HAP’s PPO customers through HAP Preferred and through AHL.<sup>55</sup>
31. HAP has more than 675,000 members.<sup>56</sup> 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.<sup>57</sup> HAP leases its PPO network to third party administrators through its subsidiary company, HAP Preferred Inc.<sup>58</sup> 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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<sup>52</sup> 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](http://www.michigan.gov/documents/difs/Health_Alliance_Plan_of_MI_413300_7.pdf).

<sup>53</sup> History of HAP available at <http://www.hap.org/corporate/history.php>.

<sup>54</sup> See, e.g., <http://www.curanet.org/pr.html> and [http://www.hap.org/internet/pcp/doc/pregeneratedPDF/ALL\\_03.pdf](http://www.hap.org/internet/pcp/doc/pregeneratedPDF/ALL_03.pdf)

<sup>55</sup> 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](https://www.hap.org/internet/pcp/doc/pregeneratedPDF/PY1_03.pdf)

<sup>56</sup> HAP fact sheet, available at [http://www.hap.org/docs/fact\\_sheet.pdf](http://www.hap.org/docs/fact_sheet.pdf).

<sup>57</sup> HAP Market Area available at [http://www.hap.org/healthinsurance/service\\_area.php](http://www.hap.org/healthinsurance/service_area.php).

<sup>58</sup> HAP fact sheet available at [http://www.hap.org/docs/fact\\_sheet.pdf](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<sup>59</sup>. As of 2013, Aetna is the third largest health care benefits company in the country with 22 million members worldwide.<sup>60</sup> Aetna’s medical insurance networks in the US include POSs, PPOs, HMOs, indemnity plans, and health savings accounts (“HSA”) networks.<sup>61</sup> Aetna also offers Medicare and Medicaid networks and services.<sup>62</sup>
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”).<sup>63</sup> Currently Aetna’s only plan offerings in Michigan are PPOs.<sup>64</sup> 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.<sup>65</sup> In 2012, Aetna represented 4 percent of commercial health coverage in Michigan, with 2

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<sup>59</sup> Aetna Corporate Profile, available at <http://www.aetna.com/about-aetna-insurance/aetna-corporate-profile/index.html>.

<sup>60</sup> Aetna at-A-Glance: Aetna Facts, available at <http://www.aetna.com/about-aetna-insurance/aetna-corporate-profile/facts.html>.

<sup>61</sup> 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>.

<sup>62</sup> 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>.

<sup>63</sup> “Aetna To Acquire HMS Healthcare,” Aetna Press Release, June 24, 2005, available at [http://www.aetna.com/news/2005/pr\\_20050624.htm](http://www.aetna.com/news/2005/pr_20050624.htm).

<sup>64</sup> 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.

<sup>65</sup> 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.”<sup>66</sup> 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.<sup>67</sup> Some consider a broad network vital.<sup>68</sup> Employees and individuals demand access to health care near where they live and work.<sup>69</sup>

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<sup>66</sup> Kongstvedt Essentials at p. 58.

<sup>67</sup> 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.”

<sup>68</sup> 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.)

<sup>69</sup> 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) [...].<sup>70</sup>

35. BCBSM has almost every Michigan hospital in its PPO network.<sup>71</sup> Figures 1 and 2 show the location within the state of acute care hospitals that participate in BCBSM's 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.”<sup>72</sup>
- “[N]etwork is a key component that clients evaluate when they purchase health insurance.”<sup>73</sup>
- “[T]he depth or the breadth of [a] network, the largeness of it, gives [the insurer] greater opportunity to sell business and retain business.”<sup>74</sup>
- 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.”)

<sup>70</sup> Kongstvedt at p. 93.

<sup>71</sup> 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.”).

<sup>72</sup> Whitford Deposition at 86:6-11.

<sup>73</sup> Whitford Deposition at 118:7-10.

<sup>74</sup> 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.<sup>75</sup>

- The absence of certain SE hospital systems “is a competitive disadvantage for [Priority Health] in the SE market and with statewide employer groups.”<sup>76</sup>
- Adding the three SE hospital systems would lead to “Opening the market of commercial members currently closed to [Priority Health] due to employer preferences.”<sup>77</sup>
- “[I]f you have a large employer with employees located in multiple locations, [then a large network is] considered a competitive advantage.”<sup>78</sup>
- “[I]t would be more difficult to be able to secure certain customers” [without a broad network].<sup>79</sup>
- The strength of [BCBSM’s] network (best access and discounts) and favorable brand positioning have traditionally provided competitive differentiation.<sup>80</sup>

## E. Hospital Reimbursement

36. Hospitals typically maintain price lists for the health care procedures they offer,<sup>81</sup> often referred to as a charge master.<sup>82</sup> Hospitals use charge masters to arrive at

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<sup>75</sup> Whitford Deposition, Exhibit 1587 at PH-DOJ-0005193.

<sup>76</sup> Whitford Deposition, Exhibit 1587 at PH-DOJ-0005202.

<sup>77</sup> Whitford Deposition, Exhibit 1587 at PH-DOJ-0005204.

<sup>78</sup> Connolly Deposition at 100:9-14.

<sup>79</sup> Darland Deposition Vol. II at 354:6-7.

<sup>80</sup> Dunn Deposition Exhibit 9 (BLUECROSSMI-99-01577870 at BLUECROSSMI-99-01577884).

<sup>81</sup> 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.<sup>83</sup> 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.<sup>84</sup> 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 and the amount that your provider charges that exceeds the allowed amount unless you and your provider agree otherwise.” <http://www.fairhealthconsumer.org/glossary.aspx>

<sup>82</sup> 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.

<sup>83</sup> 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](http://usatoday30.usatoday.com/news/washington/2011-05-09-uninsured-unpaid-hospital-bills_n.htm)

<sup>84</sup> 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.<sup>85</sup>

## 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.<sup>86</sup> 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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<sup>85</sup> See Health Terms.

<sup>86</sup> 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.<sup>87</sup> 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).<sup>88</sup> 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.<sup>89</sup> 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.<sup>90</sup> 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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<sup>87</sup> See, e.g., BLUECROSSMI-99-204723 at BLUECROSSMI-99-204754 and BLUECROSSMI-99-0623228.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).

<sup>88</sup> 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.

<sup>89</sup> 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.

<sup>90</sup> 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.<sup>91</sup> 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."<sup>92</sup> 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.<sup>93</sup>

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.<sup>94</sup> 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.<sup>95</sup>

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<sup>91</sup> See, e.g., CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256029.

<sup>92</sup> AGH 04 - 00049 at AGH 04 -000071.

<sup>93</sup> 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")

<sup>94</sup> See, e.g., Deposition of Steven Leach, March 15, 2012 ("Leach Deposition") at 78:24-79:4.

<sup>95</sup> 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.”<sup>96</sup> Lastly, BCBSM employed a “standard update factor” as the automatic annual percentage rate increase in the PHA.<sup>97</sup> 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.<sup>98</sup>

### **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,<sup>99</sup> 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.<sup>100</sup>

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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<sup>96</sup> 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.”)

<sup>97</sup> CIVLIT-BCBSM-00255983 at CIVLIT-BCBSM-00256024 and CIVLIT-BCBSM-00256030

<sup>98</sup> Deposition of Douglas Darland, November 14, 2012 - Volume I (“Darland Deposition Vol. I”), at 49:6-10.

<sup>99</sup> See Section VI.C.1 for further discussion of the PHA MRM as applied to PG 1-4 hospitals.

<sup>100</sup> *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,”<sup>101</sup> the value of a MFN spread (or “plus”) greater than 20 points being “up to \$7M.”<sup>102</sup> 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.<sup>103</sup>

## **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.<sup>104</sup> 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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<sup>101</sup> See Smith Deposition, DOJ Ex. 9 (AHSJP-037045 at -045).

<sup>102</sup> 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).

<sup>103</sup> 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.”).

<sup>104</sup> 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,<sup>105</sup> 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.

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<sup>105</sup> 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.<sup>106</sup> 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.<sup>107</sup> 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.<sup>108</sup> 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.<sup>109</sup> 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.<sup>110</sup> In the years following the effective

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<sup>106</sup> BLUECROSSMI-99-388498.

<sup>107</sup> 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).

<sup>108</sup> HAP-DOJ-003099.

<sup>109</sup> AGH04-000049.

<sup>110</sup> 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.<sup>111</sup> 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.<sup>112</sup> Under the new contract, the rate paid by Aetna increased to 73 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.<sup>113</sup> 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.

<sup>111</sup> PH-DOJ-0001440.

<sup>112</sup> AETNA-00072525.

<sup>113</sup> For a discussion of DID regression analysis, See, James H. Stock and Mark W. Watson, *Introduction to Econometrics* at p. 480-483. For examples of DID used by economists, See, Joel Waldfogel and Jeffrey Milyo, "The Effect of Price Advertising on Prices: Evidence in the Wake of 44 Liquormart," *American Economic*

DID analysis, one measures the impact of an event on the potentially affected parties by comparing their experience before and after the event (i.e. the “difference” in results observed following the event) with the difference in results across the same time periods for a control group that was unaffected by the event. As an overarching matter, the selection of the control group in this analysis is a means for controlling for factors that may also have changed across the time periods in question other than the event of interest.

52. By embedding the DID analysis in a linear regression model, I am able to further account for factors that may differ among participants in the control group and, at the same time, the possibility that some of the relevant characteristics may have changed over time as to the affected party compared with the control group.<sup>114</sup>
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.<sup>115</sup> 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, *See 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.

<sup>114</sup> 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.

<sup>115</sup> 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.<sup>116</sup> BCBSM has employed these PGs for purposes of developing common reimbursement policies to be applied across similarly situated hospitals.<sup>117</sup> According to the Second Amended PHA: “Peer groups will be re-established to consider additional factors to more appropriately segregate hospitals into comparative groups.”<sup>118</sup> 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.<sup>119</sup> 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.<sup>120</sup> 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.

<sup>116</sup> BLUECROSSMI-99-204723 at BLUECROSSMI-99-204754.

<sup>117</sup> *See supra*, footnote 108.

<sup>118</sup> *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.”).

<sup>119</sup> *See, e.g.*, Dranove Expert Report at 24-27 and Dranove Reply Report at 37-46.

<sup>120</sup> 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.<sup>121</sup>

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;

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<sup>121</sup> 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.<sup>122</sup> 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;<sup>123</sup> 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.<sup>124</sup>
- Counsel has provided effective dates (and, if available and relevant, termination dates)<sup>125</sup> for BCBSM MFN contracts (or LOUs) by network (i.e.,

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<sup>122</sup> See “OMB Bulletin No. 13-01: Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas,” February 28, 2013 at p. 2 (A Combined Statistical Area (CSA) “can be characterized as representing larger regions that reflect broader social and economic interactions, such as wholesaling, commodity distribution, and weekend recreation activities, and are likely to be of considerable interest to regional authorities and the private sector.” See also, p. 7.

<sup>123</sup> 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.

<sup>124</sup> 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.<sup>126</sup>

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 DID's 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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<sup>125</sup> 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.

<sup>126</sup> 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.<sup>127</sup> 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

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<sup>127</sup> CIVLIT-BCBSM-00255983 and BLUECROSSMI-99-01010153.

margin.<sup>128</sup> BCBSM provides the following illustration in the PHA of how the Model Reimbursement Methodology works for PG 1-4 hospitals:

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<sup>128</sup> 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, 4<sup>th</sup> 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**

<u>Cost Element</u>	<u>Percent</u>	
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)
<b>BCBSM Patient Service Reimbursement</b>	<b>107.1</b>	

(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 <sup>(1)</sup>	Percent <sup>(1)</sup>	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] = $\sum$ ([B] through [F])
Other Operating Revenue Offset	(3.0)	\$ (150,000)	[h]	[H] = [a3]*[h2]
<b>BCBSM Patient Service Reimbursement</b>	<b>107.1</b>	<b>\$ 5,355,000</b>	[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.<sup>129</sup> 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.<sup>130</sup> 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)

<sup>129</sup> The PHA also provides that, irrespective of the DRG-adjusted rate, the amount paid for the claim will not exceed the billed charge.

<sup>130</sup> 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.<sup>131</sup> 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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<sup>131</sup> 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](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”).<sup>132</sup> 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  $\$10,000 \times 0.85$  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

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<sup>132</sup> 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<sup>133</sup> 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,<sup>134</sup> percentage-of-charge reimbursement and flat rates.<sup>135</sup> 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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<sup>133</sup> And in the claims data produced by HAP.

<sup>134</sup> HAP uses the term “case rates.”

<sup>135</sup> 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<sup>136</sup>

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.<sup>137</sup> 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 Pointe 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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<sup>136</sup> Inpatient claims only.

<sup>137</sup> 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 18<sup>th</sup> (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.<sup>138</sup> Seven increased by 9.7 percent and two increased by 9.6 percent.<sup>139</sup> 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.<sup>140</sup> Inpatient procedures were

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<sup>138</sup> With a per diem or per modality reimbursement methodology, the insurer pays a fixed amount either per day or modality of treatment.

<sup>139</sup> 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.

<sup>140</sup> 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.<sup>141</sup> 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

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<sup>141</sup> 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.<sup>142</sup> 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.

[...]

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<sup>142</sup> 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.<sup>143</sup>

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.<sup>144</sup> 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.<sup>145</sup> Hospital reimbursement rates

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<sup>143</sup> "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](http://www.justice.gov/atr/public/press_releases/2013/295114.htm).

<sup>144</sup> 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.").

<sup>145</sup> BLUECROSSMI-99-00989332 at BLUECROSSMI-99-00989395. See also BLUECROSSMI-99-00989396

are the primary driver of insurer costs<sup>146</sup> and, therefore, an important aspect of a health insurer's value proposition.<sup>147</sup> By increasing rivals' costs, BCBSM can increase its own market power in the sale of health insurance.<sup>148</sup>

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.<sup>149</sup> 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.")

<sup>146</sup> 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).

<sup>147</sup> Dunn Deposition Exhibit 9 (BLUECROSS-99-01577870) at BLUECROSS-99-01577875.

<sup>148</sup> 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")

<sup>149</sup> 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.<sup>150</sup>

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.<sup>151</sup>

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."<sup>152</sup> Similarly, he

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<sup>150</sup> Darland Deposition Government Exhibit 6, BLUECROSSMI-99-051863.

<sup>151</sup> Darland Deposition Vol. II at 419:22-420:16.

<sup>152</sup> 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.”<sup>153</sup> 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.”<sup>154</sup>

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.<sup>155</sup> “The [...] anticompetitive effect is an unnecessary price increase to the entire market without any material change in networks or services.”<sup>156</sup>
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.<sup>157</sup> Monopoly power can be identified directly from evidence that

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<sup>153</sup> Dunn Deposition at 170:5-9.

<sup>154</sup> Dunn Deposition Exhibit 9 (BLUECROSSMI-99-01577870 at BLUECROSSMI-99-01577879).

<sup>155</sup> Dennis at p.80.

<sup>156</sup> 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.

<sup>157</sup> 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.<sup>158</sup> The centerpiece of this inferential exercise is relevant market definition.
87. In regards to this issue, it is important to focus properly on the nature of the monopoly power (including the business activity to which it relates) that is at issue here. As an economic matter, the only rational way to understand BCBSM's desire to increase its rivals' hospital costs, including agreements to increase its own costs as a means of doing so, is with regard to the potential benefits that such a strategy may produce for BCBSM in its capacity as a seller of insurance. As a buyer of hospital services, BCBSM would not rationally want to pay more for the same services or see other insurance company buyers offering more than it did. After all, from its standpoint, higher reimbursement rates simply mean higher costs to provide insurance. Under normal procompetitive circumstances, a seller of health insurance would prefer lower costs associated with the underlying services.
88. Hence, to understand why BCBSM would want to increase hospital reimbursement rates for it and its rivals, one must look further. Monopoly power effects can explain this conduct. However, the market in which limits on reimbursement rates extended to other insurers would matter to BCBSM's monopoly power is the market pertaining to its sales of health insurance. It is there, logically, that changes in reimbursement could be expected to impact the competition that BCBSM faces. From that perspective, the overcharges here are a direct component of an anticompetitive

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<sup>158</sup> 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.”<sup>159</sup> 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.<sup>160</sup>
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.<sup>161</sup> The goal in market definition is to identify “... a group of networks and a geographic area

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<sup>159</sup> 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”).

<sup>160</sup> Merger Guidelines, § 4.

<sup>161</sup> 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.”<sup>162</sup> Product interchangeability, substitutability, and cross-price elasticity are all factors that may be considered in this regard.<sup>163</sup> 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.<sup>164</sup> 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).<sup>165</sup>
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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<sup>162</sup> Merger Guidelines, § 2.0.

<sup>163</sup> “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)).

<sup>164</sup> 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)).

<sup>165</sup> 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.<sup>166</sup> Rather than a premium, the firm pays an administrative services fee.<sup>167</sup> 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.<sup>168</sup> Mr. Whitford of Priority Health testified similarly.<sup>169</sup> Documentary evidence shows that employers have been substituting self-insured for fully-insured BCBSM plans.<sup>170</sup>
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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<sup>166</sup> 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).

<sup>167</sup> 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.

<sup>168</sup> Dunn Deposition at 159-161.

<sup>169</sup> 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.”)

<sup>170</sup> 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.<sup>171</sup> 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.<sup>172</sup> 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).<sup>173</sup> BCBSM describes its “statewide presence” as a competitive strength, even for smaller employers.<sup>174</sup> 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.<sup>175</sup>

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<sup>171</sup> *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 8<sup>th</sup> Circuit in *Little Rock Cardiology Clinic, P.A. v. Baptist Health*, 591 F.3d 591, 598 (8<sup>th</sup> Cir. 209) *cirt. denied* 130 S. Ct. 3506 (2010).

<sup>172</sup> This requirement is consistent with the second part of the 8<sup>th</sup> Circuit test. (*Little Rock Cardiology Clinic*, 591 F.3d at 598).

<sup>173</sup> 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](http://www.michigan.gov/difs/0,5269,7-303-12902_35510-262303--,00.html) (last visited in October 2013).

<sup>174</sup> Dunn Deposition at 237-238.

<sup>175</sup> 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.<sup>176</sup> 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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<sup>176</sup> 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.<sup>177</sup> 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.<sup>178</sup> 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.<sup>179</sup> 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."<sup>180</sup> BCBSM's share of hospital

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<sup>177</sup> See Koziara Deposition, Exhibit 1564.

<sup>178</sup> Market Area, HAP Website, available at [http://www.hap.org/healthinsurance/service\\_area.php](http://www.hap.org/healthinsurance/service_area.php) (last visited in October 2013).

<sup>179</sup> Exhibit 4.

<sup>180</sup> Antitrust Health Care Handbook at p. 192.

reimbursements in the State of Michigan averages just under 60 percent between 2005 and 2010.<sup>181</sup> 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<sup>182</sup> (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.<sup>183</sup> 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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<sup>181</sup> 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.

<sup>182</sup> In terms of member months.

<sup>183</sup> Starc, A. "Insurer Pricing and Consumer Welfare: Evidence from Medigap." February 22, 2012 (Forthcoming, *RAND Journal of Economics*).

insurance plans purchased.<sup>184</sup> This result is consistent with research which shows that the price elasticity of demand for hospital care is very low, especially for inpatient services.<sup>185</sup>

#### 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.<sup>186</sup> 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.<sup>187</sup> This acquisition made

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<sup>184</sup> 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](http://www.rand.org/content/dam/rand/pubs/monograph_reports/2005/MR1355.pdf).

<sup>185</sup> [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).

<sup>186</sup> Rental networks are available, but they cannot cover an entirely new health plan for very long.

<sup>187</sup> 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.<sup>188</sup>

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.”<sup>189</sup>
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.<sup>190</sup>

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.""<sup>191</sup>

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

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<sup>188</sup> 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](http://blog.mlive.com/wmbr/2007/10/carechoices_acquisition_makes.html) (last visited October 2013).

<sup>189</sup> Antitrust Health Care Handbook at p. 191, citing Deborah Platt Majoras remarks at Health Care and Competition Law and Policy Workshop, September 9, 2002.

<sup>190</sup> 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.”).

<sup>191</sup> Koziara Deposition at 223:2-8.

<sup>192</sup> “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.<sup>193</sup>

### **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.<sup>194</sup> 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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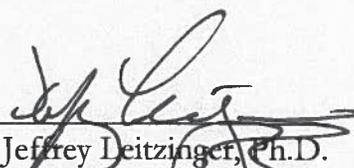
the primary quaternary facility in the UP" (BLUECROSSMI-99-04862772 at BLUECROSSMI-99-04862778). (Note: quaternary is used sometimes as an extension of the term tertiary.)

<sup>193</sup> Koziara at 219:4-24.

<sup>194</sup> Reed Abelson, *Antitrust Suit in Michigan Tests Health Law*, N.Y. TIMES, Dec. 20 2010 at 3.

CONFIDENTIAL

10/21/2013



Jeffrey Leitzinger, Ph.D.  
October 21, 2013



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**Los Angeles, California**  
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## **EDUCATION**

Ph.D., Economics, University of California, Los Angeles  
M.A., Economics, University of California, Los Angeles  
B.S., Economics, Santa Clara University

## **WORK EXPERIENCE**

*Econ One Research, Inc.*, President, July 1997 to date  
Founded *Econ One Research, Inc.*, 1997

*Micronomics, Inc.*, President and CEO, 1994-1997  
*Micronomics, Inc.*, Executive Vice President, 1988-1994  
Cofounded *Micronomics, Inc.*, 1988

*National Economic Research Associates, Inc.* 1980-1988  
(Last position was Senior Vice President and member of the Board of Directors)

*California State University, Northridge*, Lecturer, 1979-1980

## **AREAS OF EXPERTISE**

Has offered expert testimony regarding:

- Competition economics
- Commercial damages
- Econometrics and statistics
- Intellectual property
- Valuation

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## **INVITED PRESENTATIONS**

Developments in Antitrust Cases Alleging Delayed Generic Competition in the Pharmaceutical Industry, *American Antitrust Institute*, 5<sup>th</sup> 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*, 8<sup>th</sup> 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*, 20<sup>th</sup> Annual Conference of the Advanced Workshop in Regulation and Competition, May 2001.

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

Law and Economics of Predatory Pricing Under Federal and State Law, *Golden State Antitrust and Unfair Competition Law Institute*, 8<sup>th</sup> 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, 48<sup>th</sup> Annual Spring Meeting, April 2000.

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

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

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**INVITED PRESENTATIONS (cont'd.)**

Innovation in Regulation, *Center for Research in Regulated Industries*, 11<sup>th</sup> 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*, 2<sup>nd</sup> 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.

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

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### **INVITED PRESENTATIONS (cont'd.)**

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

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### **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.

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"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.

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"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.

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## **REGULATORY SUBMISSIONS**

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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.

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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.

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**REGULATORY SUBMISSIONS (cont'd.)**

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

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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.

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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.

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 October 2009 – September 2013

Proceeding	Court/Commission/Agency	Docket or File	Deposition/Trial/Hearing	Date	On Behalf Of
1. <u>Columbus Drywall &amp; Insulation, Inc., et al. v. Masco Corporation, et al.</u>	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. <u>City of San Antonio, Texas, et al. v. Hotels.com, L.P., et al.</u>	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. <u>Universal Delaware, Inc., et al., on behalf of themselves and all others similarly situated v. Comdata Corporation</u>	U.S. District Court, Eastern District of Pennsylvania	Civil Action No. 07-1078-JKG	Deposition	October 2009	Plaintiff
4. <u>Sun-Rype Products Ltd. and Wendy Weberg v. Archer Daniels Midland Company, et al.</u>	Supreme Court of British Columbia	Docket No. L051456	Deposition	February 2010	Plaintiff
5. <u>In Re: Flonase Direct Purchaser Antitrust Litigation</u>	U.S. District Court, Eastern District of Pennsylvania	Case No. 2:08-CV-03149	Deposition Deposition	March 2010 March 2012	Plaintiff
6. <u>In Re: Wellbutrin XL Antitrust Litigation</u>	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. <u>ConocoPhillips Petrozuata B.V., ConocoPhillips Hamaca B.V., ConocoPhillips Gulf of Paria B.V., and ConocoPhillips Company v. The Bolivarian Republic of Venezuela</u>	The International Centre for Settlement of Investment Disputes	Case No. ARB/07/30	Hearing	June 2010	Respondent
8. <u>Mobil Cerro Negro, Ltd. v. Petróleos de Venezuela, S.A. and PDVSA Cerro Negro S.A.</u>	The International Court of Arbitration of the International Chamber of Commerce	Case No. 15416/JRF	Hearing	September 2010	Respondent
9. <u>CNA Holdings, Inc. and Celanese Americas Corporation v. Kaye Scholer, LLP and Robert A. Bernstein</u>	U.S. District Court, Southern District of New York	No. 08 CV 5547 (NRB)	Deposition	December 2010	Counterclaim- Defendant
10. <u>Neon Enterprise Software, LLC v. International Business Machines Corporation</u>	U.S. District Court, Western District of Texas, Austin Division	No. 1:09-CV- 00896-JRN	Deposition	April 2011	Plaintiff
11. <u>State of Iowa v. Abbott Laboratories, et al. and The City of New York, et al. v. Abbott Laboratories, Inc., et al.</u>	U.S. District Court, District of Massachusetts	No. 01-CV- 12257-PBS	Deposition	May 2011	Plaintiff
12. <u>King Drug Company of Florence, Inc., et al. v. Cephalon, Inc., et al.</u>	U.S. District Court, Eastern District of Pennsylvania	No. 06-CV- 1791-MSG	Deposition	August 2011	Plaintiff

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Proceeding	Court/Commission/Agency	Docket or File	Deposition/ Trial/Hearing	Date	On Behalf Of
13. <u>Rochester Drug Co-Operative, Inc., at al. v. Braintree Laboratories</u>	U.S. District Court, District of Delaware	Case No. 07-142 (SLR)	Deposition	October 2011	Plaintiff
14. <u>In Re: Wholesale Grocery Products Antitrust Litigation</u>	U.S. District Court, District of Minnesota	Civil Action No. 09-md-02090 ADM/AJB	Deposition Hearing	December 2011 May 2012	Plaintiff
15. <u>Altana Pharma AG, and Wyeth v. Teva Pharmaceuticals USA, Inc. and Teva Pharmaceutical Industries, Ltd.</u>	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. <u>Apotex, Inc. and Apotex, Corp. v. Sanofi-Aventis, Sanofi-Synthelabo, Inc., Bristol-Myers Squibb Company and Bristol-Myers Squibb Sanofi Pharmaceuticals Holding Partnership</u>	Circuit Court, Broward County, Florida, 17 <sup>th</sup> Judicial Circuit	No. 11-001243	Deposition Trial	July 2012 March 2013	Plaintiff Plaintiff
17. <u>In Re: AndroGel Antitrust Litigation</u>	U.S. District Court, Northern District of Georgia	No. 1:09-MD-2084-TWT	Deposition	July 2012	Plaintiff
18. <u>Tyco Healthcare Group LP, and Mallinckrodt, Inc. v. Pharmaceutical Holdings Corporation, et al.</u>	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. <u>Allergan, Inc., et al. v. Athena Cosmetics, Inc., et al.</u>	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. <u>Mylan Pharmaceuticals, Inc., et al. v. Warner Chilcott Public Limited Company, et al.</u>	U.S. District Court, Eastern District of Pennsylvania	CIV No. 12-3824	Deposition	May 2013	Plaintiff
21. <u>In Re: Polyurethane Foam Antitrust Litigation</u>	U.S. District Court, Northern District of Ohio	Case No. 10-MD-2196	Deposition	July 2013	Plaintiff
22. <u>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>	U.S. District Court, Eastern District of Pennsylvania	No. 07-1078-JKG	Deposition	August 2013	Plaintiff
23. <u>Astrazeneca AB, Aktiebolaget Hässle, KBI-E Inc., KBI Inc., and Astrazeneca, LP v. Apotex Corp., Apotex Inc. and Torpharm, Inc.</u>	U.S. District Court, Southern District of New York	Civil Action No. 01-CIV-9351 (BSJ)	Deposition	August 2013	Defendant
24. <u>In re: Cathode Ray Tube (CRT) Antitrust Litigation</u>	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)  
 Velturo, 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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List of Materials Reviewed

002455 - 002465

BLUECROSSMI-99 prefix

076711  
103996 - 104020  
126613 - 126622  
139506 - 139509  
142614  
153748 - 153755  
166650  
170729 - 170732  
176762  
179584 - 179589  
194458 - 194459  
204723 - 204778  
362030 - 362074  
388498 - 388503  
390019  
396831  
403836 403839  
409543 - 409590  
637450  
848507 - 848510  
00989332 - 00989463  
01010153  
01983963 - 01983989  
02245412 - 02245426  
02279582 - 02279585  
02280185  
02984062 - 02984066  
03785568  
06233228 - 06233239

CAH prefix

000457 - 000494

CIVLIT prefix

00361349  
00270479 - 00270489

HLAP-DOJ prefix

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

NPI prefix

1023193901  
1053365924  
1083666812  
1205078920  
1427376664  
1497706964  
1538195409  
1568739423  
1578501367  
1639186521  
1750694790

PH-DOJ prefix

0001423  
0001440  
0001443  
0001447  
0001464  
0001480  
0001489  
0001638  
0001642

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List of Materials Reviewed

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□

## Exhibit 2

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List of Materials Reviewed**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**

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 doj\_2007\_2008.txt  
 doj\_2009\_2010.txt  
 doj\_2011\_2012.txt  
 doj\_membership.txt

**Priority Data**

USDOJ\_Medical\_Claims\_2005.TXT  
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 USDOJ\_Medical\_Claims\_2008.TXT  
 USDOJ\_Medical\_Claims\_2009.TXT  
 USDOJ\_Medical\_Claims\_2010.TXT  
 USDOJ\_Medical\_Claims\_2011.TXT  
 USDOJ\_Medical\_Claims\_2012.TXT

**OFIR Data**

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

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Related Cases

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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; US Able 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.

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## Exhibit 3: Michigan Acute Care Hospitals, 2011

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

## Note:

<sup>1</sup> 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.

<sup>2</sup> Total beds; HOSPBD in AHA Annual Survey Database.

<sup>3</sup> Total facility admissions; ADMTOT in AHA Annual Survey Database.

<sup>4</sup> AHA data have been adjusted to correct for partial year.

<sup>5</sup> Beds and Admissions data are from 2010.

<sup>6</sup> Beds and Admissions data are from 2009.

**Exhibit 3: Michigan Acute Care Hospitals, 2011**

Hospital (1)	System (2)	Peer Group (3)	MFN Type (4)	City (5)	City Population (6)	Core Based Statistical Area (CBSA) <sup>1</sup> (7)	CBSA Population (8)	Beds <sup>2</sup> (9)	Admissions <sup>3</sup> (10)
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<sup>7</sup> Combined with Spectrum Health United Hospital in the AHA database. These hospitals have been separated here using the relative shares in Medicare data.

<sup>8</sup> Beds and Admissions data are from 2006.

<sup>9</sup> 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. Joseph 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.

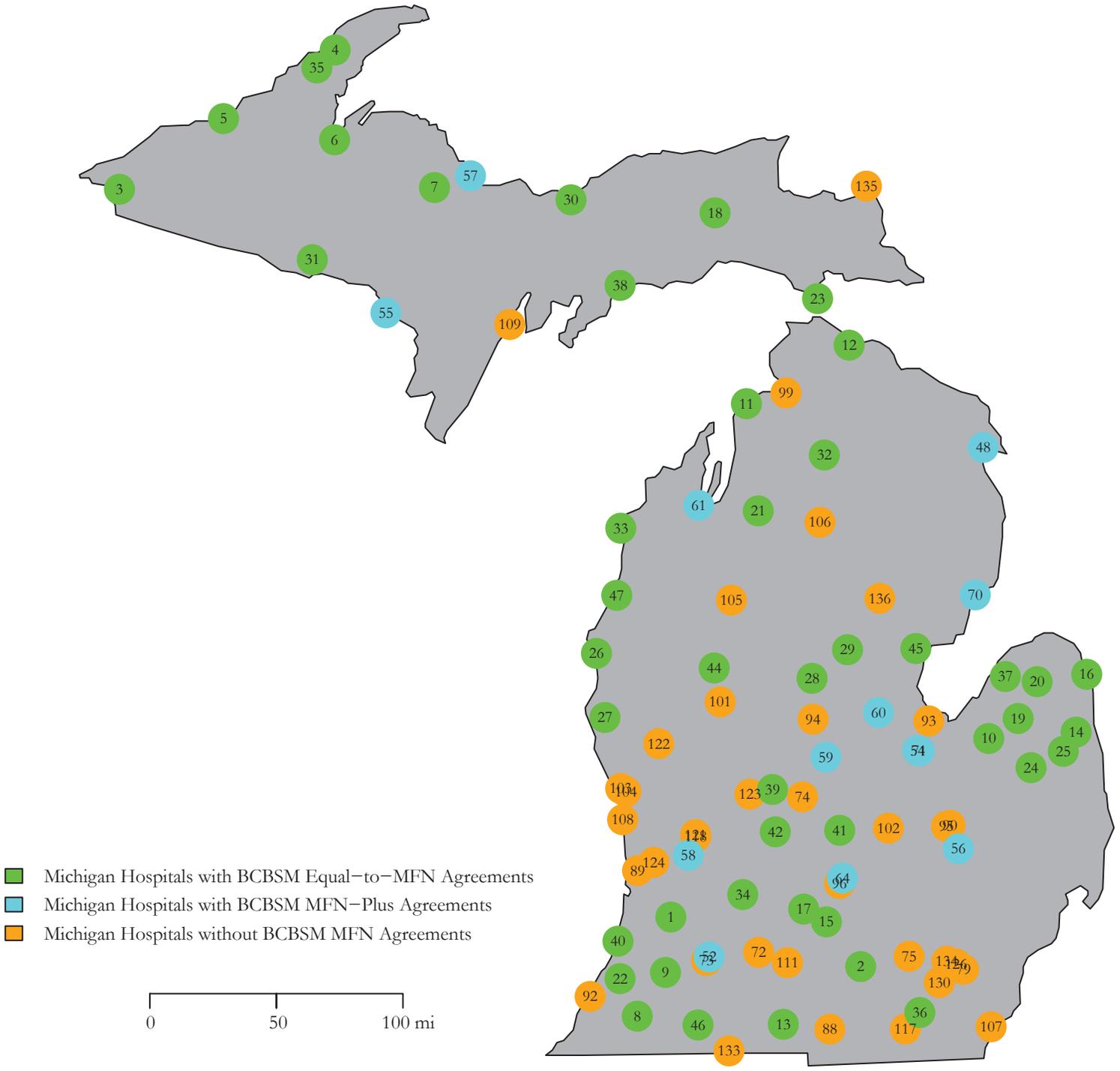
U.S. Census Bureau Population Estimates, Metropolitan and Micropolitan Statistical Areas, Annual Estimates of the Population of Metropolitan and Micropolitan Statistical Areas: April 1, 2010 to July 1, 2012 (CBSA-EST2012-01), at <http://www.census.gov/popest/data/metro/totals/2012/index.html>. Last accessed May 16, 2013.

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

	2003	2004	2005	2006	2007	2008	2009	2010	2011
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	(Percent)								
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

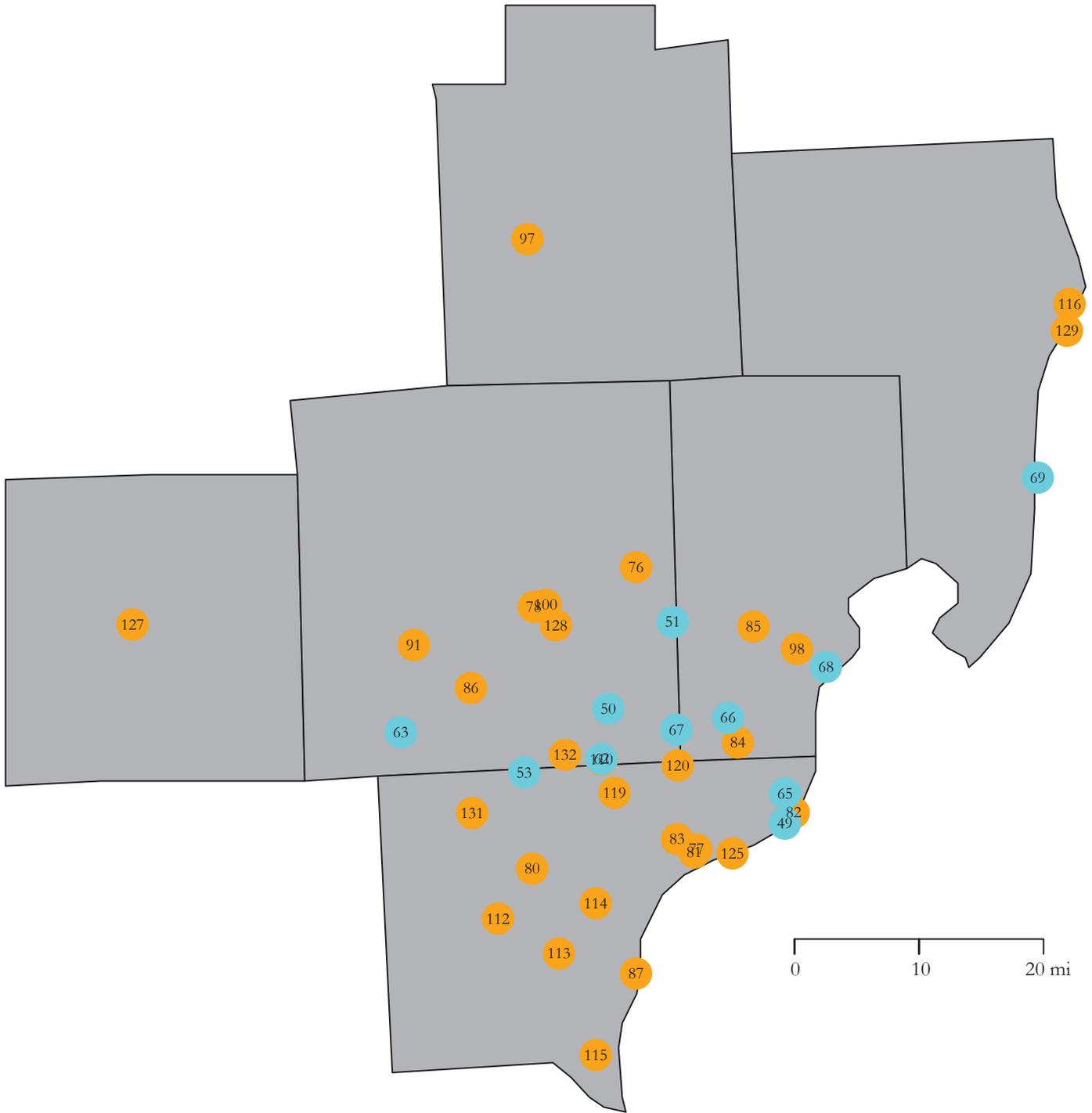
Source: Michigan Office of Financial and Insurance Regulation (OFIR).

**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

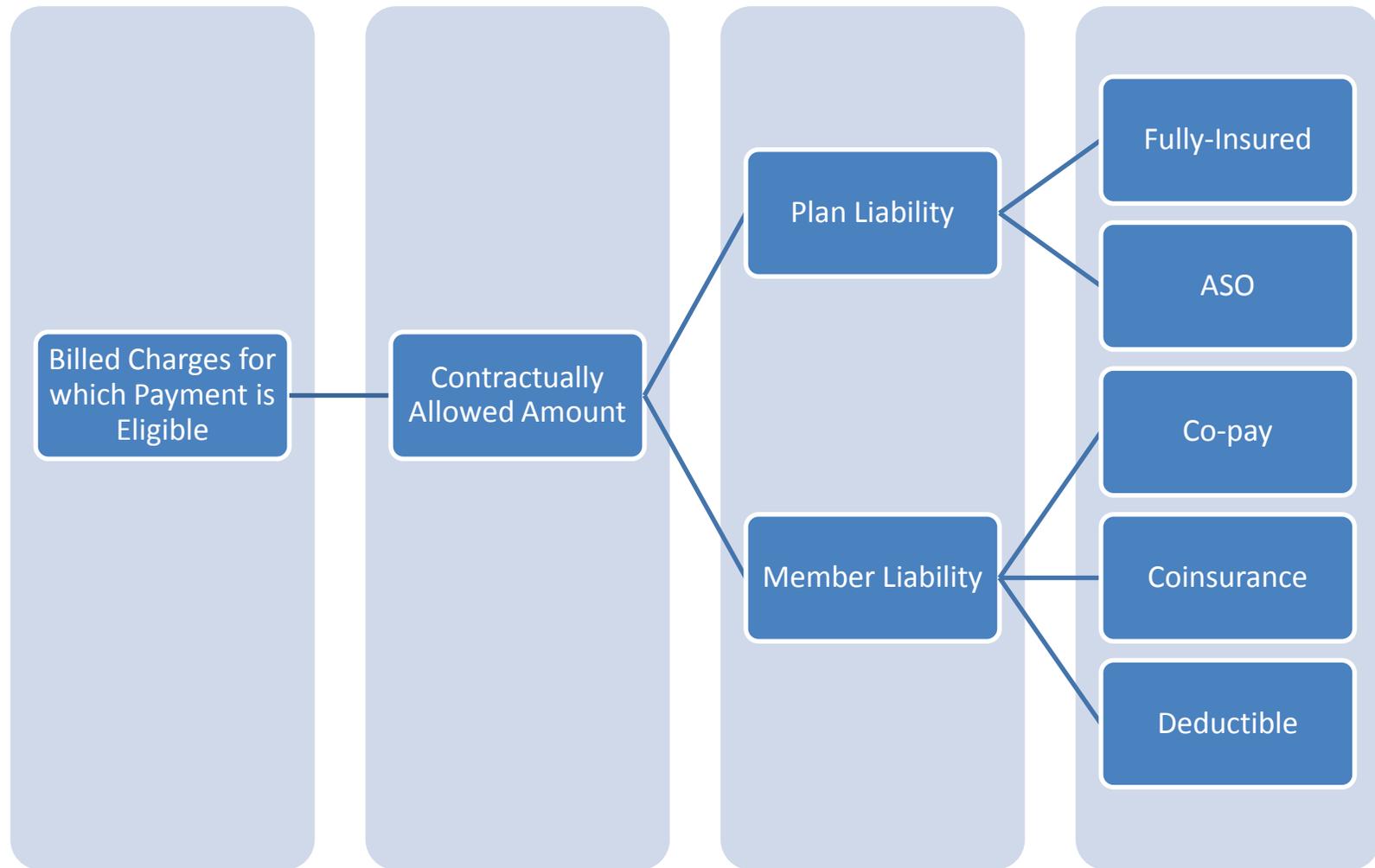
Number on Map	Hospital Name	Agreement With BCBSM
87	Henry Ford Wyandotte Hospital	NON MFN
88	Hillsdale Community Health Center	NON MFN
89	Holland Hospital	NON MFN
90	Hurley Medical Center	NON MFN
91	Huron Valley-Sinai Hospital	NON MFN
92	Lakeland Regional Medical Center-St. Joseph	NON MFN
93	McLaren 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

<b>Number on Map</b>	<b>Hospital Name</b>	<b>Agreement With BCBSM</b>
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 <sup>1</sup>		Beds <sup>2</sup>	
	Count	Share (Percent)	Count	Share (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
<b>Total</b>	<b>136</b>		<b>24,330</b>	

Note: <sup>1</sup> The following hospitals are excluded due to having no peer group information: CareLink of Jackson, Kindred Hospital-Detroit, and United Community Hospital.

<sup>2</sup> 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. Joseph 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	BCBSM Rate	Insurer Rate	Insurer Rate				
							Before	After	Before	After				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(Percent)				(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
<b>Total</b>	<b>66</b>	<b>50</b>	<b>60</b>	<b>50</b>

Source: Insurers' claims data 2004-2012.

**CORRECTED Exhibit 8: DID Results for Affected Combinations**

<u>Hospital Name</u>	<u>MFN Type</u>	<u>Insurer</u>	<u>Network</u>	<u>Hospital Peer Group</u>	<u>Control Peer Group</u>	<u>DID (MFN*Post Period)</u>
(1)	(2)	(3)	(4)	(5)	(6)	(7)
						(Percentage points)
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**

<u>Hospital Name</u>	<u>MFN Type</u>	<u>Insurer</u>	<u>Network</u>	<u>DID (MFN*Post Period)</u> <small>(Percentage points)</small>	<u>Average Reimbursement Rate After MFN</u> <small>(Percent)</small>	<u>Allowed Amount After MFN</u> <small>(Dollars)</small>	<u>Percent Overcharged</u> <small>(Percent)</small> <small>(5)/(6)</small>	<u>Overcharges</u> <small>(Dollars)</small> <small>(7)*(8)</small>
(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
<b>Total</b>						<b>\$ 994,338,324</b>		<b>\$ 118,587,576</b>

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

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

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

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

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

APPENDIX 32

**Rule 1006 Summary of MFN Differential Contract Dates, Terms and Other Information**

<b>MFN Date</b>	<b>Hospital</b>	<b>Bed Count</b>	<b>MFN Terms</b>	<b>Required differential/Year Prior Differential</b>	<b>Geography</b>
2/7/06	<b>Beaumont</b>	1,714	Guarantee differential “to the same degree” as on date of contract	Never calculated/28 <sup>1</sup>	Detroit/Warren Livonia MSA
2007	<b>None</b>	N/A	N/A	N/A	N/A
1/1/08	<b>Botsford</b>	306	No differential required; hospital “attests . . . discount provided to BCBSM . . . greater than . . . discount offered to [others]”	None/13	Detroit/Warren Livonia MSA
1/1/08	<b>Dickinson</b>	96	No differential required; hospital “attests . . . discount provided to BCBSM . . . greater than . . . discount offered to [others]”	None/52	Dickinson County on Upper Peninsula
7/1/08	<b>Ascension</b>	2,965	10 percent (not percentage points) differential required	10/20 <sup>2</sup>	Primarily Detroit/Warren Livonia MSA

<sup>1</sup> The actual amount of the differential that would have been required was never calculated by the parties in the ordinary course of business and has not been calculated by any expert in the litigation due to data limitations for parties other than Aetna and Blue Cross.

<sup>2</sup> Differential is 10 percent, not *percentage points*. Aetna rate data reported separately for different hospital in system. Year prior differential varies from 29% (Borgess) to 5% (St. Joseph Tawas).

7/1/08	<b>Marquette</b>	276	15 point differential required	15/28	Marquette
7/1/08	<b>Metro Health</b>	208	Sliding scale differential required, starting at 3.6 points in 2008	3.6/28 <sup>3</sup>	Grand Rapids MSA
7/1/08	<b>Mid-Michigan</b>	136	8 point differential required	8/23	3 hospitals in Clare, Gladwin, and Midland counties
1/1/09	<b>Beaumont</b>	1,714	10 point differential required	10/13	Detroit/Warren Livonia MSA
6/3/09 <sup>4</sup>	<b>Sparrow</b>	638	5 point differential required	5/35	Lansing
7/1/09	<b>Covenant</b>	533	15 point differential required	15/33	Saginaw
7/1/09	<b>Munson</b>	391	Blue Cross rates guaranteed "less than the next best"	Less than/33	Traverse City
1/1/10	<b>Alpena</b>	125	20 point differential required	20/28	Alpena

<sup>3</sup> Required differential is "sliding scale" starting at 3.6 and increasing to "5% for HMO, and 10% for PPO/POS" by July 1, 2011.

<sup>4</sup> Contract negotiated on this date but takes effect retroactively to 1/1/08

**Sources:**

Column 1 (“**MFN date**”) shows the effective date of the MFN Differential Contract as stated in the relevant LOU or LOA, except that the date shown for Sparrow is the date the MFN was ultimately agreed to according to paragraph 141 of Dr. Velturo’s rebuttal report.

Column 2 (**Hospital**) shows the name of the hospital.

Column 3 (“**Bed Count**”) shows the bed count as report in Dr. Velturo’s exhibit 6.

Column 4 (“**MFN Terms**”) shows the terms contained in the relevant LOU or LOA.

Column 5 (“**Required Differential/Year Prior Differential**”) shows the differential required to be maintained by the LOU, then the actual percentage point differential that existed between Aetna and Blue Cross the year prior to the MFN Differential Contract, as shown on Exhibit I to Dr. Scheffman’s report.

Column 6 (“**Geography**”) shows the relevant city, county or Metropolitan statistical area as shown in Exhibit 6 to Dr. Velturo’s report.

The LOUs summarized here are as follows:

- Alpena -- BLUECROSSMI-99-196176 at 78
- Ascension -- AHSJP-017024 at 31
- Beaumont -- BLUECROSSMI-08-004027 at 28 (2006); BLUECROSSMI-99-390466 at 470 (2009)
- Botsford -- BLUECROSSMI-08-011701
- Covenant -- BLUECROSSMI-R-00109966 at 69-70
- Dickinson – BLUECROSSMI-98-000062
- Marquette -- BLUECROSSMI-99-407870 at 73
- Metro Health BLUECROSSMI-R-00109978 at 81
- Mid Michigan -- MidMichH-DOJ-000003 at 10
- Munson -- MHC000145 at 147
- Sparrow --SHS003256 at 3264

APPENDIX 33



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1 the options, but for active commercial currently?

2 A. Okay. Currently, no, they have just one option. It's  
3 under HAP.

4 Q. Okay. And is that an HMO or PPO?

5 A. No. That's PPO.

6 Q. And have the network options changed for active  
7 commercial since 2005?

8 A. Yes.

9 Q. Let's go year by year. What are the changes? Let's  
10 start with 2005. What were the options?

11 A. In 2005, the options were the Blue Cross Community  
12 Blue PPO, the PPOM, and the HAP PPO.

13 Q. And were the deductible amounts the same under all of  
14 those options in 2005?

15 A. You know, I don't remember 2005. I can't say for  
16 sure. Let me ask you to clarify that. Are we only  
17 talking about the active commercial or each plan?

18 Q. We're still talking just about active commercial, but  
19 if there are differences -- when you say --

20 A. Okay, active commercial, yes, they were all the same.

21 Q. Okay. When you say each plan, you're distinguishing  
22 between active commercial, poured wall, millmen  
23 residential, and early retirees?

24 A. Correct, yes.

25 Q. And the deductible amounts between those four plans

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1 were different?

2 A. They could have been. That's what I'm -- I can't  
3 remember exactly if back then they were all the same.

4 Q. In order to determine that, would we have to look at  
5 the individual plan under each class; for example,  
6 we'd have to look at active commercial plan, poured  
7 wall plan, millmen plan to determine that?

8 A. Correct.

9 Q. In the same vein, to determine whether or not an  
10 individual in the active commercial in 2005 had chosen  
11 the Blue Cross PPO versus PPOM or HAP, you'd have to  
12 look at the individual choice of that employee?

13 MR. JOHNSON: Objection to the form.

14 A. Right, that would be based really on the contribution  
15 rate and then, right, absolutely, this would be the  
16 final determination.

17 BY MR. GOURLEY:

18 Q. So for active commercial in 2005, an employee could  
19 choose between Blue Cross PPO, PPOM, and HAP PPO,  
20 correct?

21 A. Correct.

22 Q. And when you said that would be based really on the  
23 contribution rate, what did you mean?

24 A. Well, whatever it was at that time. It wasn't 7.05 at  
25 the time, but the contribution rate would determine

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1 Q. And then the amount that you're, that Carpenters would  
2 reimburse the particular member would be the amount of  
3 the covered benefit, not the total amount of the  
4 charged benefit?

5 A. Correct.

6 Q. I think we've gone over some of this, but I just want  
7 to circle back, cover the bases. From 2006 to the  
8 present, which network providers did Carpenters  
9 contract with?

10 A. Okay. Starting in 2006?

11 Q. Yes.

12 A. It was the Blue Cross Blue Shield Community Blue PPO,  
13 the HAP PPO, and PPOM Cofinity PPO, and then they went  
14 down to just the Blue Cross, and then after Blue  
15 Cross, it was broken out between the Cofinity PPOM and  
16 the HAP PPO, and today they just have the HAP PPO.

17 Q. If you can, can you break down those changes by year,  
18 approximate year?

19 A. I can try. Okay. Up through October of 2008, they  
20 had the three options between the Blue Cross, HAP, and  
21 PPOM. And then from October, 2008, the commercial  
22 people, they started October, 2008. Residential and  
23 poured wall started January 1st of 2009. And they all  
24 had Blue Cross exclusively up through December 31st of  
25 2009.

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1                   So January 1st of 2010, they were given the  
2                   option to choose between the PPOM Cofinity and the HAP  
3                   PPO, and that remained in place up until it was either  
4                   February or March of 2012, and I'm going to tell you  
5                   right now, I'm not -- I'm thinking if it was 2011 or  
6                   2012. Let me think about this. The millmen came on  
7                   board -- what are we in now, 2014?

8                   I'm not going to say that for sure because  
9                   I'm not thinking right now. It was '11 or '12.

10                  MR. JOHNSON: That was a pretty good job  
11                  anyway.

12                  MR. GOURLEY: Yeah.

13                  THE WITNESS: It was close. I want to say  
14                  it was '12, but --

15 BY MR. GOURLEY:

16 Q.       When you say the millmen came on board, what do you  
17       mean?

18 A.       There was a Detroit millmen plan that merged in with  
19       the Carpenters July 1st of 2011. It was a smaller  
20       group, and they were in the poorer contribution rate.

21 Q.       So for that time period, 2006 to the present that you  
22       just kind of laid out for us, what were the reasons  
23       behind the changes in network providers?

24 A.       Okay. Starting with the changes that occurred in  
25       2008, those changes primarily came about -- there was

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1 A. From what I read in the documents, I do know those  
2 hospitals.

3 Q. And when you say "from what I read in the documents",  
4 which documents are you referring to?

5 A. I believe that was in the Complaint document.

6 Q. Other than any specific examples contained in the  
7 Complaint in this case, do you know a specific -- all  
8 hospitals that Blue Cross Blue Shield of Michigan had  
9 MFN provisions with in its contracts in Michigan?

10 MR. JOHNSON: Objection to the form.

11 A. No.

12 BY MR. GOURLEY:

13 Q. Do you know which hospitals in Michigan Blue Cross  
14 Blue Shield had MFN-plus provisions with?

15 A. No.

16 Q. Do you know whether Blue Cross Blue Shield of Michigan  
17 had MFN provisions of any kind in all of its contracts  
18 with all Michigan hospitals?

19 A. No.

20 Q. In order to determine that, we'd have to look at the  
21 individual contracts with each hospital, correct?

22 A. Correct.

23 Q. Is Carpenters interested in seeking to recover any  
24 profits that Priority might have lost as a result of  
25 MFNs?

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1 A. The Carpenters are not.

2 Q. Are the Carpenters seeking to recover any profits that  
3 United or HAP might have lost because of the MFN  
4 provisions?

5 A. The Carpenters are not seeking a profit.

6 Q. Are the Carpenters seeking to represent Priority's  
7 interests in this case in an effort to recover any  
8 profits Priority might have lost because of the MFNs?

9 A. I'm not sure of that answer.

10 Q. You might be, you might not be; you just don't know?

11 A. Right, I'm not clear.

12 MR. JOHNSON: Objection to the form.

13 BY MR. GOURLEY:

14 Q. You're just not clear?

15 A. Right.

16 Q. Do you believe that Carpenters' interest in recovery  
17 in this case would be aligned with Priority, United,  
18 HAP, or any other commercial insurer?

19 A. Yes, I think they're seeking the best interest of the  
20 insureds.

21 Q. I was asking about insurance companies, not  
22 necessarily the insureds. So do you believe that  
23 Carpenters' interest and recovery in this case is  
24 aligned with the commercial insurance companies like  
25 Priority, United, and HAP, that might also seek

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1 A. No.

2 Q. Does Carpenters know what the price of hospital  
3 services would have been for Aetna subscribers at  
4 Beaumont, St. John, and Providence in the absence of  
5 MFNs?

6 MR. JOHNSON: Same objection, calls for  
7 speculation.

8 A. No.

9 BY MR. GOURLEY:

10 Q. What about Priority subscribers?

11 A. No.

12 Q. Carpenters doesn't have knowledge of other people's  
13 alleged damages in this case, correct?

14 A. Correct.

15 Q. We'd have to look at the individual subscriber  
16 contracts for each potential insurer like Aetna, HAP,  
17 Priority, in order to determine that, correct?

18 MR. JOHNSON: Objection, calls for expert  
19 testimony and legal conclusion.

20 A. Can you restate the question, please.

21 BY MR. GOURLEY:

22 Q. Let's do it this way.

23 A. Okay.

24 Q. You can only look at the data for Carpenters members  
25 in terms of what amounts people paid for hospital

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1 healthcare services?

2 A. Correct.

3 MR. JOHNSON: Objection to the form.

4 BY MR. GOURLEY:

5 Q. You have no knowledge of what amounts subscribers in  
6 any other ERISA plan other than Carpenters would have  
7 paid?

8 MR. JOHNSON: Objection to the form.

9 A. Correct.

10 BY MR. GOURLEY:

11 Q. In determining that one of Carpenters members received  
12 a knee surgery with a certain co-pay at Beaumont would  
13 do nothing to determine whether an Aetna subscriber  
14 under a different ERISA plan also received a knee  
15 surgery with a certain deductible at Beaumont?

16 A. Correct.

17 MR. GOURLEY: This one is redacted.

18 MARKED FOR IDENTIFICATION:

19 EXHIBIT 6

20 1:19 p.m.

21 BY MR. GOURLEY:

22 Q. Ms. Janks, I'm showing you what we've marked as Blue  
23 Cross Janks Exhibit 6, which is a redacted copy of the  
24 Consolidated Amended Complaint filed in this action.  
25 Are you familiar with this document?

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1 different for any member, depending on where they  
2 sought service, what type of service, what their  
3 coverage options were, and so forth?

4 MR. JOHNSON: Objection to the form.

5 A. Well, no. There's standards as far as how the claims  
6 come in, and most of that information is required by  
7 the providers to submit with the claims. So the  
8 physician -- the facility charges and the hospital and  
9 then the physician charges, those data fields are  
10 required to be submitted. So the only thing that  
11 would differ, of course, would be the services that  
12 they had and the charges.

13 BY MR. GOURLEY:

14 Q. Right, the information to fill in the data fields?

15 A. Correct, yes.

16 Q. That's kind of what I was getting at.

17 A. Yes.

18 Q. In order to determine what service was provided, what  
19 the coverage limitations were for that service for any  
20 particular member, we would have to look member by  
21 member, claim by claim?

22 A. Correct.

23 MR. JOHNSON: Objection to the form.

24 A. Correct.

25 BY MR. GOURLEY:

APPENDIX 34

ANNE PATRICE NOAH  
January 9, 2014

1                                   IN THE UNITED STATES DISTRICT COURT  
2                                   FOR THE EASTERN DISTRICT OF MICHIGAN  
3    THE SHANE GROUP, INC., BRADLEY A.  
4    VENEBERG, MICHIGAN REGIONAL  
5    COUNCIL OF CARPENTERS EMPLOYEE  
6    BENEFITS FUND, ABATEMENT WORKERS  
7    NATIONAL HEALTH AND WELFARE FUND,  
8    MONROE PLUMBERS & PIPEFITTER  
9    LOCAL 671 WELFARE FUND, and  
10   SCOTT STEELE,  
11                                   Plaintiffs, on behalf  
12                                   of themselves and all  
13                                   others similarly  
14                                   situated,  
15                                   vs.                                   Case No. 2:10-cv-14360-DPH-MKM  
16   Hon. Denise Page Hood  
17    BLUE CROSS BLUE SHIELD OF  
18    MICHIGAN,  
19                                   Defendant.  
20    \_\_\_\_\_ /  
21                                   The Videotaped Deposition of ANNE PATRICE NOAH,  
22                                   Taken at 1901 St. Antoine, 6th Floor at Ford Field,  
23                                   Detroit, Michigan, Commencing at 9:14 a.m.,  
24                                   Thursday, January 9, 2014,  
25                                   Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

ANNE PATRICE NOAH  
January 9, 2014

1 Q. Okay. What health insurance plans does Crystal  
2 Mountain offer to its employees?

3 A. Three different Priority Health plans.

4 Q. And what are those three different Priority Health  
5 plans?

6 A. One is a catastrophic plan with a high deductible,  
7 another is a 70/30 plan, and another is an 80/20 plan.

8 Q. Can you tell me what you mean by 30/70?

9 A. It means that once I've met my deductible, I pay 30%  
10 of the costs associated with the services and Priority  
11 Health pays 70 up to a certain threshold.

12 Q. And I assume the same general concept applies to  
13 80/20?

14 A. Yes.

15 Q. So you would pay 20% after the deductible is met for  
16 that plan?

17 A. Yes.

18 Q. Okay. And which Priority Health plan do you currently  
19 have?

20 A. The 70/30.

21 Q. And have you always had the 70/30 plan since you've  
22 been employed at Crystal Mountain?

23 A. As long as they've offered it.

24 Q. And how long have they offered it?

25 A. I honestly can't recall because there have been

ANNE PATRICE NOAH  
January 9, 2014

1 several different changes in the offerings over the  
2 years.

3 Q. And there's been changes in the offerings since you've  
4 been there?

5 A. Yes.

6 Q. So have you had different coverage plans during the  
7 eight years you've been at Crystal Mountain depending  
8 on the year?

9 A. Yes, slightly different but not significantly  
10 different in terms of either cost or coverage.

11 Q. Okay. If we could, just to the best of your ability  
12 to remember, go through by year what your coverage  
13 plan was for each year, so did you start in 2005?

14 A. The very end of 2005, December 13th.

15 Q. Okay. And do you know what the benefit plan year is  
16 for your Priority coverage?

17 A. December 1st to November 30th.

18 Q. And has it always been that?

19 A. As far as I can remember, yes.

20 Q. So the December 1st to November 30th plan year is the  
21 year used to determine whether or not you met the  
22 deductible in that time period, correct?

23 A. Yes.

24 Q. So for your first year at Crystal Mountain, 2006, what  
25 health plan did you have?

ANNE PATRICE NOAH  
January 9, 2014

1 seeking as a plaintiff?

2 A. To recover costs that I paid that were higher than  
3 they should have been to receive hospital services.

4 Q. Okay. So let's break that down. First was to recover  
5 costs that you paid. With respect to those costs, can  
6 you break that down for me; is that -- are you saying  
7 you're looking for the amount of deductible payments  
8 and co-pay payments that you made?

9 A. No. I am seeking to recover any overages that I paid  
10 that were higher than they should have been otherwise  
11 without this.

12 Q. What other charges outside of deductibles and  
13 co-payments would be included in that?

14 A. Noncovered services.

15 Q. Okay. So any out-of-pocket costs for noncovered  
16 services you're also seeking as a remedy?

17 A. Yes.

18 Q. And do you know a dollar amount of noncovered services  
19 that you spent from 2006 to the present?

20 A. No, I don't.

21 Q. And how would you determine that amount?

22 A. My records with my attorneys' assistance and their  
23 expert would determine that amount.

24 Q. What records would you look at or would your attorneys  
25 look at to determine the amount of out-of-pocket costs

ANNE PATRICE NOAH  
January 9, 2014

1 for noncovered services that you spent from 2006 to  
2 the present?

3 A. They would look at payments received by the named  
4 hospitals that I sought services from, my checking  
5 account and paid receipts I have kept in my own  
6 records.

7 Q. Have you produced all checking account records and  
8 paid receipts records for payments you made for  
9 noncovered services that you're seeking to recover in  
10 this action?

11 A. I have produced as many of them as I could find. I  
12 believe that it's fairly complete.

13 Q. And for the payments that you can't find for  
14 noncovered services, how would you, how would you  
15 support the request for that, those amounts for  
16 damages?

17 A. Go to Paul Oliver Hospital's accounting office and get  
18 their record of my account and payments made.

19 Q. So for any, any payments you made, you would have to  
20 go to the service provider to get their records for  
21 what was actually paid for a particular service,  
22 correct?

23 A. If I wanted to be complete, I would get both --

24 Q. Okay.

25 A. -- and match them.

ANNE PATRICE NOAH  
January 9, 2014

1 A. Any of us who sought hospital services from those  
2 named hospitals.

3 Q. When you say "any of us", you mean individuals who  
4 received hospital services?

5 A. Yes.

6 Q. Are you seeking also to represent the interest of  
7 insurance companies like Aetna or United?

8 A. I'm seeking to represent anyone who sought hospital  
9 services and paid higher costs as a result of the MFN  
10 agreements Blue Cross Blue Shield of Michigan had with  
11 those hospitals.

12 Q. And so insurance companies like Aetna didn't seek  
13 hospital services, so I'm trying to understand if you  
14 as a class rep are trying to also represent the  
15 interest of insurance companies like, you know, like  
16 an Aetna, like a United, like a HAP?

17 A. I'm not an attorney, but I know that the request for  
18 class representation specifies who those individuals  
19 are. So I'd have to look to that class and have my  
20 attorneys tell me exactly what that definition is.

21 Q. Are you seeking to recover any profits that Priority  
22 might have lost because of use of MFNs?

23 MR. HEDLUND: Object to the form of the  
24 question, but if you understand it, you can answer.

25 A. No.

ANNE PATRICE NOAH  
January 9, 2014

1 Q. In addition to the services we've discussed already,  
2 do you also receive hospital services in a typical  
3 year?

4 A. Yes.

5 Q. And I guess to drill down on that, let's go away from  
6 general and more to specific years. So for the time  
7 period that you've been employed with Crystal  
8 Mountain, at what hospitals have you received  
9 healthcare services?

10 A. Paul Oliver Hospital and Munson Medical Center.

11 Q. Have you received healthcare services at any other  
12 hospital besides Paul Oliver and Munson Medical Center  
13 during the time you've been employed at Crystal  
14 Mountain?

15 A. Not that I can recall.

16 Q. This might get tedious.

17 A. It's okay.

18 Q. So actually, if you want to take -- I don't know if  
19 you're ready for a break?

20 A. I could use a restroom, yes.

21 MR. GOURLEY: Okay. We'll take a break.

22 THE WITNESS: Okay.

23 VIDEO TECHNICIAN: The time is now

24 10:08 a.m. We are off the record.

25 (Recess taken at 10:08 a.m.)

ANNE PATRICE NOAH  
January 9, 2014

1 A. Right.

2 BY MR. GOURLEY:

3 Q. Correct?

4 A. Yes, correct.

5 Q. And the same concept can be applied to the types of  
6 services that any individual received in a given plan  
7 year, correct, if they can differ from yours?

8 A. That's correct.

9 Q. And determining that you had a certain set of services  
10 performed in one year doesn't help to determine what  
11 services any other person might have had in that same  
12 year?

13 A. That's correct.

14 Q. And we talked a bit earlier about, I was giving you,  
15 you know, a hard time about whether you had the old  
16 checks or not, but, but, you know, looking at actual  
17 documentary evidence for the fact that you actually  
18 made a payment toward your deductible at a hospital  
19 wouldn't help to determine whether a different person  
20 actually paid a certain amount to any hospital?

21 A. That's correct.

22 Q. We also talked a little about, you know, under your  
23 plan, you know, trying to determine whether or not one  
24 service required a percentage co-pay versus a flat  
25 co-pay. Even if we were to determine that for your

ANNE PATRICE NOAH  
January 9, 2014

1 plan, we wouldn't know whether or not another person  
2 had the same percentage co-payment for the same  
3 service, correct?

4 A. Correct.

5 Q. And we wouldn't be able to determine that by looking  
6 just at your service?

7 A. That's correct.

8 MR. GOURLEY: We can go off the record for  
9 one second.

10 VIDEO TECHNICIAN: The time is now  
11 12:11 p.m. We are off the record.

12 (Off the record at 12:11 p.m.)

13 (Back on the record at 12:12 p.m.)

14 VIDEO TECHNICIAN: We are back on the  
15 record. The time is 12:12 p.m.

16 MARKED FOR IDENTIFICATION:

17 EXHIBIT 4

18 12:12 p.m.

19 BY MR. GOURLEY:

20 Q. Ms. Noah, I'm handing you what we've marked as Blue  
21 Cross Noah Exhibit 4. It will be the first in a  
22 series of exhibits of the Explanation of Benefits by  
23 year hopefully that you have produced prior to today's  
24 deposition, okay?

25 A. Yes.

APPENDIX 35

SUSAN BAYNARD  
January 13, 2014

1                                   IN THE UNITED STATES DISTRICT COURT  
2                                   FOR THE EASTERN DISTRICT OF MICHIGAN  
3   THE SHANE GROUP, INC., BRADLEY A.  
4   VENEBERG, MICHIGAN REGIONAL  
5   COUNCIL OF CARPENTERS EMPLOYEE  
6   BENEFITS FUND, ABATEMENT WORKERS  
7   NATIONAL HEALTH AND WELFARE FUND,  
8   MONROE PLUMBERS & PIPEFITTER  
9   LOCAL 671 WELFARE FUND, and  
10  SCOTT STEELE,  
11                                   Plaintiffs, on behalf  
12                                   of themselves and all  
13                                   others similarly  
14                                   situated,  
15                                   vs.                                   Case No. 2:10-cv-14360-DPH-MKM  
16   Hon. Denise Page Hood  
17  BLUE CROSS BLUE SHIELD OF  
18  MICHIGAN,  
19                                   Defendant.  
20  \_\_\_\_\_ /  
21                                   The Videotaped Deposition of SUSAN BAYNARD,  
22                                   Taken at 1901 St. Antoine, 6th Floor at Ford Field,  
23                                   Detroit, Michigan, Commencing at 9:00 a.m.,  
24                                   Monday, January 13, 2014,  
25                                   Before Lezlie A. Setchell, CSR-2404, RPR, CRR.

SUSAN BAYNARD  
January 13, 2014

1 A. I don't know.

2 Q. And in order to determine that, we would have to look  
3 at the individual benefits packages that you received  
4 from Crystal Mountain for each benefit year?

5 MR. HEDLUND: Object to the form of the  
6 question, but you can answer if you understand.

7 A. Yes.

8 BY MR. GOURLEY:

9 Q. And do you understand the term "benefit year"?

10 A. Yes.

11 Q. Okay. What does that mean to you?

12 A. It's the plan year, December 1st through  
13 November 30th.

14 Q. So Crystal Mountain's health insurance plan year runs  
15 December 1st through November 30th of each year?

16 A. Correct.

17 Q. And how long has that been the case at Crystal  
18 Mountain?

19 A. I think forever or since I've been employed there.

20 Q. Okay. Since 2006, have you had any other Priority HMO  
21 plan other than the 70/30 plan?

22 A. Yes.

23 Q. What other plans have you had?

24 A. I had the 80/20.

25 Q. And do you know which years you had the 80/20?

SUSAN BAYNARD  
January 13, 2014

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1 A. I know it was last year, the year ending  
2 November 30th, 2012 -- or 2013. And I don't recall  
3 prior to that.

4 Q. And again, in order to determine that, we would look  
5 at the records from Crystal Mountain showing which  
6 plan election you made in any given year?

7 A. Yes.

8 Q. And for all Crystal Mountain employees, to determine,  
9 you know, which plan they elected, they'd have to look  
10 at Crystal Mountain records to see whether they took  
11 the 70/30, 80/20, or the catastrophic, correct?

12 MR. HEDLUND: Object to the form of the  
13 question. You can, if you know the answer, you can go  
14 ahead.

15 A. I would think we have those records.

16 BY MR. GOURLEY:

17 Q. And if not, Priority probably would, correct?

18 A. I would think they would have those records.

19 Q. Ms. Baynard, do you have health insurance benefit  
20 packages for each plan year that explain what your  
21 coverage limitations and so forth are for that year?

22 MR. HEDLUND: Object to the form of the  
23 question, but if you understand, you can answer.

24 A. I have one for the current year.

25 BY MR. GOURLEY:

SUSAN BAYNARD  
January 13, 2014

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1 2008, correct, that was -- that we showed to you in  
2 Exhibit 1?

3 A. Exhibit 1, correct. I'm not sure it's 2008. I'm not  
4 clear on what -- it's the date of September 11th, '09.

5 Q. Sorry. I created some of the confusion that Dan tried  
6 to help me cure by not talking about benefit years,  
7 but if you look on page, the second page of Exhibit 1,  
8 in the middle where it's showing the accumulated  
9 deductible for the benefit year --

10 A. Okay, yes.

11 Q. -- it says: After this claim, accumulators for  
12 benefit year 2008.

13 A. Okay, yeah.

14 Q. Do you see that?

15 A. So they're using the start date.

16 MR. HEDLUND: Right, the December date.

17 A. Correct.

18 BY MR. GOURLEY:

19 Q. So the only documentation you've provided shows costs  
20 incurred in benefit year 2008, correct?

21 A. Correct.

22 Q. And you don't have any documentation for any other  
23 year?

24 A. No.

25 Q. From 2006 to the present using calendar years, what

SUSAN BAYNARD  
January 13, 2014

1 hospitals have you received services from?

2 A. I would think just Paul Oliver and Munson. I do not  
3 recall any other hospitals.

4 Q. To the best of your recollection, you've received  
5 services at both Paul Oliver and Munson from 2006 to  
6 the present?

7 A. Yes.

8 Q. Do you remember offhand any particular service you  
9 received at either Paul Oliver or Munson?

10 A. Most every year at Paul Oliver I have my blood test,  
11 and that's the one I can -- and I have mammograms,  
12 oops, sorry, and I have occasional bone density tests  
13 all at Paul Oliver, although I did go once to Munson,  
14 but I don't know if it was in this year, this bunch of  
15 years, for a mammogram.

16 Q. And in order to determine where you sought services in  
17 any given year and what those services are, we'd have  
18 to look at your individual claims history, correct?

19 A. Correct.

20 MARKED FOR IDENTIFICATION:

21 EXHIBIT 2

22 10:13 a.m.

23 BY MR. GOURLEY:

24 Q. Ms. Baynard, I'm showing you what we've marked as Blue  
25 Cross Baynard Exhibit 2.

SUSAN BAYNARD  
January 13, 2014

1 Q. So you're not seeking recovery of that?

2 A. No.

3 Q. And then check 4252 to Paul Oliver in the amount of  
4 15.19, do you remember what that check was for?

5 A. I do not recall. However, at the -- because of the  
6 time of year, it's after or around when I had my  
7 physical more than likely, and it's probably my  
8 percent due for some service I had related to my  
9 physical.

10 Q. In order to confirm that, we'd look at the individual  
11 claims history, correct?

12 A. Correct.

13 MARKED FOR IDENTIFICATION:

14 EXHIBIT 3

15 10:18 a.m.

16 BY MR. GOURLEY:

17 Q. Ms. Baynard, I'm showing you what we've marked as Blue  
18 Cross Baynard Exhibit 3. This is a document bearing  
19 the Bates Number 000027, and what is this document?

20 A. This is payment for Document 1's amount that I had --  
21 that I paid to Paul Oliver for the claims shown on  
22 Document 1.

23 Q. Shown on Exhibit 1?

24 A. Exhibit 1.

25 Q. Okay.

SUSAN BAYNARD  
January 13, 2014

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1 A. Yes.

2 Q. And that you had no role in crafting it, correct?

3 A. Correct.

4 Q. We've talked a bit about this case generally, and I  
5 just -- some of this might re-tread some territory,  
6 but what remedy are you seeking through this  
7 Consolidated Amended Complaint?

8 A. What remedy? Can you explain what "remedy" is?

9 Q. Sure. What do you want to get?

10 A. I would like the class to be compensated for monies  
11 that they have over-spent because of the Blue Cross  
12 Most Favored Nation agreements with hospitals in this  
13 Complaint.

14 Q. Ms. Baynard, which hospitals in Michigan are you  
15 alleging had MFNs in their contracts with Blue Cross  
16 Blue Shield of Michigan?

17 MR. HEDLUND: Objection, asked and  
18 answered, but you can answer.

19 BY MR. GOURLEY:

20 Q. Is it limited to the hospitals identified in the class  
21 certification motion?

22 A. Okay, what was the question?

23 Q. Which hospitals in Michigan are you alleging had MFNs  
24 in their contracts with Blue Cross Blue Shield of  
25 Michigan?

SUSAN BAYNARD  
January 13, 2014

1 MR. GOURLEY: If you want a continuing  
2 objection to form, we can do it that way, too.

3 MR. HEDLUND: Okay, that's fine.

4 BY MR. GOURLEY:

5 Q. And even with respect to services you receive, let's  
6 say at Paul Oliver, determining that you received a  
7 knee surgery at Paul Oliver would do nothing to  
8 determine what services anybody else received at Paul  
9 Oliver or when they received them?

10 A. Correct.

11 Q. And determining the level of deductible applicable  
12 under your health insurance plan would not aid someone  
13 in determining what another potential class member's  
14 deductible amount under their health insurance plan  
15 might be?

16 A. Correct.

17 Q. And they might have a deductible limit under an Aetna  
18 contract, a Priority contract, a HAP contract, but the  
19 fact that you have a certain deductible under the  
20 Priority contract wouldn't help determine what their  
21 level of deductible is?

22 A. Correct.

23 Q. Similarly, a determination that you met or exceeded  
24 your deductible amount in any given year wouldn't help  
25 determine whether another potential class member

SUSAN BAYNARD  
January 13, 2014

1           surpassed their deductible amount in that same year,  
2           correct?

3    A.    Correct.

4    Q.    And any determination that you made a direct payment  
5           to a particular hospital for services in any year  
6           would do nothing to determine whether another class  
7           member made a direct payment to that hospital or any  
8           other hospital for any services in the same year?

9    A.    Correct.

10   Q.    And determining that you paid for healthcare services  
11          at, let's say, Munson in any given year wouldn't help  
12          anyone in determining whether another individual paid  
13          for healthcare services at a hospital other than  
14          Munson?

15   A.    Correct.

16   Q.    And again, determining the type of services that you  
17          would have, that you received in one year, be they  
18          inpatient or outpatient services, wouldn't aid you in  
19          determining whether another potential class member  
20          received inpatient or outpatient services in the same  
21          year, correct?

22   A.    Correct.

23   Q.    And it also wouldn't aid you in determining the types  
24          of services that any other class member received in  
25          that same year, correct?

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January 13, 2014

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1 A. Correct.

2 Q. And in order to determine all of those issues for  
3 other potential class members, we would likely have to  
4 look at individual claims histories and coverage  
5 amounts and so forth for each person, correct?

6 A. I don't know how that would happen. I assume our  
7 attorneys and any experts that they might hire could  
8 do that.

9 Q. Do you think there would be any way for your attorneys  
10 or the experts in this case to determine the services  
11 and amounts, the services that someone received and  
12 the amounts someone paid in a given year other than  
13 looking at that individual person's claims histories?

14 A. I don't know methodology on that.

15 Q. Can you conceive of any way other than looking at an  
16 individual's claims history?

17 A. Maybe some kind of statistical study, some kind of  
18 analysis, but I don't know.

19 Q. Analysis of what?

20 A. Oh, I don't know. I have no idea. I don't know.

21 Q. With respect to the meeting that occurred at Crystal  
22 Mountain --

23 MR. HEDLUND: Are we, Jason, are we off  
24 that string of questions?

25 MR. GOURLEY: Yes.

APPENDIX 36

JEFFREY J. LEITZINGER, PH.D.  
December 10, 2013

1                   IN THE UNITED STATES DISTRICT COURT  
2                   FOR THE EASTERN DISTRICT OF MICHIGAN  
3   - - - - -x  
4   THE SHANE GROUP, et al.,                   :  
5                   Plaintiffs, onbehalf                   :  
6                   of themselves and all                   : Case No.  
7                   others similarly                   : 2:10-cv-14360-DPH  
8                   situated,                   : -MKM  
9                   v.                   :  
10   BLUE CROSS BLUE SHIELD OF                   :  
11   MICHIGAN,                   :  
12                   Defendant.                   :

13   - - - - -x

14

15                   CONFIDENTIAL

16

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

18                   Washington, DC

19                   Tuesday, December 10, 2013

20                   9:08 a.m.

21

22

23

24   Pages: 1 - 224

25   Reported By: Lee Bursten, RMR, CRR

JEFFREY J. LEITZINGER, PH.D.  
December 10, 2013

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1 think about it, no.

2 Q Did you analyze any conspiratorial conduct  
3 in this case?

4 A No. I don't understand the conduct that's  
5 alleged in this case to be -- to have involved a  
6 conspiracy.

7 Q And you did not analyze any, correct?

8 MR. SMALL: I'm going to object to the  
9 extent it calls for a legal conclusion.

10 A I haven't had occasion in the course of my  
11 work to go outside the allegations in this case, to  
12 somehow address or develop a conspiracy theory, no.  
13 BY MR. STENERSON:

14 Q Have you ever heard of what is known as an  
15 option demand market?

16 A No. I don't -- I don't recall having seen  
17 that, come across that expression before.

18 Q You said that you had one prior case, if I  
19 understood you correctly, where the focus was on  
20 MFNs. Do you recall saying that?

21 A Yes.

22 Q What case was that?

23 A It was a case that involved payment cards  
24 for fueling services on the part of long-distance  
25 truckers and trucking companies.

JEFFREY J. LEITZINGER, PH.D.  
December 10, 2013

1 MR. STENERSON: I'll rephrase.

2 BY MR. STENERSON:

3 Q Of the approximately 70 MFN contracts that  
4 you came to learn about in this case, how many of  
5 them have you analyzed in your report?

6 A Well, I haven't been doing the analysis of  
7 contracts per se. But the analysis of pricing and  
8 the impact in connection with MFNs in this case I  
9 think involves all told a dozen hospitals, something  
10 like that.

11 Q And how is it that you came about to focus  
12 on those dozen hospitals or so?

13 A They were the hospitals that were involved  
14 with the 23, I think it is, affected combinations  
15 that were used to define the class and were provided  
16 to me as part of the assignment for my report.

17 Q Of the hospitals that you actually  
18 analyzed, do you know how many different MFN clauses  
19 were at issue?

20 A The answer may depend on how you're  
21 defining difference, a difference, for purposes of  
22 your question. But I did understand that those 23  
23 combinations included both what had been described in  
24 this case as MFN provisions and MFN Plus provisions.

25 Q Did you understand that any of the

JEFFREY J. LEITZINGER, PH.D.  
December 10, 2013

1 clear to me that it's always been the same agreement  
2 or the same LOUs as applied to the Beaumont Grosse  
3 Pointe hospital.

4 BY MR. STENERSON:

5 Q Would it matter to your analysis whether or  
6 not Blue Cross Blue Shield of Michigan negotiated its  
7 reimbursement rates with the entire hospital system  
8 as opposed to one hospital at a time?

9 A No, not in -- not in any way I've  
10 identified.

11 Q You mentioned that you analyzed pricing in  
12 connection with the MFNs. Do you recall using that  
13 phrase?

14 A Yes.

15 Q Explain what you meant by that, please.

16 A Well, the issue that my report addresses in  
17 part is the economic evidence pertaining to whether  
18 or not the existence of a MFN provision had an impact  
19 on hospital reimbursement rates. And it's in that  
20 sense that I was referring to pricing.

21 Q You said "whether the existence of the MFN  
22 had an impact on reimbursement rates." The  
23 reimbursement rates of whom?

24 A The reimbursement rates between the  
25 healthcare insurers, Blue Cross, HAP, Priority and

JEFFREY J. LEITZINGER, PH.D.  
December 10, 2013

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1 competitive harm. The theory of competitive harm  
2 would instead get to how that conduct might -- what  
3 kind of impact it might have on competition.

4 Q We'll come back to the theory of  
5 competitive harm. Moving back slightly to the topic  
6 of geographic location of hospitals, okay, does the  
7 geographic proximity between the affected hospitals  
8 and the control group hospitals matter?

9 A Not in the -- not in the way I have done my  
10 analysis, no.

11 Q Do you think the location of the control  
12 hospitals are important?

13 A Not for the -- except, again, for the  
14 accounting I made of location in or out of the  
15 Detroit area, no, I didn't see other -- the need -- I  
16 didn't see that other locational effects were  
17 important.

18 Q Why not?

19 MR. SMALL: Objection to the form.

20 A I just -- I didn't see either facts or  
21 evidence or a need as an economic matter to make some  
22 accounting for that.

23 BY MR. STENERSON:

24 Q Who chose the control hospitals?

25 A I did.

JEFFREY J. LEITZINGER, PH.D.  
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1 Q And what methodology did you use -- well,  
2 strike that. If I understand your report correctly,  
3 it actually runs 23 separate regressions; is that  
4 right?

5 A Yes.

6 Q And are all the control group hospitals the  
7 same for each regression?

8 A No.

9 Q So the control group hospitals differ in  
10 each regression; is that right?

11 A Yes.

12 Q Was there a general methodology that was  
13 used to select the control group hospitals across the  
14 regressions?

15 A Yes.

16 Q What was it?

17 A The methodology was to use all of the  
18 hospitals that were in the same peer group as Blue  
19 Cross defines those groups that did not have MFN  
20 provisions.

21 Q So you've identified two criteria. One is  
22 the same peer group as the affected combination  
23 hospital; is that right?

24 A Yes.

25 Q The other criteria was that it had the same

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1 is tainted, it doesn't matter because it's  
2 conservative?

3 MR. SMALL: Objection to the form.

4 A I'm not saying it doesn't matter. I'm just  
5 saying, yes, it may be conservative in terms of the  
6 amount of impact it shows.

7 BY MR. STENERSON:

8 Q So whether the control group hospitals is  
9 tainted matters, but you didn't determine whether  
10 they were, correct?

11 MR. SMALL: Objection to the form.

12 A It matters potentially to the size of the  
13 impact, that is, the impact could be greater than the  
14 impact that I have found in that model. That's as  
15 far as it goes.

16 BY MR. STENERSON:

17 Q So you said that an argument exists or  
18 something of the sort. Could you describe what that  
19 argument is?

20 A The -- and I'm -- I see this laid out in  
21 the report of Dr. Vellturo. The economic notion is  
22 that as a result of the MFNs, other competing payers,  
23 his focus was on Aetna, but potentially HAP and  
24 Priority as well, did not have the -- enjoy the same  
25 success, the same competitive vigor, that they

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1 otherwise would have.

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

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

11 A That's correct.

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

16 A No.

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

23 A No.

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

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1 MR. SMALL: I'm sorry. Can you read back  
2 that question, please.

3 (Requested portion of record read.)

4 A The regression does not show whether or not  
5 any class member paid higher insurance premiums, if  
6 that's what you're asking.

7 BY MR. STENERSON:

8 Q Are there any other anticompetitive effects  
9 you can expect to see in the markets for commercial  
10 health insurance other than higher premiums?

11 MR. SMALL: Objection to the form.

12 A Well, depending on -- on context,  
13 anticompetitive effects are sometimes understood to  
14 reflect changes in the relative position of  
15 competitors.

16 And so if another -- another way in which  
17 the provisions may -- the MFN scheme may have  
18 introduced anticompetitive effects in the market for  
19 commercial health insurance would be to limit the  
20 size or even the presence of competing health  
21 insurers in the state of Michigan.

22 BY MR. STENERSON:

23 Q Does your regression, Dr. Leitzinger, show  
24 an impact on hospital prices as opposed to hospital  
25 reimbursement rates?

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1 claims data.

2 Q What's the difference between the effective  
3 rate and the contract rate?

4 MR. SMALL: Objection to the form.

5 A I think there are a couple of things that  
6 come into play in that regard. First, there may -- I  
7 would note initially there may not be a contract  
8 reimbursement rate. Contracts don't always specify a  
9 reimbursement rate.

10 However the contract operates, the result  
11 that the contract might otherwise provide and the  
12 result that appears or emerges from the analysis of  
13 the data, at least as I have done it, may be affected  
14 by timing, both in terms of the point at which the  
15 contracted terms become effective and the way that  
16 those get -- flow through into the claims data.

17 It may be affected as well by the existence  
18 of claims in the data where there is another  
19 insurance company that is paying part of the  
20 reimbursement. It may also be affected by just  
21 anomalies associated with the entry and maintenance  
22 of large scale data sets.

23 BY MR. STENERSON:

24 Q What if anything would your regression say  
25 about whether price went up at any hospital that's

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

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

5 MR. STENERSON: No.

6 BY MR. STENERSON:

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

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

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

17 A No.

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

21 A No.

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

25 A No.

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1 Q Are you giving an opinion in your report in  
2 any way that suggests that you've reached the  
3 conclusion that Priority was competitively  
4 disadvantaged in the sale of commercial insurance in  
5 Michigan?

6 A I don't -- I'm not giving that opinion in  
7 my report. I do by way of discussing the potential  
8 anticompetitive effects of the MFN cite some evidence  
9 that I saw in the course of my work that has to do --  
10 having to do with Priority's initiatives to expand  
11 into the upper peninsula and the manner in which MFNs  
12 may have adversely affected that.

13 Q Is your regression capable of answering the  
14 question of whether or not Priority was  
15 anticompetitively disadvantaged -- strike that. Is  
16 your regression capable of answering the question of  
17 whether Priority was competitively disadvantaged in  
18 Michigan vis-à-vis Blue Cross?

19 A I think my regression analysis could  
20 provide some information relevant to that question,  
21 but it -- by itself it can't ultimately answer it.

22 Q Did you reach any conclusions or opinions  
23 as to whether or not Aetna's relative competitive  
24 position was harmed in Michigan vis-à-vis Blue Cross?

25 A No, I have not.

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1 Q And same question for HAP.

2 A Same answer.

3 Q Now, as I understand your affected  
4 combinations, Doctor, HAP, Priority, and Aetna are  
5 not affected at the same hospitals in your analysis;  
6 is that correct?

7 A I think that's -- subject to check, I think  
8 that's right, yes.

9 Q Okay. And we'll spend some time with the  
10 report after lunch. But if you recall, one of the  
11 affected combinations was Priority at Allegan; do you  
12 recall that?

13 A Yes.

14 Q And what if any evidence that you found --  
15 strike that. I think in your report you call it  
16 economic evidence.

17 A (Witness nods head.)

18 Q What's your definition of "economic  
19 evidence"?

20 A I use that phrase to describe the kinds of  
21 things that economists use for purposes of analyzing  
22 market behavior and outcomes.

23 Q And did you find there is economic evidence  
24 in this case that Priority was impacted by Blue  
25 Cross's MFN at Allegan?

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1 A Yes.

2 Q And how if at all does that economic  
3 evidence relating to Priority at Allegan affect your  
4 conclusion whether or not Aetna was affected at Three  
5 Rivers Hospital?

6 A It doesn't.

7 Q And you have another combination of Aetna  
8 at Three Rivers -- or strike that, Aetna at Bronson  
9 LakeView; do you recall that?

10 A Yes.

11 Q How if at all does the economic evidence  
12 used to find impact to Priority at Charlevoix  
13 Hospital affect the ability to find impact to Aetna  
14 at Bronson LakeView?

15 A It doesn't.

16 Q And how if at all does the economic  
17 evidence for your conclusions that Priority was  
18 affected at the hospitals in your report assist you  
19 in determining whether or not for example HAP was  
20 impacted at any of the Beaumont facilities?

21 A It doesn't.

22 Q So, Dr. Leitzinger, going back to Priority,  
23 you understand that you find impact at Allegan and  
24 Charlevoix hospitals among others for Priority; is  
25 that right?

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1 A Yes.

2 Q How if at all, Doctor, does the economic  
3 evidence you found to conclude that Priority had  
4 impact at Allegan help you determine whether or not  
5 Priority had impact at Charlevoix?

6 A It doesn't, although I -- it is I guess one  
7 thing, and I'm not sure it's what you're asking or  
8 not, but there is a -- the same model that I use, the  
9 same form of the regression analysis that I use in  
10 all of these combinations. And in that sense, there  
11 is that -- that common approach to the problem  
12 assists me in the analysis of impact in all of the  
13 combinations.

14 Q Thank you for the clarification. So other  
15 than the form of the model you use, do you agree with  
16 me that each finding of impact or each combination in  
17 your report is separate and apart from the other?

18 MR. SMALL: Objection to the form.

19 A I'm not sure separate and apart. But the  
20 finding as to each combination will ultimately  
21 reflect the underlying data and the impact of the MFN  
22 scheme on that combination.

23 BY MR. STENERSON:

24 Q I'm going to get this. You say the finding  
25 as to each combination will ultimately reflect the

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1 underlying data, right? You said that?

2 A Yes.

3 Q And then the impact of the MFN scheme on  
4 that combination, right?

5 A Yes.

6 Q Okay. Is the underlying data used to  
7 determine potential impact on any affected  
8 combination the same for more than one combination?

9 A The same data sources are used across  
10 combinations and in the benchmarks, but the  
11 particulars of the data that come from those sources  
12 I think will in some respect be different in each  
13 combination.

14 Q Isn't it true, Doctor, that the underlying  
15 data in each affected combination that you used to  
16 determine MFN impact is different for each affected  
17 combination?

18 MR. SMALL: Objection, asked and answered.

19 A Some of it is. Some of it isn't.

20 BY MR. STENERSON:

21 Q What data is different?

22 A Well, data that would differ from  
23 combination to combination would be the reimbursement  
24 experience for the combination itself. The -- and as  
25 you move from combination to combination, there --

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1 there will be, although not in every case, I don't  
2 believe, at least some difference in the benchmark  
3 experience that is used for that combination,  
4 although there will be some considerable overlap as  
5 well.

6 Q For any impact -- strike that. For any  
7 affected combination of Priority's experience that  
8 you found impact, what if any data is the same for  
9 any of the affected combinations where you found  
10 impact on Aetna?

11 A To the extent that the -- there is overlap  
12 in the benchmark hospitals that are used across  
13 combinations between Priority and Aetna, there will  
14 be common data used in connection with some of the  
15 variables in the regression having to do with the  
16 inpatient/outpatient ratio, the number of beds, the  
17 expenses of the hospital, those variables.

18 Q Am I correct in understanding that the  
19 result of any -- well, strike that. Am I correct in  
20 understanding that the conclusion you reach about  
21 impact as to any affected combination does not tell  
22 you whether or not a different combination will feel  
23 impact?

24 MR. SMALL: Objection, asked and answered.

25 A Yes, I think that's correct.

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1 was in that document.

2 Q How long did you -- from the time you first  
3 received the affected combinations until the time you  
4 submitted your report, how long a period was that?

5 A I don't know sitting here.

6 Q Several months?

7 A No. Probably not that long. Perhaps  
8 something more like a month. And it may even have  
9 been that there was some changes in the list of  
10 affected combinations, even approaching the time of  
11 the report.

12 Q That was my next question. Did the  
13 affected combinations that you were pursuing an  
14 analysis of ever change during the course of your  
15 work?

16 A It's -- I don't have a specific  
17 recollection in that regard, but it may well have  
18 happened, yes.

19 Q And did you make a determination to change  
20 the affected combinations that you were analyzing?

21 A No.

22 Q Who did?

23 A That would have come from the lawyers.

24 Q And did you rely on the information from  
25 the lawyers in preparing your report?

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1           A           I did, inasmuch as that was my assignment.  
2           So yes, it determined the sort of the outlines of  
3           what I was analyzing.

4           Q           Do you recall stopping analysis on any  
5           affected combination that you started?

6           A           No.

7           Q           Did you receive the affected combinations  
8           in writing from counsel?

9           A           I'm sure we did at some point, yes.

10          Q           Did -- strike that. Do I understand that  
11          HAP insureds are part of the class that you claim to  
12          be impacted?

13          A           The affected combinations do include HAP's  
14          activities at several hospitals, yes.

15          Q           Do you know how many products HAP sold over  
16          the relevant period?

17          A           Just so I understand your question, you're  
18          talking about health insurance products?

19          Q           Commercial insurance products. You said  
20          that's the product market at issue here, right?

21          A           That is what is alleged, yes. No, I don't.

22          Q           Do you know how many different types of  
23          product design HAP has in its commercial insurance  
24          products in Michigan during the relevant time?

25                   MR. SMALL: Objection to the form.

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1 reference to them as fierce competitors, to use your  
2 language. They both serve patients in the greater  
3 Detroit area. I would imagine there is some  
4 competition between them.

5 Q Is it appropriate to use a hospital as a  
6 control group that's in the same market as the  
7 affected hospital?

8 A I don't think there's anything  
9 inappropriate about it. Certainly, if -- but at the  
10 same time, as we talked about earlier today, I didn't  
11 see the need for the control group, to limit it just  
12 to those who were in the same area.

13 Q And do you agree with me that HAP and the  
14 other payers had different volume of business at  
15 different Michigan hospitals?

16 A Yes.

17 Q Did you do anything in your DID model to  
18 adjust or account for the volume of business that a  
19 payer had at a particular control group hospital?

20 A Yes, I think one of the -- one of the other  
21 variables in the model reflected that, the level of  
22 that activity.

23 Q Which one would address that?

24 A The variable referred to at page 33 of my  
25 report as the billed amount.

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1 Q But as we established earlier -- well,  
2 strike that. You said you didn't find anything that  
3 conflicted. Did you reach the conclusion that these  
4 dates are in fact -- strike that.

5 Did you do any analysis of the financial  
6 health of any of the hospitals that are in the  
7 affected combinations you analyzed?

8 A No.

9 Q Did you do anything to control for the  
10 possibility that the hospitals in table 1, "Affected  
11 Combinations," were more likely to seek higher  
12 reimbursements than hospitals that did not have MFNs?

13 A I'm not sure even I understand what that  
14 would represent. But no, there isn't any variable in  
15 statistical analysis that would somehow account for  
16 a -- the likelihood or desire on the part of a  
17 hospital to achieve higher reimbursement.

18 Q Well, let's go to your Exhibit 9, Doctor.  
19 You've got the hospital, the MFN, the insurer, the  
20 network, and then you've got "DID MFN," asterisk,  
21 "post-period"; do you see that?

22 A Yes.

23 Q What's the number under there, the 15.8,  
24 the .9, the 2.8, what is that?

25 A That's the percentage points of

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1 whether or not damages in this case can be proven on  
2 a common basis?

3 A I have performed analysis to determine that  
4 damages can be measured in a formulaic class-wide  
5 manner, and indeed that is what Exhibit 9 is intended  
6 to show.

7 Q That aggregated damages can be shown,  
8 correct?

9 A Yes.

10 Q Does this model in any way help you  
11 determine what any individual class member was  
12 harmed -- strike that. Does the model on 9 assist  
13 you in any way to determine how much any individual  
14 class member overpaid a Michigan hospital?

15 A Well, it certainly would provide a starting  
16 point in that regard. There are other issues, I  
17 think, and other questions that one could resolve  
18 with the data if necessary in order to come to  
19 conclusions about individual amounts of overcharges.

20 Q Slightly different question. It's  
21 intentional. I want to make sure you hear the  
22 difference. Is there anything on Exhibit 9 that  
23 informs you as to whether or not any particular class  
24 member actually incurred some injury at any of the  
25 affected combinations reflected here?

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1 A It's a -- particularly the results in  
2 column 5 are a piece of the puzzle, but they do not  
3 by themselves answer that question.

4 Q And do the results in column 5 for any  
5 particular affected combination do anything to answer  
6 the question for any other affected combination?

7 MR. SMALL: Objection to the form, and  
8 asked and answered.

9 A No, not as I understand your question. No.  
10 BY MR. STENERSON:

11 Q I think this was clear, at least we  
12 understood each other, the question is whether the  
13 transcript is clear. Let me go back to the contract  
14 question about effective dates in chart 1 that begin  
15 prior to the effective date of the written MFNs,  
16 okay? Do you recall that line of questioning?

17 A Yes.

18 Q Am I correct in understanding that in order  
19 to determine whether the MFN at Allegan had effect on  
20 Priority prior to the effective date of the Blue  
21 Cross/Allegan MFN, you would have to look at the  
22 specific, among other things, negotiations between  
23 Priority and Allegan during that pre-effective  
24 period, correct?

25 A No. I don't know that you would have to

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1 look at the negotiations. For instance, it might be  
2 sufficient simply to know that there was a Priority  
3 agreement that set forth a certain reimbursement  
4 level that took effect on January 1st, 2009, and  
5 continued in that same form on the face of the  
6 agreement through 2013 or the end of the period.

7 Q So what you just identified is a type of  
8 evidence you might look at to support the inference  
9 at the Priority/Allegan combination, correct?

10 A Yes.

11 Q Would that same piece of evidence inform  
12 the answer to the same question about pre-MFN effect  
13 for Priority at the Mercy Health combination?

14 A The evidence I just described wouldn't do  
15 so, no. It might be the same kind of evidence, but  
16 it would take the form of a different agreement.

17 Q And a different inquiry, correct?

18 MR. SMALL: Objection to the form.

19 MR. STENERSON: Strike that.

20 BY MR. STENERSON:

21 Q An independent inquiry, correct?

22 MR. SMALL: Objection to the form.

23 A I'm not sure what "independent inquiry"  
24 means in that question.

25 BY MR. STENERSON:

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1 Q One is not dependent on the other.

2 MR. SMALL: Objection to the form.

3 BY MR. STENERSON:

4 Q Correct?

5 A Yes, I think that's right. I don't know  
6 any reason that the two would necessarily go  
7 together.

8 Q And you could do both inquiries and come to  
9 different answers, correct? Depending on the  
10 specific evidence that you find for that combination,  
11 right?

12 A Well, except if the dates that are shown in  
13 table 1 are the dates of the Priority agreements,  
14 then I wouldn't expect that you would come to  
15 different answers. What you will go and find is that  
16 indeed in each case there's an agreement that started  
17 and stopped at those dates.

18 Q Correct. But there's nothing about either  
19 inquiry that would require you to come to the same  
20 result or find the same type of evidence to support  
21 the inference, right?

22 A I think this is what you're asking, but I  
23 would agree that the fact of an agreement starting in  
24 January '09 and ending out in 2012 somewhere for  
25 Allegan wouldn't by itself mean there would have to

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1 be an agreement with the same dates for Mercy Health.

2 Q Right. But it's more than that. The fact  
3 of that agreement for Allegan doesn't inform whether  
4 or not there's sufficient evidence to infer early  
5 impact at Mercy Health, right?

6 A The fact of an agreement at Allegan  
7 wouldn't do that, as far as I know.

8 MR. STENERSON: Let's take a break.

9 THE VIDEOGRAPHER: We'll go off the record.  
10 The time on the monitor is 15:08.

11 (Recess.)

12 THE VIDEOGRAPHER: We'll go back on the  
13 record. The time on the monitor is 15:33.

14 BY MR. STENERSON:

15 Q Dr. Leitzinger, if you could go back to  
16 Exhibit 9 of your report, please.

17 A Yes.

18 Q Specifically, I direct your attention to  
19 the five columns or five rows at the top of Exhibit  
20 9, the Blue Cross affected combinations, okay?

21 A Yes.

22 Q And the overcharge dollars, I just did a  
23 little rough justice over here, and it seems to me  
24 the dollars in those five rows add up to  
25 approximately \$43 and a half million. Does that seem

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1 84 percent at Kalkaska where the MFN rate was only  
2 67?

3 A Well, at least for purposes of  
4 understanding the extent to which what I described a  
5 few moments ago was at work, yes, I think you would  
6 be looking at the same kind of evidence, which was  
7 simply what was the year-to-year pattern in the  
8 reimbursement rates that underlie the results in this  
9 exhibit.

10 Q I hate to be such a lawyer. Not the same  
11 type of evidence, Doctor. Would you look at the same  
12 evidence?

13 A It would not be the same numbers in each  
14 case. That's true.

15 Q It would not be the same contracts, right?

16 MR. SMALL: Objection to the form.

17 A I'm not talking about looking at contracts.  
18 But you're right, it would not be the same contracts  
19 that give rise to those reimbursement results.

20 BY MR. STENERSON:

21 Q It would not be the same data, right?

22 A It is the same data source, but it is not  
23 the same information in the data for each of the  
24 hospitals, that's correct.

25 Q And do you know what would happen to your

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1 to Beaumont?

2 MR. SMALL: Objection to the form.

3 A No, I don't hold that opinion.

4 BY MR. STENERSON:

5 Q You said it's a possibility. Is there a --  
6 well, strike that. Do you agree with me that to  
7 determine whether or not there is any benefit, it  
8 would be an affected combination by affected  
9 combination analysis?

10 MR. SMALL: Objection to the form.

11 A Just so I'm sure we're talking about the  
12 same thing, if one were looking to see whether there  
13 was a benefit in the nature or quality of care  
14 associated with increased reimbursement, it seems to  
15 me the answer to that question would necessarily  
16 involve a look at what happened at each of the  
17 affected hospitals.

18 BY MR. STENERSON:

19 Q And did you do anything in that regard?

20 A No.

21 Q Did you apply any analysis to all the MFN  
22 hospitals in this case, any analysis at all?

23 A No.

24 Q Are you reaching any opinions in your  
25 report or at this stage of the case about the effect

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1 agreement at Allegan. And part of that definition  
2 involves looking at whether a patient paid a  
3 co-payment, whether it was -- and if so, whether it  
4 was fixed, and whether -- or alternatively, whether  
5 the patient paid a deductible amount, and if so, did  
6 it pay a deductible in connection with a claim that  
7 was greater in total than the deductible.

8 BY MR. STENERSON:

9 Q And those two conditions that you just  
10 walked through, that's a determination that needs to  
11 be made for each insured, correct?

12 A It would be a determination that would be  
13 made as to each claim associated with an insured,  
14 yes.

15 Q And the answer to that inquiry for one  
16 claim does not answer the inquiry for another,  
17 correct?

18 A Certainly across different potential class  
19 members, it does not, that's correct.

20 Q Were you involved -- strike that. Did you  
21 know there were additional -- strike that. Do you  
22 know who the class reps are in this case?

23 A I'm not sure that's finally been determined  
24 yet. I think there was an original set of class  
25 members and that the plaintiffs have now proposed to

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1 one hospital at a time, right?

2 MR. SMALL: Objection, asked and answered.

3 He just answered that.

4 A At least in the method that I have  
5 employed, you would apply the regression model to  
6 each of the combinations, as I have done.

7 MR. STENERSON: Thank you for your time.

8 THE VIDEOGRAPHER: If there are no other  
9 questions --

10 MR. SMALL: I have no questions.

11 THE VIDEOGRAPHER: We'll go off the record.

12 The time is 18:13.

13 (Signature having not been waived, the  
14 videotaped deposition of JEFFREY J. LEITZINGER, Ph.D.  
15 was concluded at 6:13 p.m.)

16

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APPENDIX 37



**PAUL OLIVER  
MEMORIAL HOSPITAL**

MUNSON HEALTHCARE  
P.O. Box 1063  
Traverse City, MI 49685-1063

Walk-in 207 BEAUMONT PLACE SUITE 101 HOURS 8:00 AM - 5:00 PM  
Customer Service: TRAVERSE CITY, MI 49684 MONDAY - FRIDAY  
(231) 935-6160 OR 1-800-437-3615

00746

SUSAN J BAYNARD  
18357 TIMBERLINE DR  
THOMPSONVILLE MI 49683-9587



**Questions**



Manage your account and pay your bill online!  
Visit <http://billing.munsonhealthcare.org>

Questions about your bill? Unable to pay your bill?  
For assistance, call Patient Accounts at: (231) 935-6160 or  
(800) 437-3615 Monday through Friday 8:00 am to 5:00 pm.

*This statement represents only the hospital bill. Your personal ER physician, surgeon, pathologist, radiologist, anesthesiologist, and other specialists bill separately for their services. Please contact them directly if you have any questions concerning their bill.*

**Important Message**

Statement Date: 09/26/09

This is a statement of your account(s) with Paul Oliver Memorial Hospital. Please send payment in full for \$102.26.

The services listed on the reverse side of this page are accounts with a balance due from you as well as accounts that have been billed to your insurance company. You will continue to receive a statement until your account balance(s) are paid in full. We have indicated any balances that you are required to pay. We will notify you if the insurance claim(s) is denied or if there is no timely response.

Thank you for your prompt attention and for choosing Paul Oliver Memorial Hospital for your health care needs.

**Insurance Information**

Patients are responsible for the charges for services received. However, to assist patients in meeting their financial obligations, the hospital will bill their health insurance carrier(s) for them, as long as a valid ID card and/or information regarding insurance coverage is presented at the time of registration.

Please see back for details...



**Confidential**

Baynard000024

P1016018005

 **Priority Health**  
 Priority Health  
 1231 East Beltline NE  
 Grand Rapids, MI 49525-4501

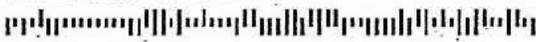
300909220107

Electronic Service Requested

If you have any questions,  
 please contact Priority Health at  
 (616) 942-1221 or (800) 446-5674  
 customer.service@priorityhealth.com



1 OF 1  
 ENV796

796 0.3584 AV 0.335 5-DIGIT 49610  
  
 SUSAN L. BAYNARD  
 18357 TIMBERLINE DR  
 THOMPSONVILLE, MI 49683-9587

Claim No.: [REDACTED]  
 Group Name: CRYSTAL MOUNTAIN WORKS  
 Group No.: [REDACTED]  
 Patient: SUSAN L. BAYNARD  
 Contract Number: [REDACTED]  
 Patient Account No: [REDACTED]  
 Date Paid: 09/20/2009

**EXPLANATION OF BENEFITS**

Dates of Service	Proc. Code	Fee Charged	Allowed Fee	Amount Not Allowed	Reason Code	Coins. Amount	Deductible Amount	Copay Amount	Other Ins.	Provider Liability	Insurance Amount	Patient Resp.
09/11/09-09/11/09	36415/0300	13.60	11.56	0.00	PDC	0.00	11.56	0.00	0.00	2.04	0.00	11.56
09/11/09-09/11/09	80053/0301	106.70	90.70	0.00	PDC	0.00	90.70	0.00	0.00	16.00	0.00	90.70
09/11/09-09/11/09	80061/0301	68.60	58.31	0.00	PDC	0.00	0.00	0.00	0.00	10.29	58.31	0.00
<b>TOTAL</b>		<b>188.90</b>	<b>160.57</b>	<b>0.00</b>		<b>0.00</b>	<b>102.26</b>	<b>0.00</b>	<b>0.00</b>	<b>28.33</b>	<b>58.31</b>	<b>102.26</b>

After this claim Accumulators for Benefit Year:2008	Met	Total	Payment To	Check No.	Amount
INDIVIDUAL DEDUCTIBLE PREFERRED/IN NETWORK	186.22	250.00	SUSAN L. BAYNARD		0.00
FAMILY DEDUCTIBLE PREFERRED/IN NETWORK	186.22	500.00	PAUL OLIVER MEMORIAL HOSPITAL	[REDACTED]	58.31
INDIVIDUAL OOP PREFERRED DOLLAR	0.00	500.00			

**Reason Cd**

**PDC** The charge has been reduced based on a discount arrangement with the provider of service

**\*\*\*** You are entitled to a review of this benefit determination if you have any questions or do not agree. Most issues can be resolved informally by our Customer Service Department at (616) 942-1221 or (800) 446-5674. You can also request a formal review of your issue. Priority Health has a two-level formal review process. To initiate the 1st level, call Customer Service and a representative will assist you in filing a formal "grievance" form. (You have two years from the date you learn of an issue to file a grievance with us.) Your grievance will be reviewed by a committee. If you disagree with the 1st level determination, you can request a 2nd level review by filing an "appeal" form. A different committee will then review your request for appeal. In most cases, a final determination will be made on your issue within 35 calendar days of the initial grievance request. At both levels, you can submit written comments, documents, and other information. You can also designate another party to represent you throughout the process. At any time, you can request access to and copies of information relevant to your claim denial. If you are not satisfied with Priority Health's final determination, you can request that the Office of Financial and Insurance Services complete a subsequent review. After exhausting both levels of Priority Health's review, you can also bring a civil court action under § 502(a) of ERISA. To obtain a complete copy of Priority Health's Grievance Procedure and Grievance Filing Form, or to find out more about your appeal rights, please contact Customer Service. You should also refer to the "Inquiry and Grievance Procedure" section of your Certificate of Coverage for further details.

**\*\*\*** THIS IS YOUR ONLY COPY. PLEASE RETAIN FOR YOUR RECORDS

**This is NOT a Bill**

Hospital Services - Summary of Charges

Guarantor Number: [REDACTED]

Page 2 of 2

Accounts With Patient Balance

ACCOUNT NO.	PATIENT NAME/DESCRIPTION	ADMIT DATE/AMT.	INSURANCE	SERVICE TYPE
[REDACTED]	SUSAN J BAYNARD	09/11/09	PRIORITY HEALTH	O/P LABORATORY
	Total Charges	188.90	PRIORITY HEALTH PC 1500	
	09/25/09 PRIORITY HEALTH PHT	86.64CR		
	Total Insurance Payment	86.64		
	Total Patient Payment	0.00		
	Account Balance	102.26		
	Patient Balance Due upon Receipt	102.26		

Accounts Pending Insurance

Your insurance payment is pending on the account(s) listed below. This could become your responsibility. Please call your insurance company for prompt payment.

ACCOUNT NO.	PATIENT NAME/DESCRIPTION	ADMIT DATE/AMT.	INSURANCE	SERVICE TYPE
[REDACTED]	SUSAN J BAYNARD	09/14/09	PRIORITY HEALTH	BRC
	Total Charges	550.20	PRIORITY HEALTH PC 1500	
	Total Insurance Payment	0.00		
	Total Patient Payment	0.00		
	Balance pending with insurance	550.20		

APPENDIX 38

74-674-724 4118

**SUSAN LAUBACH BAYNARD**  
18357 TIMBERLINE PH. 231-378-2372  
THOMPSONVILLE, MI 49683

Date 10/11/09

Pay To the Order of Paul Oliver Men Hospital \$ 102.26

One hundred two and 26/100 Dollars

Payee: \_\_\_\_\_  
Sus Baynard  
\_\_\_\_\_ 4118

4118 \$102.26  
999090002032833 TC 0

⑆42880214⑆ 19952896 4118409901

FOR DEPOSIT ONLY  
FIFTH THIRD BANK  
PAUL OLIVER MEMORIAL  
7517893744

4118 \$102.26  
999090002032833 TC 0

Confidential

**Δ π EXHIBIT 3**

Deponent Baynard

Date 1-13-14 Rptr. Jas

WWW.DEPOBOOK.COM

Baynard 000027

APPENDIX 39



TDate: 1/14/10 Page: 3 of 3  
Primary Account: [Redacted]

7487754 4245  
 SUSAN LAUBACH BAYNARD  
 18327 TIMBERLINE Pk. 231-370-2372  
 THOMPSONVILLE, MI 48663  
 Date: 10/11/10  
 To: Crystal Mountain \$100.00  
 One hundred and no/100  
 [Redacted]  
 Susan Baynard  
 4245

Ck# 4245 Date 10/15/2010 \$100.00

7487754 4246  
 SUSAN LAUBACH BAYNARD  
 18327 TIMBERLINE Pk. 231-370-2372  
 THOMPSONVILLE, MI 48663  
 Date: 10/14/10  
 To: Benjie-Leelann Heeth \$30.00  
 Thirty and no/100  
 [Redacted]  
 Susan Baynard  
 4246

Ck# 4246 Date 10/18/2010 \$30.00

7487754 4247  
 SUSAN LAUBACH BAYNARD  
 18327 TIMBERLINE Pk. 231-370-2372  
 THOMPSONVILLE, MI 48663  
 Date: 10/14/10  
 To: Crystal Mountain \$69.11  
 Sixty nine and 11/100  
 [Redacted]  
 Susan Baynard  
 4247

Ck# 4247 Date 10/16/2010 \$69.11

7487754 4249  
 SUSAN LAUBACH BAYNARD  
 18327 TIMBERLINE Pk. 231-370-2372  
 THOMPSONVILLE, MI 48663  
 Date: 10/19/10  
 To: Lucia Nainiola \$135.00  
 One hundred thirty five and no/100  
 [Redacted]  
 Susan Baynard  
 4249

Ck# 4249 Date 10/21/2010 \$135.00

7487754 4250  
 SUSAN LAUBACH BAYNARD  
 18327 TIMBERLINE Pk. 231-370-2372  
 THOMPSONVILLE, MI 48663  
 Date: 11/11/10  
 To: City Card \$91.69  
 Ninety one and 69/100  
 [Redacted]  
 Susan Baynard  
 4250

Ck# 4250 Date 11/09/2010 \$91.69

7487754 4252  
 SUSAN LAUBACH BAYNARD  
 18327 TIMBERLINE Pk. 231-370-2372  
 THOMPSONVILLE, MI 48663  
 Date: 11/11/10  
 To: Paul Oliver Memorial Hosp. \$15.19  
 Fifteen and 19/100  
 [Redacted]  
 Susan Baynard  
 4252

Ck# 4252 Date 11/05/2010 \$15.19

7487754 4253  
 SUSAN LAUBACH BAYNARD  
 18327 TIMBERLINE Pk. 231-370-2372  
 THOMPSONVILLE, MI 48663  
 Date: 11/10/10  
 To: Crystal Mountain \$100.00  
 One hundred and no/100  
 [Redacted]  
 Susan Baynard  
 4253

Ck# 4253 Date 11/10/2010 \$100.00

7487754 4254  
 SUSAN LAUBACH BAYNARD  
 18327 TIMBERLINE Pk. 231-370-2372  
 THOMPSONVILLE, MI 48663  
 Date: 11/11/10  
 To: Crystal Mountain \$204.47  
 Two hundred four and 47/100  
 [Redacted]  
 Susan Baynard  
 4254

Ck# 4254 Date 11/08/2010 \$204.47

EXHIBIT 2  
 Deponent: Baynard  
 Date: 1-13-14 Rptr: Jas  
 WWW.DEPOBOOK.COM

APPENDIX 40

MARK GROSS  
November 15, 2012

1 UNITED STATES DISTRICT COURT  
2 EASTERN DISTRICT OF MICHIGAN  
3 SOUTHERN DIVISION  
4  
5 UNITED STATES OF AMERICA, et al,  
6 Plaintiffs,  
7 vs. Case No. 2:10-cv-14155-DPH-MKM  
8  
9 BLUE CROSS BLUE SHIELD  
10 OF MICHIGAN,  
11 Defendant.

12 \_\_\_\_\_

13  
14  
15 The Confidential Videotaped Deposition of  
16 MARK GROSS,  
17 Taken at 955 South Bailey Avenue,  
18 South Haven, Michigan,  
19 Commencing at 9:07 a.m.,  
20 Thursday, November 15, 2012,  
21 Before Rebecca L. Russo, CSR-2759, RMR, CRR.

22  
23  
24  
25

MARK GROSS  
November 15, 2012

1 present, in your experience?

2 A. I can only respond to that, to the facilities that  
3 I've worked at, it has not changed.

4 Q. In your position, are you willing to accept a lower  
5 reimbursement rate from Blue Cross because they have  
6 higher volume?

7 A. In theory, yes.

8 Q. Why?

9 A. In theory, from an economic perspective, it's my  
10 opinion that if someone provides you something,  
11 whether that's patients or widgets, or wants to buy  
12 something from you, that bigger customers tend to get  
13 a better discount.

14 Q. And is that, in part, because they account for a  
15 larger percent of revenue?

16 A. Yes.

17 Q. And at South Haven, Blue Cross accounts for  
18 approximately fifteen percent of revenue, correct?

19 A. Yes.

20 Q. Is Priority the next-closest commercial payer to Blue  
21 Cross, at five percent?

22 A. Yes.

23 Q. So Blue Cross has three times its nearest -- the  
24 nearest commercial insurer in terms of volume at South  
25 Haven?

## UNPUBLISHED CASES

515 Fed.Appx. 426, 2013 WL 560635 (C.A.6 (Ohio))  
**(Not Selected for publication in the Federal Reporter)**  
**(Cite as: 515 Fed.Appx. 426, 2013 WL 560635 (C.A.6 (Ohio)))**

▶ This case was not selected for publication in the Federal Reporter.

Not for Publication in West's Federal Reporter. See Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. See also Sixth Circuit Rule 28. (Find CTA6 Rule 28)

United States Court of Appeals,  
Sixth Circuit.  
ARLINGTON VIDEO PRODUCTIONS, INC.,  
Plaintiff–Appellant,  
v.  
FIFTH THIRD BANCORP, Defendant–Appellee.  
No. 11–4077.  
Feb. 14, 2013.

**Background:** Business customer of bank brought state court action on its own behalf and on behalf of all similarly situated customers to recover for bank's breach of contract in charging unnoticed or improperly noticed fees. Cause of action was removed to federal court, and the United States District Court for the Southern District of Ohio, [James L. Graham, J., 2011 WL 3941897](#), granted bank's motion for summary judgment on breach of contract claim and declined to certify class. Appeal was taken.

**Holdings:** The Court of Appeals, [Jane B. Stranch](#), Circuit Judge, held that:

(1) genuine issues of material fact as to whether bank fulfilled its contractual obligation to disclose all fees and charges applicable to its business accounts on Fee Schedule associated with account, and whether bank provided fifteen days' advance notice to business customers of any anticipated fee alterations or amendments, precluded entry of summary judgment for bank on breach of contract claim;

(2) voluntary payment doctrine did not apply to

prevent customer from pursuing breach of contract claim;

(3) account rules and regulations did not clearly and unambiguously provide for shortening of Ohio statute of limitations applicable to customer's breach of contract claims; and

(4) district court abused its discretion in declining to certify class.

Reversed and remanded.

West Headnotes

**[1] Banks and Banking 52 ↪151**

52 Banks and Banking

52III Functions and Dealings

52III(C) Deposits

52k151 k. Depositors' passbooks and accounts. [Most Cited Cases](#)

In specifying in Rules and Regulations applicable to its business accounts that “[t]hese Rules and Regulations, as well as fees and charges contained on the Fee Schedule,” might be altered or amended in manner specified, bank reserved right to alter or amend only those fees and charges contained on Fee Schedule, and thereby accepted contractual obligation to disclose to its business customers in writing on Fee Schedule all fees and charges “associated with,” or potentially applicable to, their accounts.

**[2] Banks and Banking 52 ↪151**

52 Banks and Banking

52III Functions and Dealings

52III(C) Deposits

52k151 k. Depositors' passbooks and accounts. [Most Cited Cases](#)

In specifying in Rules and Regulations applicable to its business accounts that fee alterations and amendments “shall be binding on all Customers after having been made available in the offices of the Bank for fifteen (15) days,” bank agreed to notify its business customers of any

515 Fed.Appx. 426, 2013 WL 560635 (C.A.6 (Ohio))

(Not Selected for publication in the Federal Reporter)

(Cite as: 515 Fed.Appx. 426, 2013 WL 560635 (C.A.6 (Ohio)))

contemplated changes to fee schedule fifteen days before effective date of such changes.

### [3] Federal Civil Procedure 170A ↪2487

170A Federal Civil Procedure

170AXVII Judgment

170AXVII(C) Summary Judgment

170AXVII(C)2 Particular Cases

170Ak2487 k. Banks, cases involving.

#### Most Cited Cases

Genuine issues of material fact as to whether bank fulfilled its contractual obligation to disclose all fees and charges applicable to its business accounts on Fee Schedule associated with account, and whether bank provided fifteen days' advance notice to business customers of any anticipated fee alterations or amendments, precluded entry of summary judgment for bank on breach of contract claim arising out of its imposition of allegedly unnoticed or improperly noticed charges.

### [4] Banks and Banking 52 ↪133

52 Banks and Banking

52III Functions and Dealings

52III(C) Deposits

52k133 k. Repayment in general. [Most](#)

#### Cited Cases

### Payment 294 ↪82(3)

294 Payment

294V Recovery of Payments

294k82 Voluntary Payments in General

294k82(3) k. Character of payment in

general. [Most Cited Cases](#)

Voluntary payment doctrine did not apply to prevent customer from pursuing breach of contract claim against bank for allegedly imposing unnoticed or improperly noticed charges on customer's business account simply because bank, allegedly without disclosing to customer all the facts relating to "deposit adjustment fee" or to increase in "returned item fee," had automatically deducted those fees from customer's account, prior

to sending out bank statement that listed these fees, and prompted customer to inquire about their legitimacy.

### [5] Limitation of Actions 241 ↪14

241 Limitation of Actions

241I Statutes of Limitation

241I(A) Nature, Validity, and Construction in General

241k14 k. Agreements as to period of limitation. [Most Cited Cases](#)

Under Ohio law, while parties can agree by contract to shorten applicable statute of limitations if time limit is reasonable and contract language is clear and unambiguous, language in Rules and Regulations applicable to bank's business accounts, providing that customer agreed to carefully examine and reconcile account statements and to notify bank of any discrepancy with any item within thirty (30) days of mailing of statement, and that bank would have no liability with respect to any item for which such notice was not provided, neither mentioned nor purported to limit customer's right to pursue any "action," "lawsuit" or "demand," and did not clearly and unambiguously provide for shortening of Ohio statute of limitations applicable to customer's breach of contract claims against bank for failing to give requisite advance notice of charges imposed on customer's account.

### [6] Federal Civil Procedure 170A ↪182.5

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes Represented

170Ak182.5 k. Consumers, purchasers, borrowers, and debtors. [Most Cited Cases](#)

While proposed class, consisting of customers who had checking accounts at bank and who, during limitations period, were either charged fee for service that was not listed on bank's current Fee Schedule or that was in amount which was different from that stated current Fee Schedule, had to be

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narrowed and redefined, inter alia, to exclude customers who maintained personal checking accounts at bank or who were able to negotiate account fees with bank, district court abused its discretion in declining to certify class on ground that bank offered numerous types of accounts and fee structures, thereby preventing class from satisfying “commonality” or “typicality” requirements, and that named plaintiff, a customer with business account at bank who was allegedly charged unauthorized fees, and who was represented by competent counsel and had no interests antagonistic to class, could not adequately represent class; while different members of class may have been impacted differently, all their claims depended upon common questions of whether bank had failed to disclose initially the fees applicable to their accounts, and whether it failed to give notice to customers in accordance with its Rules & Regulations before altering or amending these fees. [Fed.Rules Civ.Proc.Rule 23, 28 U.S.C.A.](#)

\*427 On Appeal from the United States District Court for the Southern District of Ohio.

\*428 Before: [ROGERS](#) and [STRANCH](#), Circuit Judges; [PEARSON](#), District Judge.<sup>FN\*</sup>

FN\* The Honorable [Benita Y. Pearson](#), United States District Judge for the Northern District of Ohio, sitting by designation.

## OPINION

[JANE B. STRANCH](#), Circuit Judge.

\*\*1 Arlington Video Productions, Inc. (“Arlington”) filed suit against Fifth Third Bank (“the Bank”) <sup>FN1</sup> alleging individual and class claims for breach of the Bank’s contractual obligation to inform customers in advance that certain service fees would be charged to their accounts. The district court denied Arlington’s motion for class certification and subsequently granted the Bank’s motion for summary judgment

on Arlington’s individual claim. Arlington appeals both decisions. We conclude that the district court erred in granting summary judgment in favor of the Bank on Arlington’s individual claim and in denying class certification under [Federal Rules of Civil Procedure 23\(a\) & \(b\)\(3\)](#). Because it is the district court’s prerogative to define the class in accordance with this opinion and to make any refinements to the class definition that may be necessary to manage the litigation, we **REVERSE** and **REMAND** for further proceedings.

FN1. Arlington’s original Complaint incorrectly identified the defendant as Fifth Third Bancorp, a holding company. The proper defendant is Fifth Third Bank, *id.*, as specified in Arlington’s First Amended Class Action Complaint.

## I. FACTS

Arlington is an Ohio corporation that provides video services to clients. Arlington’s sole shareholder is Evan Newman, who at all times conducted Arlington’s business affairs. The Bank is an Ohio corporation conducting business in twelve states: Ohio, Kentucky, Michigan, Tennessee, Indiana, Illinois, Missouri, Pennsylvania, West Virginia, North Carolina, Georgia, and Florida.

Arlington opened a business checking account with the Bank on August 3, 2000, known as a Business 5/3 account. Newman signed a signature card that included seven paragraphs of “TERMS AND CONDITIONS,” the first two of which read:

1. The terms and conditions stated herein, together with resolutions or authorizations which accompany this signature card, if applicable, and the Rules, Regulations, Agreements, and Disclosures of Bank constitute the Deposit Agreement (“Agreement”) between the individual(s) or entity(ies) named hereon (“Depositor”) and the Bank.
2. This Agreement incorporates the Rules, Regulations, Agreements, and Disclosures

515 Fed.Appx. 426, 2013 WL 560635 (C.A.6 (Ohio))

(Not Selected for publication in the Federal Reporter)

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established by Bank from time to time, clearing house rules and regulations, state and federal laws, recognized banking practices and customs, *service charges as may be established from time to time* and is subject to laws regulating transfers at death and other taxes.

R. 83–1, Page ID 3303 (emphasis added). When Newman signed the signature card, Arlington granted the Bank a security interest in the account and agreed to allow the Bank at any time to “set off, against any balance in this account ... any debt owed to Bank by any entity listed” on the account. *Id.* ¶ 6. Arlington further agreed to all of the specified terms and conditions listed on the signature card, acknowledged receipt of a “copy of the Rules and Regulations, Agreements, and Disclosures of Bank,” and further agreed “to the terms set forth therein.” *Id.* ¶ 7.

\*429 The phrase “Rules and Regulations” referred to the Bank’s “Rules & Regulations Applicable To All Fifth Third Accounts and Cards June 1, 2000” (hereinafter “Rules & Regulations”). R. 83–1, Page ID 3304–3338. Paragraph 9 of that document provided:

**\*\*2** These Rules and Regulations, *as well as fees and charges contained on the Fee Schedule* may be altered or amended at any time by the Bank and as altered or amended shall be binding on all Customers after having been made available in the offices of the Bank for fifteen (15) days or by such other method as specifically provided by law.

*Id.*, Page ID 3307 (emphasis added). Paragraph 23 of the document specifically concerned a “returned item fee” and provided: “When a deposited item is returned unpaid and charged back to your account, the Bank reserves the right to charge a returned item fee.” *Id.*, Page ID 3310. The Rules & Regulations also included a “Fee Schedule,” which listed the fee amounts to be charged for at least twelve different bank services, but it did not include the “returned item fee”

mentioned in paragraph 23 of the Rules & Regulations, nor did it list a “deposit adjustment fee” or the amount to be charged for that fee. *Id.*, Page ID 3334. As Newman later learned, the Bank charged a “deposit adjustment fee” if a business customer tendered multiple items for deposit, but totaled the items incorrectly, requiring a bank employee to reconcile the deposit. Between August 2000, when Arlington opened its account, and December 2007, when Arlington filed this lawsuit, the Bank issued revised versions of the Rules & Regulations.

On several occasions beginning in January 2001 and continuing through early 2007, the Bank posted a non-itemized “service charge” on Arlington’s monthly account statement and deducted the amount of that charge from Arlington’s account. Upon receiving many of these statements, Newman visited the Bank to inquire about the service charge. He learned that a “service charge” is comprised of separate fees. The two most often at issue were the “deposit adjustment fee” and the “returned item fee.” Although Newman asked Bank employees to produce documentation confirming that Arlington’s business account was subject to a “deposit adjustment fee,” the Bank could not present any such writing. On most, if not all, of these occasions, Newman asked the Bank to reverse the service charges, and the Bank did so. According to Newman, the Bank reversed the service charges either because the Bank could not determine what the charges were for or the Bank could not produce any documents to confirm that the fees applied to Arlington’s account. The Bank asserts that it waived the service charges as a courtesy to its customer.

In January 2007, the Bank sent Arlington a letter asking it to choose one of three business checking accounts listed in the letter. The Bank indicated its intent to assign Arlington to one of the three accounts starting that month if Arlington did not make a choice. Arlington did not make an election, and the January 2007 statement revealed

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that the Bank had placed Arlington in a “Business Preferred Checking” account. Newman later changed the account to a “Business Advantage” account and then to a “Business Basics” account. He did not execute any new documents when these changes were made, nor did he receive any documentation relating to the changes to the account.

**\*\*3** In June 2007 the Bank revised the Rules & Regulations. The paragraph referring to fees and charges, now paragraph 8 instead of paragraph 9, provided:

**\*430** These Rules and Regulations, *as well as fees and charges contained on the Fee Schedule associated with your account(s)* may be altered or amended at any time by the Bank and as altered or amended shall be binding on all Customers after having been made available in the offices of the Bank for fifteen (15) days or by such other method as specifically provided by law.

Appellant's App'x, Vol. 1 at 130 (emphasis added). Like the 2000 version of the Rules & Regulations, the 2007 version included a paragraph explaining the “returned item fee.” *Id.* at 134, ¶ 21. The 2007 version did not include a “Fee Schedule,” but it did have a section entitled, “SPECIAL FEES THAT APPLY TO ALL CONSUMER ACCOUNTS.” *Id.* at 160–61. Listed there were approximately thirty different fees, including a charge of \$10.00 for a “Returned deposited item.” *Id.* at 161. The list did not include a “deposit adjustment fee.”

In August 2007, Arlington received a monthly account statement for July that included a non-itemized “service charge” for \$41.00. As in the past, Newman visited the Bank and asked about the service charge. The Bank provided Newman with a one-page computer printout showing that the service charge was comprised of two deposit adjustment fees of \$8.00 and two returned item fees of \$12.50 for a total service charge of \$41.00. The Bank charged Arlington \$12.50 for each “returned

item fee” even though the June 2007 Rules & Regulations in effect at that time stated that the fee was \$10.00. The Bank refused to waive the service charge and also did not produce on Newman's request a document confirming that the fees applied to Arlington's account.

Newman took other steps to try to locate written confirmation of the fees applicable to Arlington's account. He explored the Bank's website, but found nothing of help there. He visited several bank branches asking for written confirmation of the fees applicable to Arlington's account, but no documentation was provided. Newman thus believed that Arlington was entitled to rely on the Rules & Regulations as disclosing the fees that could be charged to Arlington's account.

The Bank charged Arlington another deposit adjustment fee in September 2007, which Newman also challenged. The Bank refused Newman's request to refund the fee, prompting Arlington to file suit against the Bank in December 2007.

Arlington contends that the Bank deducted fees from its account without ever providing a Fee Schedule, product brochure, or other document to verify that Arlington's account was subject to a deposit adjustment fee or to a returned item fee in excess of the amount stated for that fee in the Rules & Regulations. The only documentation the Bank produced on Newman's request was the August computer printout detailing the composition of the \$41.00 fee charged in July, after the charge had already been deducted from Arlington's account.

**\*\*4** During discovery, the Bank provided Arlington with a comprehensive list of all fees potentially applicable to Arlington's account. The Bank produced that list by culling data from a mainframe computer that is inaccessible to branch banks. Arlington asserts that the Bank's difficulty in providing the information Newman requested demonstrates that specific fee information is not readily available to business customers.

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In support of its summary judgment motion, the Bank produced a variety of evidence, including the testimony of certain bank managers. According to Greg Eiting, Manager of Retail Operations, when the Bank “decides to make a business\*431 account fee change, it sends notification of the change to each of its branches at least fifteen days prior to implementation of the fee change so that the representatives at those branches can adequately discuss the fee with the customers impacted by the change.” Appellant's App'x. Vol. 2 at 369. William Curry, Enterprise Program Manager, averred that the Bank “always provides information regarding fee changes for business accounts to its financial center branches at least fifteen days prior to that change becoming effective.” R. 82–2, Curry Second Decl. ¶¶ 6–7. Further, the Bank “updates its branches on a weekly basis regarding new applicable fees, changes in fee amounts, effective dates of fee changes, and other information concerning changes to business account fees.” *Id.* Documents supporting these general statements are notably absent from the summary judgment record.

Curry further stated that the “nature and amount of the deposit adjustment fee of \$6.00 was made available in the offices of [the Bank] for at least fifteen days before [the Bank] charged Arlington Video that fee,” and the Bank increased the amount of that fee from \$6.00 to \$8.00 in January 2006. “Information regarding this change in the amount of the deposit adjustment fee was made available in the offices of [the Bank] for at least fifteen days before [the Bank] charged Arlington Video the deposit adjustment fee of \$8.00.” *Id.* ¶ 8. Curry attested that the returned item fee changed from \$10.00 to \$12.50 in January 2006, FN2 and that “[i]nformation regarding this change ... was made available” in the Bank's offices “for at least fifteen days” before the Bank charged the \$12.50 fee to Arlington. *Id.* ¶ 11.

FN2. Curry did not explain why the June 2007 Rules & Regulations listed a returned item fee of \$10.00.

Additionally, the Bank produced testimony that it tailors the notice it gives to customers based on the specific changes being implemented and that its customers are notified of fee changes by various means, including statement inserts, letters, product brochures, signs posted in branch banks, the customer call center, and the internet. According to the Bank, Arlington never utilized the Bank's commercial call center. Further, the Bank's testimony noted that determining which service fees apply to a customer is primarily dependent on the products and services used by that customer and is unique for each customer. A business customer can determine in advance the fees that may be applicable by maintaining a Treasury Management account and negotiating the applicable fees with the Bank.

\*\*5 Newman testified that the Bank did not accurately list the fees applicable to Arlington's account on any Fee Schedule or in any product brochures; that Arlington did not receive any form of written notice about the fees or amendments to fees applicable to its account other than what was stated in the Rules & Regulations; that every time a service charge was deducted from Arlington's account he was required to visit the Bank to inquire what the charge was for; and that the Bank's employees could not tell him why the fees were charged because they could not figure out which fees were applicable to Arlington's account. Newman points out that the “Business Banking Product Descriptions,” which are available to bank employees on the Bank's intranet for use in explaining accounts and fees to bank customers, are very complicated and expressly state that they are “For Internal \*432 Use Only,” and “Note: Other fees may apply.”

James Bingham, the Bank's Senior Manager of Applications Development, testified about the Bank's computer pricing methodology. To do so, he referred to documents printed from the Bank's mainframe computer that are hundreds of pages in length. Other charts in the record confirm the

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complex nature of the Bank's fee charges. It appears, however, that the Bank is capable of determining the number of Ohio business checking account customers who were charged a non-negotiated deposit adjustment fee since December 2002.

Arlington filed this action in December 2007 in Ohio state court. The Bank removed the lawsuit to federal court under the Class Action Fairness Act, 28 U.S.C. § 1332(d). In a First Amended Complaint, Arlington asserted individual and class claims for violations of the Ohio Deceptive Trade Practices Act, Ohio Rev.Code Ann. § 4165.02(A)(11), breach of contract and the duty of good faith and fair dealing, and unjust enrichment. Arlington generally alleges that the Bank can charge a business customer fees for services as long as those fees are disclosed in writing to the customer before they are deducted from the account. On the Bank's motion, the district court dismissed all claims with the exception of the breach of contract claim. Following discovery, the court denied Arlington's motion for class certification and, on cross-motions for summary judgment, the district court entered judgment in favor of the Bank on Arlington's individual claim. Arlington timely appealed, and we have jurisdiction under 28 U.S.C. § 1291.

## II. ANALYSIS

Our first task is to review the grant of summary judgment to the Bank on Arlington's breach of contract claim. Concluding that summary judgment was improperly granted on the individual claim, we then turn to Arlington's motion for class certification and determine that the motion should have been granted in part and denied in part.

### A. Individual breach of contract claim

#### 1. Standard of Review

We examine de novo a district court's grant of summary judgment. *Binay v. Bettendorf*, 601 F.3d 640, 646 (6th Cir.2010). We consider summary

judgment properly granted if the “movant shows that there is no genuine issue as to any material fact and the movant is entitled to judgment as a matter of law.” Fed.R.Civ.P. 56(a). The factual evidence, as well as the reasonable inferences drawn from the evidence, are viewed in favor of the nonmoving party. *Banks v. Wolfe Cnty. Bd. of Educ.*, 330 F.3d 888, 892 (6th Cir.2003). A genuine issue of material fact exists for trial “if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.” *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986).

#### 2. Breach of contract under Ohio law

\*\*6 To prevail on a claim for breach of contract under Ohio common law, Arlington must prove the following elements by a preponderance of the evidence: (1) a contract existed, (2) Arlington fulfilled its contractual obligations, (3) the Bank failed to fulfill its contractual obligations, and (4) Arlington incurred damages as a result of the Bank's failure. See *Langfan v. Carlton Gardens Co.*, 183 Ohio App.3d 260, 916 N.E.2d 1079, 1087 (2009). Construction of a written contract, including the determination of whether the contract's terms are ambiguous, is a question of law for the \*433 court, and in making our inquiry we give effect to the intent of the parties in making the contract. *Savedoff v. Access Group, Inc.*, 524 F.3d 754, 763 (6th Cir.2008); *Beasley v. Monoko, Inc.*, 195 Ohio App.3d 93, 958 N.E.2d 1003, 1011 (2011). The parties' intent is presumed to lie in the language they used in their agreement. *Beasley*, 958 N.E.2d at 1011. We must read the contract as a whole and give effect to every part of it, if possible. See *id.*

If the parties dispute the meaning of their contract, the court first considers the four corners of the document to decide if an ambiguity exists. *Id.* at 1012. If the contract terms are clear and precise, the contract is not ambiguous, and the court is not permitted to consider any evidence concerning the parties' intent that is outside the contract itself. *Id.*

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at 1012. If the parties' intent cannot be discerned from the four corners of the agreement or if the language is susceptible of two or more reasonable interpretations, the meaning of the language is construed against its drafter, and a question of fact must be decided by a jury. *Geczi v. Lifetime Fitness*, 973 N.E.2d 801, 805–06 (Ohio Ct.App.2012). Contract language can be interpreted by the court on summary judgment if the contract's terms are clear and unambiguous or, if the contract language is ambiguous, the extrinsic evidence supports only one of the conflicting interpretations, notwithstanding the ambiguity. *United Rentals (N. Am.), Inc. v. Keizer*, 355 F.3d 399, 406 (6th Cir.2004).

One of the disputes in this case centers on the third element of the claim: whether the Bank fulfilled its obligations under the contractual agreement with Arlington.<sup>FN3</sup> The parties agreed in their contract that the Bank could collect service charges, with Arlington giving the Bank a security interest in its business checking account to permit the Bank to withdraw any debt Arlington owed to the Bank. Our inquiry is directed to what the parties' contract required of the Bank with respect to apprising its business customers of the applicability and amount of particular service fees.

FN3. At oral argument, Arlington conceded that it did not point the district court to any ambiguity in the contract language. As a result, Arlington raises ambiguity for the first time on appeal and that issue is not properly before us. See *United States ex rel. Wall v. Circle C Constr., L.L.C.*, 697 F.3d 345, 357 (6th Cir.2012).

[1] The district court focused on whether the Bank breached its contractual obligation to notify Arlington concerning any *changes in fees* because the deposit adjustment fee did not appear on any comprehensive fee list which was made available to or given to. The court concluded that “the Rules and Regulations do not require that a charged fee

appear on a ‘then current Fifth Third Fee Schedule’ or any other compiled list of fees, and the Bank is permitted to charge any fee as long as prior notice of the fee is provided in an appropriate manner to the customer.” The court further reasoned:

\*\*7 The language of ¶ 9 of the Rules and Regulations indicates that as long as information concerning the altered or amended rule, regulation, fee or charge was made available in defendant's offices for fifteen days prior to the fee or charge being imposed, or the customer was notified of the amendment or alteration by some other method provided by law, the change in the fee or charge is binding on defendant's account holders.

R. 92, Page ID 3689.

When the district court referred to paragraph 9 of the Rules & Regulations in effect in 2000, the court overlooked an \*434 important contractual phrase. Paragraph 9 actually stated that “[t]hese Rules and Regulations, *as well as fees and charges contained on the Fee Schedule*” could be altered or amended as specified in that paragraph. R. 83–1, Page ID 3307 (emphasis added). Paragraph 8 of the Rules & Regulations in effect in 2007 was even more specific, stating that “[t]hese Rules and Regulations, *as well as fees and charges contained on the Fee Schedule associated with your account(s)*” could be altered or amended as provided in that paragraph. Appellant's App'x, Vol. 1 at 130 (emphasis added). The language employed in both of these versions presupposed that the Bank had stated the fees and charges applicable to the account on the “Fee Schedule” before the Bank would take any action to alter or amend those fees and charges by following the procedure set forth in paragraph 9 (2000 version) or paragraph 8 (2007 version). We interpret this unambiguous language to mean that the Bank accepted a contractual obligation to disclose to its customers in writing on a “Fee Schedule” all of the fees and charges “associated with” the account or potentially applicable to the account.

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The district court reached its contrary interpretation by disregarding the words, “contained on the Fee Schedule” or “contained on the Fee Schedule associated with your account(s).” The court’s approach did not consider the contract as a whole or give effect to every part of it. *See Beasley*, 958 N.E.2d at 1011. Only by omitting the specified contractual phrases could the court reach its conclusion that the Bank could alter, amend, and presumably add fees and charges “so long as the information concerning fees was made available in defendant’s offices for fifteen days prior to the imposition of the fees.” R. 92, Page ID 3690. This interpretation of the contract was erroneous as a matter of law. *See Savedoff*, 524 F.3d at 763; *Beasley*, 958 N.E.2d at 1011.

The district court then credited the Bank’s evidence without considering contrary evidence presented by Arlington. Bank managers testified that the Bank updated its branch offices weekly about new fees, changes in fees, effective dates of fee changes, and similar information; that the Bank “always” provides information to its branches at least fifteen days prior to the effective date of a fee change; and that the Bank tailors the notice it gives to personal and business customers based on the specific changes being implemented by using statement inserts, letters, product brochures, signs posted in branch banks, the customer call center, and the internet.

**\*\*8** This general testimony lacked specific detail and evidentiary support. As the moving party, the Bank has the burden to identify those portions of the record “which it believes demonstrate the absence of a genuine issue of material fact.” *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). Moreover, some of the Bank’s evidence related to personal bank accounts, which are governed by the Truth in Savings Act. 12 U.S.C. §§ 4301–4313. That Act, however, does not apply to Arlington’s business account. *See* 12 U.S.C. § 4313(1) (“The term ‘account’ means any account intended for use by

and generally used by consumers primarily for personal, family, or household purposes.”).

In contradiction to the Bank’s evidence, Newman testified that Arlington did not receive any written fee information from the Bank, other than a copy of the Rules & Regulations, *before* fees were assessed to Arlington’s account. After the fees were assessed in one non-itemized “service charge,” Newman visited a branch bank seeking written information about the \*435 composition of the “service charge” and written documentation that the fees applied to Arlington’s account, but very little information was provided to him. The only written documentation Newman received was an August 2007 computer printout showing the composition of the \$41.00 service charge for July, after the amount had already been deducted from Arlington’s account. Newman took other steps to obtain information. He visited other branch banks seeking written confirmation that the fees charged actually applied to Arlington’s account, but bank tellers were unable to provide such documentation. He looked at the Bank’s internet website, but he did not find any fee information available there.

The district court summarily disregarded Arlington’s evidence, reasoning that the Bank’s inability to justify the fees *after* they had been assessed was immaterial to the ultimate issue of whether the Bank informed its customers of the fees *before* they were charged. But this analysis misses the precise point Arlington makes. If the Bank possessed written documentation to show business customers all of the potentially applicable fees before those fees were charged, surely the Bank would have produced it to Newman when he inquired or at the very least the Bank would have disclosed it during discovery and provided it to the court to support the Bank managers’ declarations.

Similarly, if the Bank “made available in the offices of the Bank for fifteen (15) days or by such other method as specifically provided by law” information about anticipated alterations or amendments to fees, it stands to reason that the

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Bank would have produced that material. The Bank's obvious inability to produce any documentation that it provided to business customers or "made available in the offices of the Bank" before charging fees is circumstantial evidence that no such documentation existed. See *V & M Star Steel v. Centimark Corp.*, 678 F.3d 459, 469 (6th Cir.2012) (observing that V & M Star Steel "produced sufficient circumstantial evidence to justify a jury trial"); *Newell Rubbermaid, Inc. v. Raymond Corp.*, 676 F.3d 521, 531 (6th Cir.2012) (noting that circumstantial evidence is sufficient to survive summary judgment). Only after this lawsuit was filed did the Bank resort to its mainframe computer to produce hundreds of pages of fees potentially applicable to Arlington's business account. Yet, it appears that this information was not accessible to the staff in the branch banks.

**\*\*9** [2] The Bank contends that it fulfilled its contractual obligations if it made information about fee alterations or amendments available to staff in the branch banks, and not to business customers. This argument disregards the intent of the parties as expressed in their unambiguous contract language. The Rules and Regulations provided that fee alterations and amendments "shall be binding on all Customers *after having been made available* in the offices of the Bank for fifteen (15) days or by such other method as specifically provided by law." The emphasized language evidences the parties' intent to create a notice provision. In other words, the Bank agreed to notify its business customers of contemplated changes to fees fifteen days before the effective date of those changes. Once proper notice of the changes was provided, the customers agreed to be bound by the changes. This language did not obligate Arlington to contact the Bank every fifteen days to inquire whether any new fees or fee modifications affecting its account were about to take effect. Rather, the contract placed the obligation on the Bank to give the business customer proper advance notice of any impending **\*436** fee changes, after which the changes would be binding on the customer.

[3] In summary, we conclude that the critical contract language must be considered in interpreting the agreement between the Bank and Arlington. In our interpretation of the contract, we consider all of the evidence presented and draw all reasonable factual inferences in favor of Arlington. See *Banks*, 330 F.3d at 892. When we do so, genuine issues of material fact emerge for trial concerning whether the Bank fulfilled its contractual obligation to disclose all fees and charges applicable to business accounts on the "Fee Schedule" associated with the account and whether the Bank provided fifteen days' advance notice to business customers of any anticipated fee alterations or amendments.

### 3. The Bank's Defenses

The Bank contends that Arlington's breach of contract claim is barred by the voluntary payment doctrine and the contractual statute of limitations. We disagree on both counts.

[4] Under Ohio law, money voluntarily paid by one person laboring under a mistake of fact to another person who claims the right to such payment is generally recoverable, but money voluntarily paid as a result of a mistake of law is not. See *State ex rel. Dickman v. Defenbacher*, 151 Ohio St. 391, 86 N.E.2d 5, 7 (1949) (per curiam); *Consol. Mgmt., Inc. v. Handee Marts, Inc.*, 109 Ohio App.3d 185, 671 N.E.2d 1304, 1307 (1996). "Simply stated, 'a person who voluntarily pays another with full knowledge of the facts will not be entitled to restitution.'" *Scott v. Fairbanks Capital Corp.*, 284 F.Supp.2d 880, 894 (S.D. Ohio 2003) (quoting *Randazzo v. Harris Bank Palatine*, 262 F.3d 663, 667 (7th Cir.2001)).

Viewed most favorably to the non-moving party, the evidence shows that Arlington did not voluntarily pay the Bank the fees with full knowledge of the facts. The Bank did not disclose to Arlington all of the facts relating to the deposit adjustment fee or the increase in the returned item fee before automatically withdrawing those fees from Arlington's account and listing unexplained

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“service charges” on the monthly bank statements. Newman had to contact the Bank to question the composition and applicability of the “service charges.” Cf. *Harris v. ChartOne*, 362 Ill.App.3d 878, 299 Ill.Dec. 296, 841 N.E.2d 1028, 1032 (2005) (holding plaintiffs voluntarily paid charges listed on invoices where they made no effort to investigate the exact nature of the fees charged). In response to Newman's inquiries, the Bank could not produce any documentation confirming that these fees, in the amounts charged, were applicable to Arlington's account. On this record, the voluntary payment doctrine does not bar Arlington's breach of contract claim as a matter of law. See *Nelson v. Am. Power and Light*, No. 2:08-cv-549, 2010 WL 3219498, \*12-14 (S.D. Ohio Aug. 12, 2010).

**\*\*10** The Bank points out that Arlington received actual notice of the “deposit adjustment fee” and the proper amount of the “returned item fee” before August 2007 because charges for those fees appeared on Arlington's monthly bank statements. But evidence that a general “service charge” was posted on the bank statements does not necessarily compel a finding that Arlington knew what the charge was for without further investigation. The ultimate issue is whether the Bank honored its contractual obligation as stated in the Rules & Regulations to disclose the fees and any changes to them *before* assessing the fees and whether Arlington had full knowledge of the facts before paying the fees.

**\*437** Next, the Bank argues that Arlington's suit to recover fees incurred prior to July 2007 is barred by the contractual statute of limitations. Under Ohio law, parties can agree by contract to shorten the applicable statute of limitations if the time limit is reasonable and the contract language is clear and unambiguous. *Angel v. Reed*, 119 Ohio St.3d 73, 891 N.E.2d 1179, 1181 (2008); *R.E. Holland Excavating Co. v. Montgomery Cnty. Bd. of Comm'rs*, 133 Ohio App.3d 837, 729 N.E.2d 1255, 1259 (1999); *Universal Windows & Doors, Inc. v. Eagle Window & Door, Inc.*, 116 Ohio

App.3d 692, 689 N.E.2d 56, 59 (1996); *Arcade Co. Ltd. v. Arcade, LLC*, 105 Fed.Appx. 808, 810 (6th Cir.2004). The Ohio Supreme Court ruled that a clear and unambiguous two-year statute of limitations in an automobile insurance policy was reasonable and enforceable. *Angel*, 891 N.E.2d at 1181. In *R.E. Holland Excavating Company*, the parties agreed that certain claims and disputes between them would be subject to a resolution process governed by specific notice periods, potentially culminating in a sixty-day period to file “a formal proceeding ... in a forum of competent jurisdiction to exercise such rights or remedies as the appealing party may have with respect to such claim, dispute or other matter in accordance with applicable laws and Regulations.” 729 N.E.2d at 1257. The Ohio Court of Appeals upheld that contractual clause as a reasonable reduction in the length of the statutory limitations period. *Id.* at 1259. The same court later held that a dealer agreement providing for a one-year period to file suit for breach of the agreement was a reasonable and enforceable contractual statute of limitations. *Universal Windows & Doors*, 689 N.E.2d at 58-59.

[5] In this case, however, the language of the Rules & Regulations does not clearly and unambiguously shorten the Ohio breach-of-contract statute of limitations applicable to Arlington's lawsuit against the Bank. Paragraph 28 of the June 2007 version provided in pertinent part:

Customer agrees to carefully examine and reconcile account statements.... Customer agrees that Bank will not be liable if Customer fails to exercise ordinary care in examining their (sic) statements. Customer will notify Bank of any discrepancy with any item, including, but not limited to, deposits, withdrawals, and checks, within thirty (30) days of the statement mailing or made available to customer date.... If notification is not received, Bank will have no liability for such item(s).

**\*\*11** The plain language of this provision “neither mentions nor purports to limit any ‘action,’

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‘lawsuit,’ or ‘demand.’ ” *Arcade Company Ltd.*, 105 Fed.Appx. at 810. At most this paragraph attempts to release the Bank from liability if its customer fails to exercise ordinary care in examining and reconciling its bank statements and fails to notify the Bank of “any discrepancy with any item” within thirty days. “[U]nder Ohio’s case law, something more than this language is required to support a finding that the parties intended to modify the statute of limitations.” *Id.* No language like that used in the contracts at issue in *Angel, Universal Windows & Doors*, or *R.E. Holland Excavating Company* is found in the Bank’s Rules & Regulations. *See id.* at 811. “In the absence of such language, we will not infer an intent to create a contractual limitation period.” *Id.* (noting that the finality achieved by a statute of limitations “must be made manifest in clear, unequivocal language.”)

Accordingly, the Bank’s defenses fail. Summary judgment in favor of the Bank was not warranted on Arlington’s individual breach of contract claim.

#### \*438 B. Class Certification

[6] The district court denied Arlington’s motion to certify a class action, and Arlington now appeals that decision. In light of our contract analysis, the district court should have an opportunity to reconsider the class-certification motion. While it appears to us that Arlington can meet all of the *Rule 23(a)* and *(b)(3)* prerequisites to class certification, we agree with the district court that the class definition as initially proposed by Arlington is too broad and must be narrowed. Accordingly, for the reasons stated below, we vacate the decision to deny the class-certification motion and remand to the district court for further proceedings consistent with this opinion.

##### 1. Standard of Review

The district court has broad discretion to decide whether to certify a class, and we review its certification determination for an abuse of discretion. *Glazer v. Whirlpool Corp. (In re Whirlpool Corp. Front-Loading Washer Prods.*

*Liab. Litig.)*, 678 F.3d 409, 416 (6th Cir.2012). “An abuse of discretion occurs if the district court relies on clearly erroneous findings of fact, applies the wrong legal standard, misapplies the correct legal standard when reaching a conclusion, or makes a clear error of judgment.” *Id.*

##### 2. Requirements for Class Certification

“The class action is ‘an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.’ ” *Wal-Mart Stores, Inc. v. Dukes*, — U.S. —, 131 S.Ct. 2541, 2550, 180 L.Ed.2d 374 (2011) (quoting *Califano v. Yamasaki*, 442 U.S. 682, 700–01, 99 S.Ct. 2545, 61 L.Ed.2d 176 (1979)). The class representative must be a member of the class and must also possess the same interest and suffer the same injury as the class members. *Young v. Nationwide Mut. Ins. Co.*, 693 F.3d 532, 537 (6th Cir.2012). “To be certified, a class must satisfy all four of the *Rule 23(a)* prerequisites—numerosity, commonality, typicality, and adequate representation—and fall within one of the three types of class actions listed in *Rule 23(b)*.” *Id.* (citing *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 397 (6th Cir.1998) (en banc)). Arlington sought class certification under *Rule 23(b)(3)*, which demands proof that questions of law or fact common to the class predominate over individual questions and that the class action is a superior method to adjudicate the case fairly and efficiently. *See Glazer*, 678 F.3d at 416.

**\*\*12** As the party requesting class certification, Arlington must affirmatively prove the *Rule 23* certification requirements, and the court must subject that proof to “rigorous analysis.” *Young*, 693 F.3d at 537 (citing *Dukes*, 131 S.Ct. at 2551). It is not enough for Arlington to recite the language of *Rule 23*. *Pipefitters Local 636 Ins. Fund v. Blue Cross Blue Shield of Mich.*, 654 F.3d 618, 629 (6th Cir.2011), *cert. denied*, — U.S. —, 132 S.Ct. 1757, 182 L.Ed.2d 532 (2012). Rather, it “must be prepared to prove that there are *in fact* sufficiently numerous parties [and] common questions of law or

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fact,” and the required “rigorous analysis” may “entail some overlap with the merits of [Arlington's] underlying claim.” *Dukes*, 131 S.Ct. at 2551.

### 3. Class Definition

Before a court may certify a class under [Rule 23](#), the definition of the class must be sufficiently precise to allow the court to determine administratively whether a particular individual is a member of the proposed class. See *Young*, 693 F.3d at 539. “[D]istrict courts have broad discretion to \*439 modify class definitions.” See *Powers v. Hamilton Cnty. Pub. Defender Comm'n*, 501 F.3d 592, 619 (6th Cir.2007). Likewise, we may “amend sua sponte the class certification to conform to the arguments that the parties have made in this court and below.” *Barney v. Holzer Clinic, Ltd.*, 110 F.3d 1207, 1213–15 (6th Cir.1997) (amending class definition to encompass named plaintiffs and those similarly situated).

Arlington moved to certify a class defined as:

[A]ll individuals and entities who have or have had checking accounts with Fifth Third Bank (“Fifth Third”) in the United States, who were charged and paid a fee for a service that was not listed on a then current Fifth Third Fee Schedule, or was in an amount that was different from that stated on a then current Fifth Third Fee Schedule, prior to the assessment of the charge, during the applicable limitations period. Excluded from the class are employees, officers, directors, legal representatives, heirs, successors and assignees of Defendant.

Arlington's App'x Vol. 1 at 12. But because the statute of limitations applicable to a breach of contract claim varies among the states in which the Bank conducts operations, Arlington sought certification of five subclasses, grouping bank customers by states with similar limitations periods: (1) Ohio and Kentucky; (2) Illinois, Indiana, and West Virginia; (3) Michigan, Tennessee, and Georgia; (4) Florida and Missouri; and (5)

Pennsylvania. <sup>FN4</sup> *Id.* at 12 n. 1.

FN4. Arlington did not specify which group would include customers located in North Carolina. Arlington's App'x Vol. 1 at 12 n. 1.

The Bank contends that Arlington's proposed class definition is overly broad, and in certain respects we agree. Arlington is a business customer of the Bank. It has not alleged or produced evidence of any breach of contract claim relating to a personal bank account, such as those governed by the Truth in Savings Act. 12 U.S.C. §§ 4301–4313. Thus, Arlington cannot seek to hold the Bank liable for any fees it charged to personal bank accounts, and Arlington is not a proper named plaintiff to serve as class representative for customers with personal bank accounts. Furthermore, Arlington cannot represent the interests of business customers who maintain Treasury Management accounts, as bank fees applicable to those accounts are negotiated by the Bank and those customers. Therefore, the proposed class definition must be narrowed to exclude personal bank accounts and Treasury Management customers and must include only business account customers who do not negotiate their fees with the Bank (hereinafter “business customers”). See *Powers*, 501 F.3d at 618 (characterizing class as overbroad and modifying it to include only those persons who were represented by the Public Defender and excluding others who did not suffer the same harm as alleged by the class representative).

\*\*13 Another aspect of the proposed class definition is also problematic. Arlington includes as members of the class both those “who were charged and paid a fee for a service that was not listed on a then current Fifth Third Fee Schedule” and those who were charged and paid a fee that “was in an amount that was different from that stated on a then current Fifth Third Fee Schedule.” These descriptions of potential class members do not reflect Arlington's litigation position nor are they \*440 supported by our legal interpretation of the

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contract or the evidence.

Under our construction of the Rules & Regulations, the Bank agreed to disclose to its business customer on a “Fee Schedule” all of the fees and charges “associated with” the customer's account before the Bank charged the fees to the customer. Thus, the class would include all business customers who were charged and paid fees for services that were not initially disclosed on a Fee Schedule that was made available to the customer before the fees were charged.

The Bank further agreed that it would not make alterations or amendments to the disclosed fees without first giving customers fifteen (15) days advance notice of the changes “in the offices of the Bank” or “by such other method as specifically provided by law.” Thus, the class would also include business customers who were charged and paid fees that were altered or amended in some way after initial disclosure on a Fee Schedule, if the Bank failed to give customers fifteen days' advance notice of the changes “in the offices of the Bank” or by some other method provided by law.

To summarize, the class Arlington seeks to represent may include only business checking account customers and should exclude customers who maintain personal checking or Treasury Management accounts. The class may include those business checking account customers who paid a service fee that the Bank did not initially disclose on a Fee Schedule before it charged the fee and those who paid a service fee that the Bank initially disclosed on a Fee Schedule, but then subsequently altered or amended without giving fifteen days' advance notice of the change in the offices of the Bank or by some other method provided by law. The district court on remand should consider appropriate class or subclass definitions in light of the concerns we have noted.

#### 4. Rule 23(a) Prerequisites

##### a. Numerosity

“ Federal Rule of Civil Procedure 23(a)(1)

requires as a prerequisite to class action that ‘the class [be] so numerous that joinder of all members is impracticable.’ ” *Young*, 693 F.3d at 541 (quoting *In re Am. Med. Sys., Inc.*, 75 F.3d at 1079). “While no strict numerical test exists, ‘substantial’ numbers of affected consumers are sufficient to satisfy this requirement.” *Glazer*, 678 F.3d at 418 (citing *Daffin v. Ford Motor Co.*, 458 F.3d 549, 552 (6th Cir.2006)). However, “impracticability of joinder must be positively shown, and cannot be speculative.” *Golden v. City of Columbus*, 404 F.3d 950, 966 (6th Cir.2005) (internal quotation marks omitted).

\*\*14 Under the specific facts presented, the numerosity requirement appears to be satisfied. *See id.* The Bank has more than 300,000 business checking account customers. Arlington will be able to determine which of these customers are class members because the Bank is able to retrieve information from its computer databases identifying the customers who paid particular fees during specified periods of time. Because thousands of business customers are potentially class members, the numerosity requirement is likely satisfied.

##### b. Commonality

To demonstrate commonality, Arlington must show that “there is a single factual or legal question common to the entire class.” *Powers*, 501 F.3d at 619. The claims must depend on a common contention “of such a nature that it is capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke.” \*441 *Dukes*, 131 S.Ct. at 2551. The court's inquiry focuses on whether a class action will generate common answers that are likely to drive resolution of the lawsuit, not on whether common questions are raised. *See id.*

The district court found that this requirement was not satisfied, reasoning “[t]his is not a case in which the defendant engaged in a single act of failure to give notice or a single course of action which impacted all class members equally. Here,

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proof of each class member's claim still depends upon the facts and circumstances peculiar to that class member.” R. 66, Page ID 3006. The district court rested its finding on the following concerns: that the Bank offers numerous types of accounts and fee structures; that it would be difficult or impossible to determine how each customer received notice of a particular fee; and that individualized inquiries would be necessary to determine whether the fees were actually paid by the customer or waived by the Bank.

These concerns do not compel a finding of no commonality. Although class members may have been impacted differently, the questions that will generate common answers applicable to all class members are whether the Bank failed to disclose initially the fees applicable to its business accounts and whether the Bank failed to give notice to business customers in accordance with the Rules & Regulations before altering or amending the fees. The answers to these common questions will drive resolution of the lawsuit. See *Dukes*, 131 S.Ct. at 2551. Arlington produced sufficient evidence in its own case to suggest that the Bank did not initially disclose the fees applicable to Arlington's business account on a Fee Schedule and that the Bank made subsequent alterations or amendments to the fees without giving proper notice to its customers as provided in the Rules & Regulations. The record also includes evidence retrieved from the Bank's computer database identifying the business customers that actually paid particular fees during specified periods of time. Under the parameters of the revised class, there may be factual or legal questions presented that are common to the entire class and that are capable of class wide resolution.

**\*\*15** Moreover, the size of a potential class and the need to review data concerning individual class members are not reasons to deny class certification. See *Young*, 693 F.3d at 539. Otherwise, large corporations effectively would be immune from many class actions simply due to the large number of customers who may have been

harmed. See *Bateman v. Am. Multi-Cinema, Inc.*, 623 F.3d 708, 722 (9th Cir.2010) (holding that if size of the defendant's potential liability alone were a sufficient reason to deny class certification, “the very purpose of Rule 23(b)(3) —‘to allow integration of numerous small individual claims into a single powerful unit’—would be substantially undermined.”); *Perez v. First Am. Title Ins. Co.*, No. CV-08-1184-PHX-DGC, 2009 WL 2486003, at \*7 (D.Ariz. Aug. 12, 2009) (“Even if it takes a substantial amount of time to review files and determine who is eligible for the [denied] discount, that work can be done during discovery.”); *Slapikas v. First Am. Title Ins. Co.*, 250 F.R.D. 232, 250 (W.D.Pa.2008) (finding class action manageable despite First American's assertion that “no database exists easily and efficiently to make the determinations that would be required for each file”).

Under our established precedent, Arlington appears to satisfy the commonality requirement. See *Powers*, 501 F.3d at 619. Accordingly, the district court abused its discretion in finding otherwise.

#### **\*442 c. Typicality**

The typicality test “limit[s] the class claims to those fairly encompassed by the named plaintiffs' claims.” *Sprague*, 133 F.3d at 399 (quoting *In re Am. Med. Sys., Inc.*, 75 F.3d at 1082). “The premise of the typicality requirement is simply stated: as goes the claim of the named plaintiff, so go the claims of the class.” *Id.* The representative's interests must be aligned with those of the representative group such that the representative's pursuit of its own claims advances the interests of the class. *Id.* “[A] plaintiff's claim is typical if it arises from the same event or practice or course of conduct that gives rise to the claims of other class members, and if his or her claims are based on the same legal theory.” *Powers*, 501 F.3d at 618 (quoting *In re Am. Med. Sys., Inc.*, 75 F.3d at 1082). The commonality and typicality requirements “tend to merge” into one inquiry.

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*Gen. Tele. Co. of Sw. v. Falcon*, 457 U.S. 147, 157 n. 13, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982); *Young*, 693 F.3d at 542; *Rutherford v. City of Cleveland*, 137 F.3d 905, 909 (6th Cir.1998).

The requirement of typicality is also likely met. The proper focus is not on whether business customers actually *received* initial disclosure of fees applicable to their accounts or actual notice of fee changes. The focus is on whether the Bank *provided* the contractually required disclosure and notice.

The Bank attempts to distinguish Arlington from other class members, but nothing in the record suggests that Arlington is unique when compared to the Bank's other business customers who maintained business checking accounts like Arlington's. The Bank also contends that Arlington's allegations are directly contradicted by the Bank's un rebutted declaration testimony and are not supported by any evidence. We disagree based on our previous discussion reversing the grant of summary judgment in favor of the Bank on Arlington's individual claim. Arlington produced sufficient evidence to generate genuine issues of material fact for trial on the common, typical questions at issue.

**\*\*16** By advancing central theories—that the Bank breached its contractual obligation to disclose fees initially and then failed to provide proper notice of fee changes in accordance with the Rules & Regulations—Arlington advances the interests of the class because the same alleged conduct by the Bank triggers each class member's claim. *See Powers*, 501 F.3d at 618; *see also Beattie v. CenturyTel, Inc.*, 511 F.3d 554, 561 (6th Cir.2007) (finding typicality where named plaintiffs' claim “is the same allegation any other class member would bring”). In *Beattie*, we recognized that questions such as whether a customer was actually affected by an allegedly deceptive billing practice or would have abandoned the service in question in the absence of the deception are not dispositive of typicality but instead affect the issue of damages,

which can be resolved through resort to subclasses, if necessary. 511 F.3d at 562. The same is true here.

#### d. Adequacy of Representation

“The adequacy inquiry under Rule 23(a)(4) serves to uncover conflicts of interest between named parties and the class they seek to represent. A class representative must be part of the class and possess the same interest and suffer the same injury as the class members.” *Young*, 693 F.3d at 543 (quoting *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 625–26, 117 S.Ct. 2231, 138 L.Ed.2d 689 (1997)). To evaluate this requirement, courts “review [ ] the adequacy of class representation to determine whether class counsel are qualified, experienced and generally able to conduct the litigation, and to consider\*443 whether the class members have interests that are not antagonistic to one another.” *Beattie*, 511 F.3d at 562–63 (quoting *Stout v. J.D. Byrider*, 228 F.3d 709, 717 (6th Cir.2000)).

There appears to be no dispute that class counsel are competent to conduct this litigation. In light of all we have said, Arlington is a proper class representative. The district court found that Arlington is not a proper class representative for several reasons, including: it received actual notice and waiver of the deposit adjustment fee several times before it was required to pay the fee; it does not have standing to pursue the claims of other class members that arose prior to 2000, the date Arlington opened a business checking account; it does not have standing to challenge the validity of certain types of fees it did not pay; and it has diverse interests from personal account holders, who are entitled to receive a different form of notice and are not subject to the deposit adjustment fee.

These reasons do not warrant a finding that Arlington is an inadequate class representative. As we have already explained, the class is narrowed to eliminate personal checking account holders, and the focus is on the Bank's initial disclosure of fees and subsequent notice of fee alterations to its

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business customers, as we have defined them above. It is not relevant whether class members received actual notice. With respect to standing, once a plaintiff establishes individual standing, whether that plaintiff is able to represent the putative class depends solely on whether the plaintiff meets the criteria of Rule 23. See *Gooch v. Life Investors Ins. Co. of Am.*, 672 F.3d 402, 422 (6th Cir.2012). Finally, Arlington proposes subdividing the class according to the applicable statutes of limitations to account for the Bank's concern about any stale claims.

**\*\*17** There is no basis for a finding that Arlington and the class members have interests that are antagonistic to one another. See *Beattie*, 511 F.3d at 563. Ultimately, Arlington advances the same interest and injury as every other class member. The adequacy requirement therefore does not fail for the reasons given by the district court.

#### 5. Rule 23(b)(3) Prerequisites

Arlington sought class certification under Rule 23(b)(3), “which requires a demonstration that questions of law or fact common to the class predominate over individual questions and that the class action is superior to other available methods to adjudicate the controversy fairly and efficiently.” *Glazer*, 678 F.3d at 416. The matters pertinent to these findings include: (A) the interest of class members in controlling the prosecution of separate actions individually; (B) the extent and nature of any litigation concerning the controversy that the class members have already commenced; (C) the desirability or undesirability of concentrating the litigation in the forum; and (D) the difficulties likely to be encountered in managing the class action. Fed.R.Civ.P. 23(b)(3).

##### a. Predominance

The predominance requirement of Rule 23(b)(3) tests whether a proposed class is sufficiently cohesive to warrant adjudication by representation. *Beattie*, 511 F.3d at 564. “To meet the predominance requirement, a plaintiff must establish that issues subject to generalized proof

and applicable to the class as a whole predominate over those issues that are subject to only individualized proof.” *Young*, 693 F.3d at 544 (quoting *Randleman v. Fid. Nat'l Title Ins. Co.*, 646 F.3d 347, 352–53 (6th Cir.2011)). “[T]he fact that a defense may arise and may affect different class members differently does not compel a finding that individual issues predominate \*444 over common ones.... [C]ommon issues may predominate when liability can be determined on a class-wide basis, even when there are some individualized damage issues.” *Beattie*, 511 F.3d at 564 (citations and internal quotation marks omitted). This requirement “parallels” the commonality inquiry in Rule 23(a)(2) but is “more stringent.” *In re Am. Med. Sys., Inc.*, 75 F.3d at 1084; see also *Powers*, 501 F.3d at 619 (noting that the assertion of “a single factual theory of wrongdoing and seek[ing] to recover based on the single legal claim” is sufficient to satisfy predominance where “[t]he dispositive facts and law are the same as to each class member”).

Whether the Bank initially disclosed to business customers the fees applicable to their accounts and whether the Bank later made alterations to the fees after giving proper advance notice as required by the Rules & Regulations are issues common to the class that predominate over any individual issues that may arise. See *Beattie*, 511 F.3d at 564; *Powers*, 501 F.3d at 619. Answering these liability questions with regard to the entire class is preferable to separate litigation of individual claims. Therefore, the predominance requirement appears to be met. Although some individualized inquiries may arise with regard to damages, the court may decide to utilize subclasses as an appropriate means of handling those issues. See *In re Whirlpool Corp.*, 678 F.3d at 421.

##### b. Superiority

**\*\*18** Finally, the class action appears to be a superior method to litigate the claims because of the relatively small amount of damages each business customer is likely to have suffered from

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the breach of contract alleged. See *Beattie*, 511 F.3d at 567 (citing *Amchem Prod., Inc.*, 521 U.S. at 617, 117 S.Ct. 2231) (holding that the “small possible recovery” of \$124 per class member warranted a finding in favor of superiority). We affirmed a superiority determination on the ground that “members are not likely to file individual actions because the cost of litigation would dwarf any potential recovery.” *Glazer*, 678 F.3d at 421. The same analysis applies here.

### III. CONCLUSION

For all of the reasons discussed above, the district court erred in granting summary judgment in favor of the Bank on Arlington's individual claim. The court also erred, even under our deferential abuse-of-discretion standard, in declining to certify a class. The class as proposed must be narrowed and redefined along the lines stated in this opinion. We leave to the district court implementation of these and any further refinements to the class definition it deems necessary for management of the litigation.

Accordingly, we **REVERSE** the grant of summary judgment to the Bank, we **REVERSE** the denial of class certification, and we **REMAND** to the district court for proceedings consistent with this opinion.

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(Cite as: 2010 WL 3397501 (S.D. Ohio))



Only the Westlaw citation is currently available.

United States District Court,  
S.D. Ohio,  
Eastern Division.  
CERDANT, INC., and the Laptop Guy, Inc.,  
individually and on behalf of all others similarly-  
situated, Plaintiffs,  
v.  
DHL EXPRESS (USA), INC., Defendant.

No. 2:08-cv-186.  
Aug. 25, 2010.

Joseph F. Murray, Brian K. Murphy, Murray  
Murphy Moul & Basil, Columbus, OH, for  
Plaintiffs.

Anthony C. White, O. Judson Scheaf, III,  
Thompson Hine LLP, Columbus, OH, Brian A.  
Troyer, Jennifer Mingus Mountcastle, Thompson  
Hine LLP, Cleveland, OH, for Defendant.

### **OPINION AND ORDER**

ALGENON L. MARBLEY, District Judge.

#### **I. INTRODUCTION**

\*1 This matter is before the Court on Plaintiffs, Cerdant, Inc. (“Cerdant”) and the Laptop Guy, Inc.’s (“LTG,” and together with Cerdant, “Plaintiffs”) Motion for Class Certification. (Doc. 43.) Plaintiffs claim that Defendant, DHL Express (USA), Inc. (“DHL”) had a scheme and engaged in a common course of conduct to charge customers for items that DHL never delivered. In particular, Plaintiffs claim that it was DHL’s regular practice to assess customer accounts as soon as a shipping waybill was created and that DHL charged “shipping fees” and “fuel surcharges” regardless of whether the waybill was later used to ship a package.

Plaintiffs now move to certify a class pursuant to [Federal Rule of Civil Procedure 23\(b\)\(3\)](#). For the

reasons set forth below, the Court **DENIES** Plaintiffs’ Motion for Class Certification.

## **II. BACKGROUND**

### **A. Factual**

DHL is a subsidiary of Deutsche Post, AG, a company providing package delivery. In August 2003 DHL acquired Airborne Express (“Airborne”) and entered the United States market of domestic and international package delivery services. In January 2009, DHL stopped general domestic package delivery services in the United States, instead focusing on international delivery services for its United States customers.

In order to ship packages using DHL’s services, customers generated waybills. A “waybill” is a shipping label and it provides passage within DHL’s shipping services to any package upon which it is affixed. Allegedly, it was DHL’s policy and practice to bill customers for any waybills printed using DHL shipment automation tools unless a waybill was specifically voided.

Waybills could be created using a number of shipping options provided by DHL. One such shipping option was WebShip, a program allowing DHL’s domestic customers to print shipment paperwork, select billing options, schedule the pick-up and delivery of packages, and track packages that were in transit. In order to use WebShip, customers were required to register online with DHL by providing an email address and certain billing information. Customers also agreed to be bound by DHL’s terms and conditions prior to using any of DHL’s online services. DHL states that these terms of conditions have been revised several times and that DHL has been unable to determine all versions of the WebShip terms and conditions used during the proposed class period. Registration with WebShip allowed customers the ability to create and print their own waybills. The customer then affixed the waybill to a package and tendered the package and the attached waybill to DHL for

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delivery. DHL also provided to its customers a WebShip Quick Reference Guide. One of the functions of the WebShip Quick Reference Guide was to notify customers who created waybills using WebShip that they would be billed for those waybills unless they were properly voided. DHL states that the WebShip Quick Reference Guide has been revised several times and that DHL has been unable to determine all versions of the WebShip Quick Reference Guide used during the proposed class period.

\*2 Cerdant used WebShip to generate waybills in DHL's system. In June 2004, Mr. Michael Johnson ("Johnson"), Cerdant's president, reviewed an invoice showing that Cerdant had been charged for five waybills. Upon review, Johnson realized that Cerdant had only shipped packages using two of the waybills. Johnson called DHL's customer service department and he was able to obtain a credit adjustment of \$40.11 on Cerdant's invoice for waybills that had allegedly not been properly voided. Johnson was also encouraged to contact DHL if Cerdant was billed and paid for a waybill that had been created but not used to ship a package. Johnson then reviewed Cerdant's previous invoices from DHL and Airborne and discovered an Airborne invoice, dated October 29, 2003, that reflected a charge for a waybill Cerdant had created in DHL's shipping system but had not been submitted to DHL with a package. Johnson sent a letter to DHL about DHL's policy of charging customers for all waybills that are created, regardless of whether the waybill is used to ship a package within the DHL shipping system. It is the waybill dated October 29, 2003, upon which Cerdant now bases its claims in this litigation.

Another shipping option offered by DHL was EasyShip. EasyShip was a system used by high volume customers. It was installed by DHL at the customer's request on the customer's business premises and allowed the customer efficiently to ship a large number of packages with DHL. Some EasyShip customers received DHL hardware and

software to enable them to use the shipping system while others received only software, which was downloaded and installed on the customer's computer. Similar to WebShip, DHL provided its EasyShip customers with an EasyShip Quick Reference Guide. The EasyShip Quick Reference Guide allegedly informed customers that they would be billed for waybills created using EasyShip unless they were properly voided. DHL states that the EasyShip Quick Reference Guide has been revised several times and that DHL has been unable to determine all versions of the EasyShip Quick Reference Guide used during the proposed class period. Only some EasyShip customers executed a formal written agreement with DHL to access the EasyShip system. Where customers did execute written agreements with DHL, there was no form agreement used. Instead some customers executed an EasyShip Placement Agreement. DHL states that several different versions of Placement Agreements have been used and that it has not been able to locate all versions of the Placement Agreements executed by DHL and the EasyShip customers during the proposed class period. Other EasyShip customers were required to sign an EasyShip Licensing Agreement.<sup>FN1</sup>

FN1. DHL states that after 2007, all EasyShip Placement Agreements and Licensing Agreements included a term informing customers that shipments not picked up by DHL should be voided prior to the transaction to DHL of EasyShip data because "all shipments that are included in the end of the day manifest will be billed." (Ex. 1 to Code Decl.; Judge Aff at ¶ 18.)

LTG was an EasyShip customer. LTG never executed an EasyShip Placement Agreement or a Licensing Agreement. Like other customers without executed formal written agreements, the terms and conditions of LTG's use of EasyShip would have been communicated orally by DHL. These oral communications, which may have occurred between the customer and a variety of DHL

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employees may have included notification that the customer would be shipped for any waybills created in DHL's system that were not properly voided. Between January 2006 and April or June 2007, LTG used EasyShip exclusively to ship packages, and 10 to 20 LTG employees may have been involved in LTG's shipping activities. DHL held a training for LTG employees on the use of EasyShip, but it is unclear which LTG employees attended and if those employees were trained on how properly to void unused waybills and any consequences for failing so to do. As an EasyShip customer, LTG contacted DHL numerous times to make adjustments on specific waybill charges and requested between 20 and 50 refunds or credits. According to DHL, however, LTG is unable to identify any specific waybill that was improperly charged and on which LTG bases its claims in this case.

\*3 In addition to WebShip and EasyShip, DHL had other shipping systems, such as Libra and Linkage. Libra and Linkage had both been developed by Airborne prior to its acquisition by Deutsche Post, AG. Other DHL customers had individual contracts with DHL. DHL states that it has not maintained copies of all of the individual agreements that it and Airborne entered into with customers during the proposed class period.

Over the course of the litigation, DHL came to the determination that it is unable to identify those waybills that were: (1) generated by a DHL customer; (2) not submitted to DHL with a package for delivery; (3) paid by the customer; and (4) on which the customer did not obtain a refund or credit from DHL ("Orphan Waybills"). DHL used the Service Audit Database Archive ("SVA") to attempt to identify potential Orphan Waybills.<sup>FN2</sup> The resulting list was termed the "Speculative Waybill List."<sup>FN3</sup> The Speculative Waybill List is comprised of some 11 million Orphan Waybills that are associated with tens of thousands of DHL customers.

<sup>FN2</sup>. Specifically DHL employee, Mr.

DiProva wrote computer programs attempting to isolate waybills with certain characteristics: (1) including waybills for which a package was never tendered for delivery; (2) including waybills that had neither a pick-up scan nor a proof-of-delivery scan; (3) excluding waybills relating to international shipments; (4) excluding waybills without revenue information because those are waybills for which the customer was never billed; and (5) excluding waybills with corresponding recovery codes because a recovery code indicates that DHL misrouted the package and therefore would necessarily have meant that a package was tendered along with the waybill.

<sup>FN3</sup>. DHL alleges that LTG is basing its claims in this litigation on the Speculative Waybill List exclusively.

DHL alleges that there are several problems with attempting to use this Speculative Waybill List to determine the class in this litigation. For example, out-of-origin waybills are included on the Speculative Waybill List. Each DHL customer has an assigned origin station. When a customer tenders a package to DHL from a location outside of its designated origin station, DHL creates a new waybill number with the correct origin station to the package. DHL states that there is no way to purge all out-of-origin waybills from the Speculative Waybill List because a customer's assigned origin station may change multiple times a year. Therefore, a manual check would be required.

Another problem with the Speculative Waybill List was duplicate records, which DHL eliminated. According to DHL, however, it was only possible to eliminate duplicate records created within the same month. If a duplicate record did not occur in the same month, then it is still on the Speculative Waybill List. Other problems include waybills on the Speculative Waybill List listed as "undefined." Undefined waybills are those that were not assigned

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to a category and not assigned to a customer, and therefore, could not have been used by a customer for a package. Undefined waybills can not be Orphaned Waybills.

Another problematic category included SDI Fast Track Labels, which must have a pickup scan for it to be in DHL's system and which are manually scanned into the DHL system. An SDI Fast Track Label cannot be a potential Orphan Waybill, yet SDI Fast Track Labels continue to appear on the Speculative Waybill List. Other categories of waybills that should not appear on the Speculative Waybill List include: (1) waybills that are not DHL waybill numbers and for which there is no corresponding DHL customer; (2) waybills that have invoice numbers and not DHL waybill numbers; (3) Airborne@home sub shipments waybill numbers that reflect waybill numbers DHL automatically substitutes when a customer uses a duplicate waybill number.

\*4 Further, DHL states that it is unable to identify those Orphan Waybills located on the Speculative Waybill List for which the customer had received a refund or credit. It is DHL policy and practice to issue credits and refunds at the account level and not at the waybill level. DHL also does not formally memorialize in a centralized database or at the customer account level, the reason for a given refund. According to DHL, it regularly issues refunds for a variety of reasons other than for Orphan Waybills including billing an incorrect, or a lost or damaged shipment.

### B. Procedural

In November 2004, Cerdant commenced a similar class action in Broward County, Florida. After conducting class discovery and on the day of morning of the hearing on the motion to certify the proposed class, Cerdant voluntarily dismissed the Florida case.

That same day, on August 16, 2007, Cerdant filed a Class Action Complaint in the Court of Common Pleas for Franklin County, Ohio. On

February 1, 2008, Cerdant filed a Motion for Leave to File First Amended Complaint seeking to add LTG as an additional plaintiff and class representative. The case was then removed to this Court on the basis of diversity jurisdiction.

DHL responded to the Complaint with a Rule 12(b)(6) Motion to Dismiss. On March 16, 2009, this Court issued an Order granting DHL's Motion and dismissing all non-contract claims.<sup>FN4</sup> In addition, the Court also held that DHL qualifies as a "motor carrier" under the Interstate Commerce Commission Termination Act ("ICCTA"), 49 U.S.C. § 13102(14), for the purposes of the transactions at issue in this litigation. On March 31, 2009, Plaintiffs filed an Amended Class Action Complaint against DHL alleging seven grounds on which they are entitled to relief: (1) breach of contract; (2) breach of the obligation of good faith, fair dealing, and commercial reasonableness; (3) unjust enrichment; (4) promissory estoppel; (5) money had and received; (6) declaratory judgment; and (7) an individual breach of contract claim on behalf of LTG.

FN4. On March 30, 2009, this Court docketed an Amended Opinion and Order to reflect the correct title of the statute, pursuant to which some of Plaintiffs claims were dismissed.

On January 19, 2010, Plaintiffs submitted the Motion for Class Certification that is now before this Court. On August 11, 2010, after the issues had been fully briefed by the parties, the Court held a hearing on Plaintiffs Motion.

### III. STANDARD OF REVIEW

Federal Rule of Civil Procedure 23 governs class actions. A plaintiff seeking class certification bears the burden of establishing compliance with all four requirements of Rule 23(a), referred to by the shorthand of "(1) numerosity, (2) commonality, (3) typicality, and (4) adequacy." Fed.R.Civ.P. 23(a); *Alkire v. Irving*, 330 F.3d 802, 820 (6th Cir.2003). In addition, the plaintiff must satisfy one of the

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three sub-sections of Rule 23(b). *Powers v. Hamilton County Pub. Defender Comm.*, 501 F.3d 592, 619 (6th Cir.2007). Before certifying a class action, this Court is required to conduct a “rigorous analysis” to determine whether the requirements of Rule 23 have been met. *Gen. Tel. Co. v. Falcon*, 457 U.S. 147, 161, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982). In ruling on a motion for class certification, a district court is prohibited from considering the merits of the plaintiffs' claims, but the court may consider evidence outside of the pleadings to determine whether the prerequisites of Rule 23 are met. *Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 177, 94 S.Ct. 2140, 40 L.Ed.2d 732 (1974) (establishing the principle that courts determining class certification should not consider the merits of the case); *Coopers & Lybrand v. Livesay*, 437 U.S. 463, 469 n. 12, 98 S.Ct. 2454, 57 L.Ed.2d 351 (1978) (stating that examination of the merits may be relevant to the determination of specific requirements of Rule 23); *In re Lorazepam & Clorazepate Antitrust Litig.*, 289 F.3d 98, 105 (D.C.Cir.2002) (same); see also 1 Joseph M. McLaughlin, *McLaughlin on Class Actions* § 3:12 (6th ed. 2009) (“Consensus is rapidly emerging among the United States Courts of Appeal. The First, Second, Third, Fourth, Fifth, Seventh, Eighth, Tenth and Eleventh Circuits have expressly adopted certification standards that require rigorous factual review and preliminary factual and legal determinations with respect to the requirements of Rule 23 even if those determinations overlap with the merits.”). Plaintiffs bear the burden of showing that the elements of Rule 23 are met. See *Falcon*, 457 U.S. at 161; *Senter v. General Motors Corp.*, 532 F.2d 511, 522 (6th Cir.), cert. denied, 429 U.S. 870, 97 S.Ct. 182, 50 L.Ed.2d 150 (1976).

#### IV. LAW AND ANALYSIS

##### A. Requirements Under Rule (23)(a)

\*5 Under Rule 23(a), Plaintiffs must show that their proposed class is defined and ascertainable. Additionally, Plaintiffs must meet each of the Rule's enumerated requirements.

##### 1. Ascertainability

Though not an express requirement of Rule 23(a), “[a]scertainability goes to whether the class has been defined such that it encompasses and identifiable group.”<sup>FN5</sup> *Stewart v. Cheek & Zeehandelaar, LLP*, 252 F.R.D. 387, 391 (S.D. Ohio 2008). The proposed class “must be capable of concise and exact definition.” *Metcalf v. Edelman*, 64 F.R.D. 407, 409 (N.D. Ill. 1974). This prerequisite for class certification has been implied by other courts. See *Romberio v. Unumprovident Corp.*, Case No. 07-6404, 2009 WL 87510, \*7 (6th Cir. 2009) (stating that “the need for individualized fact-finding” made the “class definition unsatisfactory”) (citing *John v. Nat'l Sec. Fire and Cas. Co.*, 501 F.3d 443, 445 (5th Cir. 2007) (noting that “[t]he existence of an ascertainable class of persons to be represented by the proposed class representative is an implied prerequisite of Federal Rule of Civil Procedure 23”); *Crosby v. Social Sec. Admin.*, 796 F.2d 576, 580 (1st Cir. 1986) (explaining that a class definition should be based on objective criteria so that class members may be identified without individualized fact finding)). The “touchstone of ascertainability is whether the class is objectively defined, so that it does not implicate the merits of the case or call for individualized assessments to determine class membership.” *Stewart*, 252 F.R.D. at 391 (citing *Napier v. Laurel County*, No. 06-368, 2008 WL 544468, \*6 (E.D. Ky. Feb. 26, 2008) (“[A] class should not be certified where extensive factual inquiries are required to determine whether individuals are members of a proposed class.”); *In re Chiang*, 385 F.3d 256, 272 (3d Cir. 2004) (commenting that classes defined in terms of subjective criteria, such as the class members' state of mind, are not ascertainable, and re-drawing the class definition so that it was not contingent upon class members' “belief” that they were discriminated against)).

FN5. Where Plaintiffs have failed to meet the implied requirement of ascertainability, courts have not found it necessary to conduct a full analysis of all Rule 23

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prerequisites. See *Metcalfe v. Edelman*, 64 F.R.D. 407, 409–10 (N.D. Ill. 1974); *Owner–Operator Indep. Drivers Ass’n. Inc. v. Arctic Express, Inc.*, No. C2:97–CV–00750, 2001 WL 34366624 (S.D. Ohio Sept. 4, 2001).

Where certification is sought pursuant to Rule 23(b)(3), as is the case here, precise definition of the class is required because Rule 23(b)(3) provides for monetary relief and requires notice to allow class members to opt out of the litigation. See *Finch v. New York State Office of Children and Family Services*, 252 F.R.D. 192, 198 (S.D.N.Y. 2008).

Here, Plaintiffs' proposed class is defined as:

All individuals and businesses who have been charged “shipping fees” and/or “fuel surcharges” by DHL, or its predecessors of interest, for items that were never tendered to DHL for delivery. (Doc. 33 Am. Compl. ¶ 28.)

This Court has previously ruled that DHL qualifies as a motor carrier under the ICCTA, 49 U.S.C. § 13102(14), for the purposes of the transactions at issue in this litigation. (See Doc. 30 Order.) The ICCTA provides in part that shippers “must contest the original bill or subsequent bill within 180 days of receipt of the bill in order to have the right to contest such charges.” 49 U.S.C. § 13710(a)(3)(B). Under the statute, “[t]he term ‘individual shipper’ means any person who—(A) is the ... of a household goods shipment; (B) is identified as the shipper ... on the face of the bill of lading; (3) owns the goods being transported; and (D) pays his or her own tariff transportation charges.” 49 U.S.C. § 13102(13). Other courts have found that this 180–day rule applies to all actions, whether before the Surface Transportation Board or in court, and regardless of the nature of the claim. *Avery Dennison Corp. v. Con–Way Transp. Servs. Inc.*, No. 2005–L–218, 2006 WL 3350761, \*5–6 (Ohio Ct.App. Nov. 17, 2006) (applying 49 U.S.C. § 13710(a)(3)(B) to a breach of contract claim and finding that the statute “does not discuss a formal

method for notification of a billing dispute,” but “merely requires a shipper to contest the original bill within 180 days of receipt”).

\*6 Under the terms of the statute, any DHL customer who failed to contest a bill within 180 days lacks standing. Neither Cerdant nor LTG has shown that they satisfied the 180–day rule prior to filing this suit.<sup>FN6</sup> While Cerdant and LTG claim that Orphan Waybills do not fall under the purview of the ICCTA, at its core this litigation is about the relationship between DHL, a motor carrier, and Cerdant and LTG, as shippers, and the ICCTA was implemented to address shipping disputes. To the extent that the proposed class definition does not limit the class to those DHL customers who complied with the 180–day notice provision, it is overbroad. Additionally, to the extent that this court would have to engage in individualized factual inquiries to determine those class members who complied with the 180–day requirement, the class is not ascertainable.

FN6. In *Mastercraft Interiors, Ltd. v. ABF Freight Sys., Inc.*, a district court held that the “180 day regulatory requirement cannot be imposed upon actions to enforce a contract under Maryland law.” 350 F.Supp.2d 686, 694 (D.Md. 2004). This case is however, is not binding on this Court and goes against the natural language of the statute. Further, the Mastercraft court was considering the 180 day requirement in the context of Maryland contract law. *Id.* In contrast, state courts considering the relationship between the statute and Ohio law have found that imposition of the 180 day notice requirement was proper. See *Avery Dennison Corp. v. Con–Way Transp. Servs. Inc.*, No. 2005–L–218, 2006 WL 3350761, \*5–6 (Ohio Ct.App. Nov. 17, 2006)

Further, DHL has identified numerous reasons why Plaintiffs reliance upon the Specutive Waybill

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List to identify proposed class members is flawed. Out of origin waybills, undefined waybills, STFL waybills, Easy Return waybills, wabybills lacking waybill numbers and instead having invoice numbers, and waybills for which credits and refunds may have been issued all appear on the Speculative Waybill List. DHL has stated that the only way properly to identify a class would be an individualized assessment of Orphan Waybills. Plaintiffs have made no effort to rebut this assertion and have instead relied upon the Speculative Waybill List. Where individualized assessments are required, the proposed class is not ascertainable, and class certification is not proper. *Stewart*, 252 F.R.D. at 391. Plaintiffs have not met their burden to show that their proposed class is ascertainable. Class certification is therefore, improper.

## 2. Numerosity

To establish this requirement for class certification, Plaintiffs must demonstrate that “the class is so numerous that joinder of all members is impracticable.” Fed.R.Civ.P. 23(a)(1). The Sixth Circuit has stated that “[r]ather than naming a specific number, Rule 23 places the size of the class in the context of actual impracticability of joinder.” *Turnage v. Norfolk Southern Corp.*, 307 Fed. Appx. 918, 921 (6th Cir.2009); Though “[w]hen class size reaches substantial proportions ... the impracticability requirement is usually satisfied by the numbers alone.” *In re Am. Med. Sys.*, 75 F.3d 1069, 1079 (6th Cir.1996); see also *Golden v. City of Columbus*, 404 F.3d 950, 966 (6th Cir.2005) (“impracticability of joinder must be positively shown, and cannot be speculative”).

Plaintiffs rely on the Speculative Waybill List for their assertion that there are 11 million Orphan Waybills and potentially tens of thousands of DHL customers that are class members. DHL, while pointing out several problems with Plaintiffs' reliance on the Speculative Waybill List, does not contest that the proposed class meets this requirement. Therefore the numerosity requirement is satisfied here.

## 3. Commonality

\*7 To establish this prerequisite for class certification, Plaintiffs need to show that “there are questions of law or fact common to the class.” Fed.R.Civ.P. 23(a)(2). This “predominance requirement is met if this common question is at the heart of the litigation.” *Powers v. Hamilton County Public Defender Com'n.*, 501 F.3d 592, 619 (6th Cir.2007) (holding that the commonality requirement was met where “[t]he despositive facts and law [were] the same as to each class member”). Where plaintiffs allege a “single course of wrongful conduct,” class certification may be particularly appropriate. See *Sterling v. Velsicol Chem. Corp.*, 855 F.2d 1188, 1197 (6th Cir.1988). The Sixth Circuit has elaborated that “the mere fact that questions peculiar to each individual member of the class remain after the common questions of the defendant's liability have been resolved does not dictate the conclusion that a class action is impermissible.” *Id.* Where, however “any claim the class may have had in common [threatens] to splinter into individualized claims,” the requirement of predominance is not met. *Ball v. Union Carbide Corp.*, 385 F.3d 713, 728 (6th Cir.2004).

In this case, Plaintiffs's proposed class definition is not limited to those DHL customers who had written contracts for shipping services with DHL. Indeed, LTG did not have a written contract with DHL though it was an EasyShip customer. Plaintiffs breach of contract claim necessitates showing that there was a contract between each of the class members, which DHL breached. Plaintiffs contend that at the end of 2004 DHL's Terms and Conditions provided that any “agreement shall be governed by the laws of the State of Florida and the United States.” (Doc. 33 Am. Compl. Ex. 1 p. 3.) DHL states that not all contracts contain this choice of law provision. Further, DHL contends that there is variation among the contracts, including oral contracts and other contracts some which contain mandatory arbitration clauses. In addition, DHL has stated that

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it unable to identify all formally executed contracts which it had with clients.

The Sixth Circuit has previously held that where there are multiple governing contracts a class cannot establish commonality. *Sprague*, 133 F.3d at 398 (finding that the proposed class of early retirees lacked commonality because some early retirees had signed one of three different contracts and others had based their claims on oral representations from the defendant's employees); see also *Jenkins v. Macatawa Bank Corp.*, Nos. 1:03-CV-321, 1:05-CV-460, 1:05-CV-499, 2007 WL 1295991 (W.D.Mich., 2007) (finding that the claims were not common because there “were three materially different versions of the agreement” and “individual class members could only be placed in the appropriate group after individualized proof about a given investor's contract”); *Mayo v. Sears, Roebuck & Co.*, 148 F.R.D. 576, 590 (S.D. Ohio 1993) (finding that only class members who had used a specific credit application met the requirement of commonality but others who utilized substantially different credit agreements were uncommon). Here, there are a number of contracts at issue relating to different shipping programs provided by DHL. Moreover, there are customers who did not have a formal written contract with DHL. Inquiry into the understanding of those customers, like LTG, as to what was conveyed, via training or otherwise, about the policy for billing customers once a waybill had been printed undermines the requirement that common issues predominate. Plaintiffs would like to rely on DHL's policy of charging customers once a waybill was generated and printed as wrongful conduct, despite the fact that customers were subject to a variety of oral or written agreements governing shipping services. Indeed, “plaintiffs can not advance a single collective breach of contract action on the basis of multiple contracts.” FN7

*Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.3d 331, 331 (4th Cir.1998); see also *Carpenter v. BMW of N. Am., Inc.*, 1999 WL 415390, \*2 (E.D.Pa.1999) (noting that “where the

applicable law derives from the law of the 50 states, as opposed to a unitary federal cause of action, differences in state law will ‘compound the [ ] disparities’ among the class members from the different states”). Thus, the requirement that common issues predominate is not met and class certification is not appropriate.

FN7. Under *Broussard*, class certification is also improper where a defendant's affirmative defenses depend on facts particular to each plaintiff's case. 155 F.3d at 342. Plaintiffs have cited no authority supporting their statement that DHL's defenses sometimes create common issues.

#### 4. Typicality

\*8 The requirement of typicality is met by demonstrating that “the claims or defenses of the representative parties are typical of the claims or defenses of the class.” Fed.R.Civ.P. 23(a)(3); see also Fed.R.Civ.P. 23(c)(1)(B) (requiring a district court, when certifying a class, to define not only the class but also the “class claims, issues, or defenses”). Under Rule 23, “a claim is typical ‘if it arises from the same event or practice or course of conduct that gives rise to the claims of other class members, and if his or her claims are based on the same legal theory.’ “ *Beattie v. CenturyTel, Inc.*, 511 F.3d 554, 561 (6th Cir.2007) (citing *In re Am. Med. Sys., Inc.*, 75 F.3d at 1082. The premise of this requirement is “simply stated: as goes the claim of the named plaintiff, so go the claims of the class.” *Sprague v. General Motors Corp.*, 133 F.3d 388, 399 (6th Cir.1998) (finding that a proposed class of “early retirees” failed the typicality test because “[i]n pursuing their own claims, the named plaintiffs could not advance the interests of the entire early retiree class”). To meet the typicality requirement “a representative's claim need not always involve the same facts or law, provided there is a common element of fact or law.” *Senter*, 532 F.2d at 525 n. 31. Nonetheless, “[t]here must be some connection ... between the merits of each individual claim and the conduct affecting the

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class.” *Romberio*, Case No. 07–6404, 2009 WL 87510 at \*8. Where “individualized assessments are necessary,” the requirement for typicality is not satisfied. *Id.*, see also *Parke v. First Reliance Standard Life Ins. Co.*, 368 F.3d 999, 1005 (8th Cir.2004) (affirming denial of class certification where even if the plaintiff could show that a breach by the defendant caused her harm, whether a breach caused harm to others in the proposed class remained “a case-by-case determination”) *Holmes v. Pension Plan of Bethlehem Steel Corp.*, 213 F.3d 124, 137–38 (3d Cir.2000) (affirming district court’s denial of class certification for class of beneficiaries whose benefits were wrongfully delayed because “the issue of liability itself requires an individualized inquiry into the equities of each claim.”

DHL argues that by refusing to seek a refund on the October 29, 2003 waybill, Cerdant:(1) manufactured its claim in a way that renders Cerdant atypical; (2) failed to mitigate damages; and (3) has unclean hands because it misrepresented the origin of the waybill in question in order to save on shipping costs. These actions allegedly render Cerdant atypical. Further, LTG has asserted an individual claim under Count 7 of the First Amended Class Action Complaint for an individual breach of contract action unrelated to the claim advanced by the class. This claim involves billing errors resulting in overcharges and problems with renegotiated rates. The claim does not apply to the class or any class member. DHL argues that there is no relationship between the individual injury alleged by LTG and the practice relating to the Orphan Waybills subject to the class litigation.

\*9 Plaintiffs make no effort to address or rebut DHL’s claims that they are atypical. Plaintiffs have failed to meet their burden to show that in this case, “as goes the claim of the named plaintiff[s], so go the claims of the class.” *Sprague v. General Motors Corp.*, 133 F.3d 388, 399 (6th Cir.1998). The requirement of typicality is not met and class certification is inappropriate.

## 5. Adequacy

To establish the prerequisite of adequacy Plaintiffs must show that they, as “the representative parties[,] will fairly and adequately protect the interests of the class.” Fed.R.Civ.P. 23(a)(4). Under Rule 23, the named Plaintiffs must belong to the class, have the same interest as the class, and suffer the same injury as the class members. *Amchem Prod., Inc. v. Windsor*, 521 U.S. 591, 625–26, 117 S.Ct. 2231, 138 L.Ed.2d 689 (1997). The adequacy requirement “serves to uncover conflicts of interest between named parties and the class they seek to represent.” *Id.* The Sixth Circuit has stated that it “reviews the adequacy of class representation to determine whether class counsel are qualified, experienced and generally able to conduct the litigation, and to consider whether the class members have interests that are not antagonistic to one another.” *Stout v. J.D. Byrider*, 228 F.3d 709, 717 (6th Cir.2000). Representation is not adequate when “there is evidence that the representative plaintiffs appear unable to vigorously prosecute the interests of the class.” *Id.* (internal citations omitted). Adequacy also considers “whether class counsel has the qualifications and experience to effectively prosecute the case.” *Stewart*, 252 F.R.D. at 393 (citing *Int’l Union, United Auto., Aerospace, & Agric. Implement Workers of Am. v. Gen. Motors Corp.*, 497 F.3d 615, 626 (6th Cir.2007)).

DHL alleges that Plaintiffs are not adequate representatives because they do not have common interests with the unnamed class members and because Plaintiffs have failed adequately to represent and to vigorously prosecute the class action. DHL alleges that Plaintiffs official Rule 30(b)(6) representatives lack basic factual knowledge of the case, have not reviewed previous Court rulings in this case, and are not engaged in supervising the work of class counsel. Plaintiffs respond that “Named Plaintiffs need not be lawyers and they need not pour hundreds of hours into case [sic] in order to be adequate.” (Doc. 56 Pl. Reply to Mot. for Class Cert. p. 5.)

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Although Plaintiffs advocate rigorously to solidify their role as class representatives in this litigation, they have not demonstrated that they can prosecute this case adequately. For instance, LTG was unable to point to a single Orphan Waybill at issue in the litigation without reliance on the Speculative Waybill List. Since the Plaintiffs have failed to meet the requirements of ascertainability, commonality, and typicality, and therefore, do not share the same interests as the proposed class members, Plaintiffs are not adequate class representatives. The adequacy requirement is not met and class certification is inappropriate.

#### **B. Requirements Under Rule 23(b)(3)**

\*10 Rule 23(b) (3), under which Plaintiffs seek certification, “a class action may be maintained if [(1) ] Rule 23(a) is satisfied;” and (2) “the court finds that the questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy.”  
 FN8 Fed.R.Civ.P. 23(b).

FN8. Matters relevant to a determination pursuant to class certification under Rule 23(b)(3) include:

- (A) the class members’ interests in individually controlling the prosecution or defense of separate actions;
- (B) the extent and nature of any litigation concerning the controversy already begun by or against class members;
- (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; and
- (D) the likely difficulties in managing a class action.

Fed.R.Civ.P. 23(b)(3).

As discussed above, Plaintiffs have failed to meet the requirements under Rule 23(a) for class certification. Fed.R.Civ.P. 23(b)(3). Additionally, as discussed in Section IV.A.5, *supra*, Plaintiffs have failed to demonstrate that common issues of law or fact predominate “over any questions affecting only individual members” because of the variety of contracts at issue. *Id.* Therefore, class certification is not appropriate.

#### **IV. CONCLUSION**

For the reasons set forth above, Plaintiffs Motion for Class Certification is **DENIED**.

#### **IT IS SO ORDERED.**

S.D. Ohio, 2010.

Cerdant, Inc. v. DHL Express (USA), Inc.

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208 F.R.D. 174, 2002-1 Trade Cases P 73,698  
(Cite as: 208 F.R.D. 174)



United States District Court,  
E.D. Michigan,  
Southern Division.  
In re NORTHWEST AIRLINES CORP., et al.,  
Antitrust Litigation.

No. 96-74711.  
May 16, 2002.

Airline customers brought antitrust action against airlines, alleging that airlines engaged in restraint of trade and monopolistic practices by eliminating “hidden city” ticketing. On customers' motion for class certification, and on airlines' motion for summary judgment, the District Court, [Rosen, J.](#), held that: (1) airlines were not entitled to “fraud prevention” exception to Sherman Act liability; (2) fact issues regarding business interests of airlines in adopting unilateral prohibition against hidden city ticketing precluded summary judgment on antitrust conspiracy claim; (3) full “rule of reason” analysis was not required on antitrust conspiracy claim; (4) fact issues regarding monopoly power in airline markets precluded summary judgment on antitrust monopolization claim; and (5) certification of customers as class of plaintiffs was proper.

Plaintiffs' motion granted in part; defendants' motion denied.

West Headnotes

**[1] Antitrust and Trade Regulation 29T** **606**

29T Antitrust and Trade Regulation  
29TVI Antitrust Regulation in General  
29TVI(E) Particular Industries or Businesses  
29Tk606 k. Transportation. [Most Cited Cases](#)  
(Formerly 265k12(1.8))  
Defendant airlines in antitrust lawsuit brought by airline customers were not entitled to fraud

prevention exception to Sherman Act liability for their alleged actions in eliminating “hidden city” ticketing; species of fraud allegedly practiced by customers in purchasing tickets was not essential prerequisite to achievement of fare structure sought by customers, but was only byproduct of their self-help efforts to circumvent allegedly unlawful pricing scheme imposed by airlines. Sherman Act, § 1, as amended, [15 U.S.C.A. § 1](#).

**[2] Federal Civil Procedure 170A** **2484**

170A Federal Civil Procedure  
170AXVII Judgment  
170AXVII(C) Summary Judgment  
170AXVII(C)2 Particular Cases  
170Ak2484 k. Antitrust and price discrimination cases. [Most Cited Cases](#)

To resolve motion for summary judgment on antitrust conspiracy claim, court must inquire: (1) whether plaintiff's evidence of conspiracy is ambiguous, meaning that it is as consistent with defendants' permissible independent interests as with illegal conspiracy, and (2) if so, whether there is any evidence that tends to exclude possibility that defendants were pursuing these independent interests. Sherman Act, § 1, as amended, [15 U.S.C.A. § 1](#).

**[3] Antitrust and Trade Regulation 29T** **977(2)**

29T Antitrust and Trade Regulation  
29TXVII Antitrust Actions, Proceedings, and Enforcement  
29TXVII(B) Actions  
29Tk973 Evidence  
29Tk977 Weight and Sufficiency  
29Tk977(2) k. Restraints and misconduct in general. [Most Cited Cases](#)  
(Formerly 265k28(7.5))  
Plaintiff fails to demonstrate antitrust conspiracy under Sherman Act if, using ambiguous evidence, inference of conspiracy is less than or

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(Cite as: 208 F.R.D. 174)

equal to inference of independent action. Sherman Act, § 1 et seq., as amended, 15 U.S.C.A. § 1 et seq.

**[4] Antitrust and Trade Regulation 29T ↪979**

29T Antitrust and Trade Regulation

29TXVII Antitrust Actions, Proceedings, and Enforcement

29TXVII(B) Actions

29Tk978 Trial, Hearing and

Determination

29Tk979 k. In general. **Most Cited**

Cases

(Formerly 265k28(8))

Litigant in antitrust action under Sherman Act may not proceed by first assuming conspiracy, and then explaining evidence accordingly. Sherman Act, § 1 et seq., as amended, 15 U.S.C.A. § 1 et seq.

**[5] Federal Civil Procedure 170A ↪2484**

170A Federal Civil Procedure

170AXVII Judgment

170AXVII(C) Summary Judgment

170AXVII(C)2 Particular Cases

170Ak2484 k. Antitrust and price discrimination cases. **Most Cited Cases**

Genuine issues of material fact regarding individual business interests of airlines in adopting unilateral prohibition against “hidden city” ticketing precluded summary judgment on antitrust conspiracy claim brought by airline customers under Sherman Act. Sherman Act, § 1 et seq., as amended, 15 U.S.C.A. § 1 et seq.

**[6] Federal Civil Procedure 170A ↪2484**

170A Federal Civil Procedure

170AXVII Judgment

170AXVII(C) Summary Judgment

170AXVII(C)2 Particular Cases

170Ak2484 k. Antitrust and price discrimination cases. **Most Cited Cases**

Genuine issues of material fact as to whether

defendant airlines’ claimed justifications for prohibitions against “hidden city” ticketing were valid, and thus whether full rule of reason analysis was required, precluded summary judgment on antitrust conspiracy claim brought by airline customers under Sherman Act. Sherman Act, § 1 et seq., as amended, 15 U.S.C.A. § 1 et seq.

**[7] Federal Civil Procedure 170A ↪2484**

170A Federal Civil Procedure

170AXVII Judgment

170AXVII(C) Summary Judgment

170AXVII(C)2 Particular Cases

170Ak2484 k. Antitrust and price discrimination cases. **Most Cited Cases**

Genuine issues of material fact regarding whether hub-spoke city pairs were appropriate markets upon which airline customers could base antitrust monopolization claims against airlines, whether monopoly power existed in each of these markets, and whether customers and their experts drew unwarranted inferences from mere existence of some hidden-city savings opportunities for each hub-spoke market precluded summary judgment on monopolization claims under Sherman Act. Sherman Act, § 2, as amended, 15 U.S.C.A. § 2.

**[8] Antitrust and Trade Regulation 29T ↪972(3)**

29T Antitrust and Trade Regulation

29TXVII Antitrust Actions, Proceedings, and Enforcement

29TXVII(B) Actions

29Tk972 Pleading

29Tk972(2) Complaint

29Tk972(3) k. In general. **Most Cited Cases**

(Formerly 265k28(6.2))

In order to state viable monopolization claim under Sherman Act, anti-trust plaintiff must allege: (1) possession of monopoly power in relevant market, and (2) willful acquisition, maintenance, or use of that power by anti-competitive or exclusionary means. Sherman Act, § 2, as amended,

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15 U.S.C.A. § 2.

**[9] Antitrust and Trade Regulation 29T ↪ 972(3)**

29T Antitrust and Trade Regulation

29TXVII Antitrust Actions, Proceedings, and Enforcement

29TXVII(B) Actions

29Tk972 Pleading

29Tk972(2) Complaint

29Tk972(3) k. In general. **Most**

**Cited Cases**

(Formerly 265k28(6.2))

Airline customers alleged that airlines, in eliminating “hidden city” ticketing, used their monopoly power in hub-spoke markets by anti-competitive means, as required to maintain their antitrust monopolization claim under Sherman Act, where customers identified diminished intrabrand competition and dominant market positions in relevant interbrand markets. Sherman Act, § 2, as amended, 15 U.S.C.A. § 2.

**[10] Antitrust and Trade Regulation 29T ↪ 687**

29T Antitrust and Trade Regulation

29TVII Monopolization

29TVII(E) Particular Industries or Businesses

29Tk687 k. Manufacturers. **Most Cited**

**Cases**

(Formerly 265k12(11/4))

Manufacturer cannot be charged with antitrust violations under Sherman Act if it monopolizes its own brand. Sherman Act, § 2, as amended, 15 U.S.C.A. § 2.

**[11] Antitrust and Trade Regulation 29T ↪ 687**

29T Antitrust and Trade Regulation

29TVII Monopolization

29TVII(E) Particular Industries or Businesses

29Tk687 k. Manufacturers. **Most Cited**

**Cases**

(Formerly 265k12(11/4))

In case claiming violation of section of Sherman Act making it unlawful to monopolize trade, manufacturer's refusal to deal designed to accomplish vertical integration, without more, should not be basis for imposing liability. Sherman Act, § 2, as amended, 15 U.S.C.A. § 2.

**[12] Federal Civil Procedure 170A ↪ 172**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)2 Proceedings

170Ak172 k. Evidence; pleadings and supplementary material. **Most Cited Cases**

Parties seeking class certification bear burden of establishing that requirements for certification are satisfied; class is not maintainable merely by virtue of its designation as such in pleadings. Fed.Rules Civ.Proc.Rule 23, 28 U.S.C.A.

**[13] Federal Civil Procedure 170A ↪ 163**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)1 In General

170Ak163 k. Impracticability of joining all members of class; numerosity. **Most Cited Cases**

There is no strict numerical test for determining impracticability of joinder of parties seeking certification as class; mere allegation that class is too numerous to make joinder practicable, by itself, is not sufficient to meet numerosity prerequisite. Fed.Rules Civ.Proc.Rule 23(a), 28 U.S.C.A.

**[14] Federal Civil Procedure 170A ↪ 163**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

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170AII(D)1 In General

170Ak163 k. Impracticability of joining all members of class; numerosity. [Most Cited Cases](#)

To meet numerosity requirement for certification as class, plaintiffs must ordinarily demonstrate some evidence or reasonable estimate of number of purported class members. [Fed.Rules Civ.Proc.Rule 23\(a\), 28 U.S.C.A.](#)

**[15] Federal Civil Procedure 170A ↪181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

[Most Cited Cases](#)

Airline customers who brought antitrust action against airlines satisfied numerosity prerequisite for class action certification, where proposed class members numbered in hundreds of thousands and were located across nation. [Fed.Rules Civ.Proc.Rule 23\(a\), 28 U.S.C.A.](#)

**[16] Federal Civil Procedure 170A ↪165**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)1 In General

170Ak165 k. Common interest in subject matter, questions and relief; damages issues. [Most Cited Cases](#)

To fulfill commonality requirement of class certification, complete identity of issues is not required; rather, it is enough if resolution of one particular issue will affect all or significant number of members of putative class. [Fed.Rules Civ.Proc.Rule 23\(a\), 28 U.S.C.A.](#)

**[17] Federal Civil Procedure 170A ↪181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

[Most Cited Cases](#)

Airline customers who brought antitrust action against airlines demonstrated common issues of law and fact, as required to fulfill commonality prerequisite for class action certification; customers alleged that airlines agreed upon common course of action to eliminate “hidden city” ticketing, and antitrust claims rested heavily upon common analysis regarding hub-based approach to market definition. [Fed.Rules Civ.Proc.Rule 23\(a\), 28 U.S.C.A.](#)

**[18] Federal Civil Procedure 170A ↪181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

[Most Cited Cases](#)

Airline customers who brought antitrust action against airlines properly utilized national market analyses of airlines' hub airports, focusing on product and geographic scope of markets, as means of fulfilling typicality prerequisite for class action certification, since claims based on results of such analyses were typical of those within class as a whole. [Fed.Rules Civ.Proc.Rule 23\(a\), 28 U.S.C.A.](#)

**[19] Federal Civil Procedure 170A ↪181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

[Most Cited Cases](#)

Airline customers who brought antitrust action against airlines properly utilized “hidden city” fares as benchmarks for allegedly supracompetitive hub-

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spoke fares, as means of demonstrating typicality prerequisite for class action certification; customers alleged that hidden city savings opportunities confirmed airlines' exercise of monopoly power, and established existence and extent of each class member's injury as result of such conduct. [Fed.Rules Civ.Proc.Rule 23\(a\)](#), 28 U.S.C.A.

**[20] Federal Civil Procedure 170A ↪181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

**Most Cited Cases**

At class certification stage of antitrust class action, plaintiffs must show that antitrust impact can be proven with common evidence on classwide basis; plaintiffs need not show antitrust impact in fact occurred on classwide basis. [Fed.Rules Civ.Proc.Rule 23\(a\)](#), 28 U.S.C.A.

**[21] Federal Civil Procedure 170A ↪181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

**Most Cited Cases**

Proof of injury offered by airline customers in antitrust action against airlines sufficed for typicality requirement of class certification, where such evidence, if credited, would have established that many class members would have sought out and purchased "hidden city" tickets, and that practice would have become widespread if airlines had not acted to prohibit it. [Fed.Rules Civ.Proc.Rule 23\(a\)](#), 28 U.S.C.A.

**[22] Federal Civil Procedure 170A ↪181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

**Most Cited Cases**

Proof of damages offered by airline customers in antitrust action against airlines sufficed for typicality requirement of class certification, since issue could only be resolved by expert testimony, customers were not required to establish losses to certainty at certification stage, and individualized damage inquiries, standing alone, did not warrant denial of certification. [Fed.Rules Civ.Proc.Rule 23\(a\)](#), 28 U.S.C.A.

**[23] Federal Civil Procedure 170A ↪181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

**Most Cited Cases**

In antitrust action brought by airline customers against airlines alleging improper ticket pricing practices, reimbursements paid to customers would not destroy typicality of proposed class of plaintiffs, as would deny certification, since such inquiry would go to actual merits of each prospective class member's claim. [Fed.Rules Civ.Proc.Rule 23\(a\)](#), 28 U.S.C.A.

**[24] Federal Civil Procedure 170A ↪164**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)1 In General

170Ak164 k. Representation of class; typicality; standing in general. **Most Cited Cases**

To satisfy requirement that prospective class members in class action have adequate representation, it must be shown that representatives have interests in common with, and

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not antagonistic to, interests of unnamed members of the class, and that representatives will vigorously prosecute these interests through qualified counsel. [Fed.Rules Civ.Proc.Rule 23\(a\)](#), 28 U.S.C.A.

**[25] Federal Civil Procedure 170A**  **181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

[170Ak181.5 k](#). Antitrust plaintiffs.

**Most Cited Cases**

Airline customers who brought antitrust action against airlines reasonably defined their proposed classes to ensure that their membership was limited to those who stood to benefit in event that they were to prevail, as required to satisfy adequacy of representation element for class certification. [Fed.Rules Civ.Proc.Rule 23\(a\)](#), 28 U.S.C.A.

**[26] Federal Civil Procedure 170A**  **181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

[170Ak181.5 k](#). Antitrust plaintiffs.

**Most Cited Cases**

Airline customers who brought antitrust action against airlines, and sought certification for class action, were not required to certify separate classes of plaintiffs for those seeking injunction rather than damages, since single category of classes could serve as appropriate vehicle for award of both monetary and injunctive relief. [Fed.Rules Civ.Proc.Rule 23\(b\)](#), 28 U.S.C.A.

**[27] Federal Civil Procedure 170A**  **181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

[170Ak181.5 k](#). Antitrust plaintiffs.

**Most Cited Cases**

In antitrust action brought by airline customers against airlines, customers' proposed method of proving liability rested upon predominantly common questions of law and fact, as required to certify customers as class of plaintiffs. [Fed.Rules Civ.Proc.Rule 23\(b\)](#), 28 U.S.C.A.

**[28] Federal Civil Procedure 170A**  **181.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

[170Ak181.5 k](#). Antitrust plaintiffs.

**Most Cited Cases**

Airline customers who brought antitrust action against airlines demonstrated that class relief would be superior to other methods of adjudicating their claims, as required to certify customers as class of plaintiffs; airlines' success in persuading trier of fact to reject customers' hub-dominated market analysis would largely determine fate of each class member's claim, since customers would not be in position to offer additional, market-by-market evidence in event that their hub-based evidence were discounted. [Fed.Rules Civ.Proc.Rule 23\(b\)](#), 28 U.S.C.A.

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**OPINION AND ORDER REGARDING  
PLAINTIFFS' MOTION FOR CLASS  
CERTIFICATION AND DEFENDANTS'  
MOTION FOR SUMMARY JUDGMENT**

ROSEN, District Judge.

**I. INTRODUCTION**

On October 11, 1996, Plaintiff Nelson Chase brought the first of these four consolidated antitrust actions on behalf of himself and other similarly situated air travelers, alleging that Defendants Northwest Airlines Corp., Northwest Airlines, Inc., Airline Reporting Corporation (“ARC”) and others have conspired among themselves to restrain trade in violation of § 1 of the Sherman Act, 15 U.S.C. § 1, and that Defendant Northwest has engaged in unlawful monopolistic practices in violation of § 2 of the Sherman Act, 15 U.S.C. § 2.<sup>FN1</sup> The three remaining suits were filed in 1999, with Defendants Northwest and ARC again named as Defendants, but with the addition of Defendants Delta Air Lines, Inc., U.S. Airways Group, Inc., and U.S. Airways, Inc. as parties. These four actions, with their substantially similar allegations, were consolidated for all pretrial purposes through a stipulated Order dated September 16, 1999.

<sup>FN1</sup>. The initial complaint also asserted claims under Michigan antitrust law, but these claims were omitted from Plaintiff's more recent amended complaints.

As detailed in a prior Opinion and Order, *see Chase v. Northwest Airlines Corp.*, 49 F.Supp.2d 553 (E.D.Mich.1999), this case concerns the Defendant Airlines' refusal to sell so-called “hidden-city” tickets, whereby a passenger who wishes to travel to or from one of the Airlines' hub airports is able to obtain a cheaper fare by purchasing a “spoke-hub-spoke” ticket that encompasses the desired “hub-spoke” route, and then simply discarding the unused portion of the ticket. Each of the Defendant Airlines has adopted a policy prohibiting the sale of such tickets, and the Airlines also have devised various mechanisms to enforce their prohibitions.\*179 Plaintiffs allege that the Defendant Airlines, Defendant ARC, and others have conspired to enforce these prohibitions, and that each Airline's separate prohibition constitutes an unlawful exercise of monopoly power over many of the routes that originate or terminate at its hub

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airports.

By motion filed on November 15, 2000, Plaintiffs now request certification of several proposed classes of airline customers under Fed.R.Civ.P. 23, including: (i) a class of ticket purchasers who seek injunctive relief from Defendants' alleged Section 1 and 2 violations; (ii) a class of ticket purchasers who purportedly suffered monetary losses as a result of Defendants' alleged Section 1 conspiracy to eliminate hidden-city ticketing; and (iii) subclasses of customers of each individual Defendant Airline who seek to recover damages for each Airline's alleged violation of Section 2. For their part, the Defendant Airlines filed a motion for summary judgment on November 15, 2000, arguing that Plaintiffs' Section 1 and 2 claims are deficient as a matter of law in a number of respects.

Both of these motions have been fully briefed by the parties. In addition, on November 14, 2001, the Court heard oral argument on these matters. Having reviewed the parties' submissions and the voluminous record, and having considered the arguments of counsel at the November 14 hearing, the Court now is prepared to rule on Plaintiffs' and the Airline Defendants' motions. This Opinion and Order sets forth the Court's rulings.<sup>FN2</sup>

<sup>FN2</sup>. Defendant ARC filed a separate motion for summary judgment on November 15, 2000. The Court orally granted this motion at the November 14 hearing, and will issue a separate Opinion and Order setting forth the grounds for this ruling.

## II. FACTUAL AND PROCEDURAL BACKGROUND

The parties have submitted lengthy recitations of the facts of this case,<sup>FN3</sup> and have provided innumerable boxes of exhibits in support of their respective positions. Needless to say, a full account of all of the facts of this case would fill an entire volume of the Federal Supplement. Accordingly,

what follows is necessarily a summary of the most pertinent facts and circumstances, with more details to follow as necessary to the Court's analysis of the arguments raised in the parties' motions.

<sup>FN3</sup>. Tellingly, Plaintiffs did not even attempt to state the facts of their case within the confines of the 50-page briefing limit established by stipulation of the parties, but instead submitted a separate "Factual Appendix" that includes 267 numbered paragraphs and spans 169 pages.

### A. The Parties to These Actions

The named Plaintiffs in this consolidated action are Nelson Chase, Norman Volk, Nitrogenous Industries Corp., and Keystone Business Machines, Inc. The Defendants are (i) Northwest Airlines Corp. and Northwest Airlines, Inc. (collectively "Northwest"); (ii) U.S. Airways Group, Inc. and U.S. Airways, Inc. (collectively "U.S. Airways"); (iii) Delta Air Lines, Inc. ("Delta"); and (iv) Airline Reporting Corporation ("ARC").

Defendant ARC is an airline trade association owned and controlled by its constituent member airlines. ARC provides accreditation for travel agencies and a central clearinghouse for ticket sales made by these agencies. The remaining Defendants, of course, are major passenger airlines that provide air travel service throughout the nation and the world.

Each of the named Plaintiffs purchased at least one unrestricted, full-fare ticket from one of the Defendant Airlines during the relevant time period—on or after October 10, 1992, as to the claims against Northwest; on or after May 18, 1995, as to the claims against U.S. Airways; and on or after June 11, 1995, as to the claims against Delta. These ticket purchases all involved travel that began or ended at a Defendant Airline's hub airport—either Minneapolis, Detroit, or Memphis, for Northwest; Pittsburgh or Charlotte, for U.S. Airways; and Atlanta and Cincinnati, for Delta. In all, Plaintiffs have identified 234 "Affected

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City–Pair Routes” that begin or end at one of these hub airports.<sup>FN4</sup> The named Plaintiffs seek to serve \*180 as class representatives for all passengers who purchased unrestricted, full-fare tickets on or after the above-cited dates for travel on one of these “Affected City–Pair Routes.”<sup>FN5</sup>

**FN4.** To be completely accurate, Plaintiffs and their experts have identified 246 city-pair routes as the relevant markets for their antitrust claims. However, 12 of these routes are double-counted, as they involve travel between two Defendants' hub airports. It also should be noted that these 246 routes do not exhaust all, or even most, of the cities served by the Defendant Airlines from their hub airports. However, Plaintiffs' experts have excluded various city-pairs from their analysis, including (i) “short haul” routes of less than 150 miles, where ground transportation could readily serve as a substitute for air travel; (ii) low-travel routes, involving fewer than 30,000 round-trip passengers per year, as such low volumes likely could support only one airline, and thereby create “natural monopoly” situations; and (iii) routes on which the Defendant hub carrier holds less than a 50–percent market share, under the reasoning that it would be more difficult to establish monopoly power on such routes. (See Plaintiffs' Exhibits, Tab 71, Beyer Expert Report at 24–25.)

**FN5.** More specifically, Plaintiffs propose a single “injunctive class” for all such passengers, a single “damages class” of all such passengers for purposes of their Section 1 antitrust conspiracy claim, and three separate “damage classes” of customers of each individual Defendant Airline for purposes of their Section 2 antitrust claims.

## B. The Practice of “Hidden–City” Ticketing

This case arises from the Defendant Airlines'

efforts to discourage or eliminate the practice of “hidden-city” ticketing (also referred to as “point-beyond” ticketing). To use an example that has become ubiquitous in these proceedings, consider a passenger who wishes to travel from New York to Northwest's hub airport in Detroit. Upon calling Northwest or a travel agent to inquire about fares, this passenger might discover that the unrestricted, one-way full fare for travel from New York to Detroit is \$394.00. However, upon further inquiry, the passenger might learn that a one-way full fare ticket for travel from New York to Columbus, Ohio costs only \$238.73.<sup>FN6</sup> Yet, because of the hub-and-spoke layout of Northwest's flight network, it happens that a trip from New York to Columbus actually involves two segments, one from New York to Detroit and one from Detroit to Columbus. Thus, a savvy—or, Defendants would say, unscrupulous—traveler might elect to purchase a New York–Columbus ticket, disembark in Detroit, and simply throw away the unneeded portion of the ticket for travel from Detroit to Columbus.<sup>FN7</sup>

**FN6.** As indicated in the Court's prior published opinion in this case, these fares were the ones in effect on September 29, 1995. See *Chase*, 49 F.Supp.2d at 557 n. 7.

**FN7.** The parties also occasionally refer to the practice of “back-to-back” ticketing, which involves the purchase of two round-trip tickets for travel in opposite directions—for example, New York/Detroit and Detroit/New York—and permits the purchaser to avoid the premium charged for travel that does not satisfy a minimum-stay requirement. For example, if a business traveler wished to make a round trip between New York and Detroit on two consecutive midweek days, thereby failing to qualify for a less expensive fare involving a Saturday stayover, he might discover that it is cheaper to purchase *two* discounted round-

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trip tickets, each including a Saturday stayover, and to use only the first legs of these two tickets to form a composite midweek round-trip ticket, rather than purchasing a single, much more expensive round-trip ticket that reflected his actual travel plans. The practice of back-to-back ticketing, though sometimes relevant to the arguments made by the parties, is not directly at issue in this case.

The Defendant Airlines oppose this practice, and have devised various measures to prevent it. The focus of this case is to determine the reasons for this opposition, and the lawfulness of these reasons. Plaintiffs allege that Defendants have two motives for seeking to eliminate the practice of hidden-city ticketing: (i) an agreement among themselves and other airlines that they would do so; and (ii) a concern that this practice, if permitted, would undermine the Airlines' overall fare structure, including an alleged "hub premium" imposed upon passengers traveling to or from hub airports by virtue of the Airlines' alleged monopoly power at these airports. Plaintiffs further assert that the first of these motivations violates [Section 1](#) of the Sherman Act, and that the second violates [Section 2](#).

The Defendant Airlines, for their part, deny that they have acted in concert in adopting and enforcing their rules against hidden-city ticketing, deny that they possess monopoly power at their respective hub airports, and affirmatively contend that their \*181 fare structures are an economically rational and wholly lawful means to recover the fixed costs of their hub-spoke systems, notwithstanding that these fare structures might give rise to the occasional hidden-city fare anomaly. Defendants further assert that each Airline may lawfully protect its fare structure by prohibiting hidden-city ticketing, and that, in the face of these prohibitions, a passenger's attempt to employ the practice of hidden-city ticketing is tantamount to fraud.

## C. The History of the Airlines' Prohibitions on Hidden-City Ticketing

### 1. The Airlines' Tariff Rules Against Hidden-City Ticketing

Over the course of the 1980's, each of the Defendant Airlines, as well as several other airlines, adopted two tariff rules that have some bearing upon the practice of hidden-city ticketing. The first of these, Tariff Rule 100, dealt only indirectly with the practice (at least in the form initially enacted by the airlines), but the second, Tariff Rule 1, <sup>FN8</sup> was more explicit in its prohibition. These and other tariff rules are incorporated by reference into the "contract of carriage" that is a part of each passenger ticket.

FN8. U.S. Airways' version of this rule was designated Rule 150.

As an example, Northwest adopted its version of Rule 100 in 1983, and this rule provides, in pertinent part:

#### TICKETS—GENERAL

(A) No person shall be entitled to transportation except upon presentation of a valid ticket. Such ticket shall entitle the passenger to transportation only between point of origin and destination and via the routing designated thereon.

(B) Flight coupons will be honored only in the order in which they are issued, and only if all unused flight coupons and the passenger coupons are presented together.

(Defendants' Exhibits, Tab 1, A-9.) Some airlines (*e.g.*, Delta), but not others (*e.g.*, Northwest), issued detailed amendments to Rule 100 that expressly address hidden-city ticketing. Delta's 1997 version of Rule 100, for example, includes language that "specifically prohibits the practice[ ] commonly known as ... 'HIDDEN CITY/POINT BEYOND TICKETING.'" (*Id.* at A-16.)

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As noted, the Airlines' Rule 1 is more directly applicable to hidden-city ticketing. For example, Northwest's initial Rule 1, as adopted in 1983, states in pertinent part:

(E) Fares apply for travel only between the points for which they are published. Tickets may not be issued at fare(s) published to and/or from a more distant point(s) than the points being traveled, even when issuance of such tickets would produce a lower price.

(*Id.* at A-24.) By 1988, each of the Defendant Airlines had adopted this rule, or one to similar effect. Some Airlines (*e.g.*, Northwest) amended their versions of this rule to more expressly identify the means of its enforcement and consequences of its violation. As amended in 1987, Northwest's Rule 1 now provides, in pertinent part:

(E) Fares apply for travel only between the points for which they are published. Tickets may not be issued at fare(s) published to and/or from a more distant point(s) than the points being traveled, even when issuance of such tickets would produce a lower fare. When a through or connecting passenger enplanes at an intermediate point between the origin and destination shown on his/her ticket, NW may require evidence, such as a boarding pass, of use of a preceding flight for the portion of the ticket from point of origin to intermediate point. Absent such evidence, NW may require additional fare collection from the passenger for any difference between the fare paid for the ticket from origin to destination and the fare which would apply from the intermediate boarding point to the destination.

(*Id.* at A-26.)

Until the mid 1980's, one of the mechanisms used by the Airlines to enforce their tariff rules was the Air Traffic Conference ("ATC"), the predecessor to Defendant ARC.<sup>FN9</sup> In particular, ATC required that each \*182 accredited travel agent enter into a "Passenger Sales Agency Agreement," under which the agent agreed to

"adhere to and comply with" the Airlines' tariffs. (Plaintiffs' Exhibits, Tab 11, Passenger Sales Agency Agreement at 11.) The failure to do so could lead to a loss of accreditation.

FN9. ATC was a division of the Air Transport Association ("ATA"), a trade group of 22 passenger airlines (including all three of the Defendant Airlines).

In 1984, the travel agent oversight function of ATC was assumed by Defendant ARC. However, ARC abandoned ATC's practice of assisting in the enforcement of the Airlines' tariff rules, and removed any reference to tariffs from its "Agent Reporting Agreement" (the successor to ATC's "Passenger Sales Agency Agreement"). ARC's reason for doing so was an investigation conducted by the Civil Aeronautics Board ("CAB"), which had expressed antitrust concerns with any collective tariff enforcement efforts through an airline trade group. As stated in a 1992 letter from an ARC representative to Delta Air Lines:

ARC's jurisdiction does not extend to individual carrier tariff-related matters .... While under the controlling agreement of ARC's predecessor, the Air Traffic Conference, an agent was obligated to "adhere to and comply with the tariffs, rules and regulations of the carriers", ... thereby providing ATC with jurisdiction over agents failing to comply with applicable tariffs; parallel language was *not* carried over to the ARC Agent Reporting Agreement. This omission was intentional, reflecting not only the competitiveness brought about by deregulation of the airline industry, but also attendant antitrust concerns.

(*Id.*, Dep. Ex. 737.)

As for other tariff enforcement efforts by the Airlines, Plaintiffs have produced a fair amount of evidence that, at least through the late 1980's, many airlines tolerated the practice of hidden-city ticketing and, in some cases, even encouraged it.

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Plaintiffs cite various newspaper articles which, in turn, quote airline executives as stating that their companies would have to “live with” the practice and that there was little they could do to prevent it, and which quote others in the air travel industry as stating that travel agents could easily evade the airlines' uneven efforts to enforce their tariff rules against the practice. Likewise, Plaintiffs point to the deposition testimony of Jerry Strong, the manager of Northwest's agency audit department until 1988, that Northwest did not audit for hidden-city tickets while he worked in that department. Plaintiffs also have offered the affidavit of a former airline employee, Bruce Bishins, who recounts his efforts in the late 1970's and early 1980's—initially on behalf of Trans World Airlines, and then on behalf of the airlines collectively through the Air Traffic Conference—to teach the airlines' sales agents and independent travel agents how to write hidden-city tickets. Finally, Plaintiffs point to the 1988 edition of Defendant ARC's travel agent handbook, which expressly instructs agents on the practice of writing hidden-city tickets.

## **2. The Airlines' Discussions of Hidden-City Ticketing at Trade Association Meetings, and Their Formation of Industry “Fraud Prevention” Groups**

According to Plaintiffs, the economics of the airline industry changed in response to the economic downturn experienced throughout the nation in the early 1990's. The result, according to Northwest memoranda offered by Plaintiffs, was to widen the gap between business and leisure fares, thereby increasing the incentive of business travelers to seek out hidden-city ticketing opportunities, as well as other devices for avoiding high business fares. Plaintiffs also cite newspaper accounts of surveys indicating the increased employment in the late 1980's and early 1990's of the practice of hidden-city ticketing and other fare-saving devices. They further point to reports and testimony indicating that travel agents felt more pressure in this time period to sell hidden-city tickets in order to keep pace with other agents who

did so.

In Plaintiffs' view, these developments led the airlines to consider anew their responses to the practice of hidden-city ticketing. Whether or not one subscribes to this cause-and-effect theory, the record contains\*183 ample evidence that the airlines did, in fact, discuss the practice of hidden-city ticketing at various trade group meetings during this time frame. Plaintiffs trace this back to the mid-1980's, when the airlines collectively addressed a similar practice, involving international travel and known as “cross-border” ticketing, at meetings of the International Air Transport Association (“IATA”). In 1986, for example, the IATA formed a “Fraud Prevention Steering Group,” which issued a report in 1987 stating that cross-border ticketing “is not fraud in the strict sense of criminal activity” and is “virtually impossible to detect,” but “does however infringe IATA rules,” and represents a “prevalent form of revenue dilution” and a “potentially substantial threat to yield maximization.” (Plaintiffs' Exhibits, Tab 12, Dep. Ex. 206.) The report recommended that the airlines “take fraud prevention seriously,” that they “make every effort to enhance systems and procedures to detect, evaluate and eliminate fraudulent practices,” and that they take steps to “ensure that a dialogue and effective action takes place on fraud prevention measures.” (*Id.*) This report was distributed as part of the agenda for a September 1987 joint conference of the IATA and its U.S. counterpart, the ATA, which was attended by representatives of Defendants Northwest and Delta, among other airlines.

Several airlines, including Northwest and Delta, responded to these recommendations by forming a “Joint IATA/ATC Cross Border Selling Working Group,” which was charged, in part, with the task of developing and recommending solutions to the “fraud problem” created by cross-border ticketing. This group issued a 1988 report to the IATA which, among its various recommendations, proposed that the airlines report any agents who

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engaged in cross-border ticketing to the IATA Agency Administrator for “appropriate compliance action.” The report also recommended that the airlines develop in-house fraud prevention and detection programs, and that they alert other carriers whenever they detected an instance of cross-border selling involving the other carrier's tickets. Plaintiffs also offer evidence of other IATA meetings, fraud prevention seminars, and training sessions at which airline representatives discussed cross-border ticketing and possible means of preventing it.

Plaintiffs contend, in essence, that these IATA efforts served as a “blueprint” for a similar, if less overt, collective endeavor involving the domestic U.S. airlines and the domestic analogue to cross-border ticketing—namely, hidden-city ticketing. <sup>FN10</sup> This “crossover” allegedly began in 1990, when Mark Hawes, IATA's director of fraud prevention, wrote to Richard Lally, ATA's vice president for security, to propose a joint fraud prevention group that would, among other things, identify trends and “main areas” of fraud in the North American airline industry, collect and disseminate information through IATA and ATA to each airline's fraud representatives, and use industry training facilities to increase awareness of fraud prevention. (Plaintiffs' Exhibits, Tab 18.) Hawes also opined that ARC should attend this group's meetings.

<sup>FN10</sup>. Plaintiffs further assert that, in moving from a discussion of international fare-related issues to U.S. fare-related concerns, even if only at IATA meetings, the airlines crossed the line from permissible conduct to impermissible antitrust violations. In support of this proposition, they cite the testimony of Michael Levine, Northwest's former head of marketing and pricing, that the airlines' antitrust immunity extended only to discussions of international pricing issues at IATA meetings, and not to any

discussions of matters relating to domestic pricing or fares. In particular, Levine testified that “the discussion of domestic tariff abuse would not have been, in my judgment, immunized by and therefore would have been exposed in an IATA meeting.” (Plaintiffs' Exhibits, Tab 90, Levine Dep. at 593.)

The security committee of the ATA ratified this proposal in a March 1991 meeting, and a “Joint ATA/IATA North American Fraud Prevention Task Force” was formed as a result, with Defendant Northwest chairing this task force, and with representatives of Defendants U.S. Airways and ARC attending its meetings. The Northwest representative who chaired these meetings, Doug Laird, made a presentation to ATA's 1992 annual security workshop regarding the task force's activities. In addition, this task force met a number of times, during which its members \*184 discussed tariff abuse issues, including hidden-city ticketing, and shared new methods for detecting the various forms of tariff abuse. The minutes of the March 17, 1993 meeting of this task force, for example, reflect a discussion as to whether practices such as hidden-city ticketing should be considered “simply as tariff matters,” and thus outside the reach of ARC's enforcement role, or whether these practices should be “characterized as fraud,” in light of their “elements of deception and dishonesty that were prejudicial to the airlines.” (Plaintiffs' Exhibits, Tab 34, 3/17/93 Meeting Minutes at 6.) The minutes further indicate an agreement among the membership “that there were indeed problems in this area and that there was a need for an increasing awareness of these practices,” but that “no positive action was proposed.” (*Id.*)

In addition to suggesting the formation of this task force, IATA also, according to Plaintiffs, played an active role in urging airlines to combat various forms of even domestic “ticket fraud,” including hidden-city ticketing. For example, IATA conducted a fraud prevention seminar in April of

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1992 in Miami, during which a representative of American Airlines discussed methods of preventing hidden-city ticketing and other types of practices. The agenda for this seminar compared ticket fraud to shoplifting, stated that “[i]ndustry cooperation” was a “critical element in combating fraud,” and set forth as the goal of the seminar to increase “industry consideration of ticket fraud and to establish what positive steps can be taken to improve industry responses.” (Plaintiffs’ Exhibits, Tab 19, ATA 01532.) In addition, Mark Hawes made a presentation at this seminar, and observed that “[a]nyone who has experience of policing well knows that the important thing is not necessarily how many you catch but how many you deter; and that unless a certain degree of ‘presence’ is apparent, the risk is that things can deteriorate to a level where recovery is at best painful and at worst impossible.” (*Id.*, Dep. Ex. 389 at 4.) Hawes further opined that “if we don’t want to lose control we need to have a clear message,” and that “[w]e need to be telling the market that attempts to defraud airlines will be discovered and dealt with severely.” (*Id.*) <sup>FN11</sup>

**FN11.** Other such fraud prevention seminars were held in 1993, 1994, and 1995. Hawes made another presentation at the 1993 seminar, in which he again made many of the same points. At the 1994 seminar, United Airlines’ head of corporate security, Ken Gilbert, gave a presentation on “tariff abuse” in which he addressed hidden-city ticketing. The participants have confirmed that hidden-city ticketing also was discussed at a workshop during the 1995 seminar.

Regarding the impact of these IATA efforts, Plaintiffs point, for example, to the testimony of United’s head of corporate security, Ken Gilbert, who stated:

Q: Prior to the issue being raised at the International Airline Transportation Association—that is IATA, correct?

A: Correct.

Q: Was United seeking to prohibit back-to-back ticketing?

A: Not in a very active way.

Q: Would the same answer be for hidden-city ticketing?

A: Correct.

Q: United was not actively enforcing hidden-city ticketing. Correct?

A: Not unless somehow or another we determined that a particular agency was very abusive in that area.

Q: So it was the people at IATA that stirred up the fire to start enforcing hidden-city ticketing and back-to-back in a more active way?

A: I don’t know that I would characterize them as being the pot stirrer, but if you want to, that’s fine, I guess.

Q: Well, would you consider—who stirred the pot for United Airlines, if they were not actively enforcing it prior to that time?

A: To the extent that tariff abuse was an agenda item on any of these meetings, some abusive practices were discussed. And more carriers were saying, yeah, we think this is a big problem. So I don’t know if we were saying IATA did it first or ATA did it first, just it all got going kind of at the same time.

\*185 (Plaintiffs’ Exhibits, Tab 82, Gilbert Dep. at 92–93.)

Plaintiffs also offer other evidence of the Airlines’ alleged use of IATA as a means of taking collective action against hidden-city ticketing. They note, for instance, that IATA’s annual fraud survey for 1992 asked airlines to estimate their losses from various practices, including hidden-city ticketing,

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and that IATA's 1992 report of its 1991 fraud survey identified the "areas of most concern" as encompassing "tariff abuse including cross border or hidden city fares." (Plaintiffs' Exhibits, Tab 22, Dep. Ex. 383.) Moreover, in November of 1992, IATA issued a version of its "Fraud Detection Training Handbook" that addressed "'Cross Border Sales' (or Hidden City Fares as it is called in the US)." (Plaintiffs' Exhibits, Tab 14, Dep. Ex. 102, § 13 at 1.) IATA conducted another survey in 1993, and again urged industry cooperation in addressing the issue of fraud.

According to Plaintiffs, these meetings, task forces, and the like led the Defendant Airlines and other domestic air carriers to adopt a uniform stance that hidden-city ticketing was a fraudulent practice that should be prevented. As evidence of this purported collective decision, Plaintiffs point first to a June 1992 memo by Donna Kizer-Devine, a regional manager in Defendant Delta's corporate security department, recounting what she had learned at the 1992 IATA fraud prevention seminar in Miami. This memo restated the recommendation of Mark Hawes that "the airline industry must tell the market that attempts to defraud the airlines ... will be discovered and dealt with severely," and that a "proactive stance is necessary ... because what is important is how many are deterred, not how many are caught." (Plaintiffs' Exhibits, Tab 19, Dep. Ex. 407.)<sup>FN12</sup> More generally, Plaintiffs cite the testimony of various airline officials that the information shared at industry meetings gave them a better understanding of (i) the extent of the problem of tariff abuse, (ii) the best use of their resources to combat tariff fraud, and (iii) the efforts used by other airlines to prevent such occurrences.

<sup>FN12</sup> Plaintiffs note that, shortly after this memo was sent, Delta reorganized its corporate security department and began, for the first time, to address the general issue of "loss prevention." However, the record does not support Plaintiffs' further suggestion that this loss prevention

program was directed in part at the practice of hidden-city ticketing. To the contrary, Delta's security personnel, when questioned at their depositions, did not seem particularly familiar with the practice of hidden-city ticketing, nor did they state that the 1992 reorganization of Delta's corporate security department encompassed any particular effort to deter hidden-city ticketing.

Plaintiffs also assert that this alleged collective decision led to Defendant ARC's formation of a "Fraud Prevention Advisory Committee" in late 1992, for the stated purpose of assisting ARC's management in the development of a "Fraud Program." Several of the members of this committee, including representatives of all three Defendant Airlines, previously had participated in ATA's fraud prevention task force. Plaintiffs offer evidence that this committee provided another means through which the airlines were able to share information regarding hidden-city ticketing practices and prohibitions.

### 3. Other Alleged Examples of Collective Efforts to Eliminate Hidden-City Ticketing

In addition to this trade group involvement with hidden-city ticketing issues, Plaintiffs point to other evidence which, in their view, is suggestive of a collective effort by the airlines in the early 1990's to eliminate this practice. First, they cite Defendant Northwest's development of certain computer software, the Passenger Revenue Accounting ("PRA") system, which Northwest and its business partner, Andersen Consulting, began to share with other airlines in 1992.<sup>FN13</sup> While the PRA system apparently does not directly identify instances of hidden-city ticketing, Plaintiffs have produced evidence that it facilitates the detection of this practice, as part of its general detection of tariff violations,\*186 by automating the ticket auditing process that previously had been performed manually, and thereby identifying potential tariff violations that could be further investigated by an

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airline's revenue accounting staff.

**FN13.** In May of 1992, Northwest licensed the PRA system to Andersen, which in turn began to license and market the software to other airlines through a wholly-owned subsidiary called PRA Solutions. PRA Solutions formed an advisory board, consisting of one representative from each airline which had purchased a software update service.

Plaintiffs further point to evidence that, beginning in 1992, the airlines touted their improved technology and computer systems for detection of such practices as hidden-city ticketing. A March 30, 1992 article in the Atlanta Journal and Constitution, for example, quoted Delta Air Lines executive Bob Blumberg as stating at a conference of travel agents that “Delta and other carriers are developing software to combat such tactics” as hidden-city ticketing, and that “the new systems, due to roll out in the next 12 to 24 months, will audit every ticket to match the segments flown with the reservation made.” (Plaintiffs' Exhibits, Tab 26, Dep. Ex. 370.)

Plaintiffs also have placed into the record various warning letters issued by the airlines to travel agents regarding the practice of hidden-city ticketing. In June of 1992, for example, Defendant Northwest prepared a form letter reminding travel agents that “[d]omestic published tariffs prohibit hidden-city and point-beyond ticketing,” and cautioning that “Northwest Airlines will audit all agencies believed to be ticketing hidden cities ... regardless of agency size or geographic location.” (Plaintiffs' Exhibits, Tab 26, NWC 0039123.) Northwest also issued a letter to a particular travel agent in July of 1992, noting an apparent hidden-city ticketing “discrepanc[y],” and warning that such “violations are considered fraudulent by Northwest Airlines and will not be tolerated.” (Plaintiffs' Exhibits, Tab 28, NW 63768.) Plaintiffs also have produced a September 9, 1992 newspaper article recounting warnings issued by Defendants

Delta and Northwest to travel agents regarding hidden-city and other such ticketing practices.

Next, Plaintiffs cite evidence of communications among the airlines' fraud prevention personnel regarding tariff abuse and, more specifically, hidden-city ticketing. For example, Ken Gilbert of United testified about the formation of an ATA fraud task force in 1992 or 1993, and confirmed that the airlines' security directors used the meetings of this task force to discuss problems of tariff abuse, including hidden-city ticketing, and to share new methods for detecting such abuses. Continental Airlines' director of fraud prevention, Fred Koch, testified to similar sorts of discussions with his colleagues at other airlines. Plaintiffs further cite mid-1992 Northwest memoranda that disclose information obtained from the airline's competitors regarding their various efforts to monitor and enforce hidden-city ticket prohibitions.

Finally, Plaintiffs have presented evidence of Defendant Northwest's attempt in the fall of 1993 to enlist ARC in the effort to identify and eliminate hidden-city ticketing. An August 1993 internal Northwest memo surveyed various industry groups, including IATA, ATA, and ARC, in an effort to identify a “policyperson” on the matters of hidden-city and back-to-back ticketing, but reported that an ARC representative “strongly feels that [ARC] would not be willing to intervene on this issue,” in light of possible antitrust concerns. (Plaintiffs' Exhibits, Tab 34, Dep. Ex. 605.) Nevertheless, at an ARC Executive Committee meeting in September of 1993, attended by representatives of all three Defendant Airlines, Northwest executive Mark Osterberg proposed “that ARC look into the possibility of detecting and enforcing tariff violations such as back-to-back ticketing and hidden city ticketing,” and “it was agreed that ARC would examine the issue, including technical and legal concerns.” (Plaintiffs' Exhibits, Tab 34, Dep. Ex. 400 at ARC00109.) This matter was again raised at the next Executive Committee meeting in

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October of 1993.

In support of its proposal, Northwest argued that “[t]ariff violations result in *theft*,” and that such violations came within ARC’s right to enforce the “Agent Reporting Agreement” governing each travel agent. (*Id.* at ARC00124.) Northwest further asserted that “each airline could individually enforce tariff rules,” but that “enforcement of certain published tariffs by ARC would likely be more efficient and effective,” in part because “known enforcement would likely *deter* violations,” which was the “real objective of enforcement.” (*Id.*) Northwest also provided a \*187 letter to ARC’s general counsel stating that it had “analyzed the antitrust implications” of using ARC to police hidden-city and back-to-back ticketing practices, and had concluded that “ARC may enforce travel agency compliance with airline rules without fear of violating the antitrust laws.” (Plaintiffs’ Exhibits, Tab 34, Dep. Ex. 399 at ARC00317.) Despite these efforts, Northwest’s proposal was not adopted. FN14

FN14. The proposal apparently was never formally voted upon, but was merely tabled, for reasons that do not appear in the record.

#### D. Plaintiffs’ Specific Claims of Sherman Act Violations

Against this factual backdrop, the Court now turns to Plaintiffs’ specific claims in this case. First, Plaintiffs allege that the Defendant Airlines, ARC, and other non-party airlines agreed among themselves to deter the practice of hidden-city ticketing, allegedly so that this practice would not jeopardize each Airline’s ability to charge supra-competitive fares for travel on many of the routes to and from its hub airports. Plaintiffs assert that this was a conspiracy in restraint of trade, in violation of § 1 of the Sherman Act, 15 U.S.C. § 1.

As the Court observed at the November 14, 2001 hearing, and as acknowledged by Plaintiffs’ counsel, the precise form of this alleged conspiracy

has evolved through further development of the factual record. Initially, Plaintiffs alleged “that competing carriers conspired through ARC to successfully implement [the Airlines’] refusal to sell policy.” *Chase*, 49 F.Supp.2d at 564. It is now plain that ARC was not the instrument through which the Airlines implemented their hidden-city ticket prohibitions; indeed, as noted earlier, the Court has concluded that ARC is entitled to summary judgment for lack of evidence that it even participated in a conspiracy to adopt or enforce such prohibitions. Instead, Plaintiffs now allege that, in the early 1990’s, the Airlines abandoned their past, disparate policies and enforcement efforts regarding hidden-city ticketing, and collectively adopted a uniform stance designed to substantially deter the practice of hidden-city ticketing, focused around a collective determination that this practice should be deemed “fraudulent” and treated as “tariff abuse.”

Next, Plaintiffs have asserted claims against each of the individual Defendant Airlines under § 2 of the Sherman Act, 15 U.S.C. § 2. Plaintiffs allege that each of the Airlines possesses monopoly power over many of the “city-pair” markets that offer air travel to or from the Airline’s hub airports. FN15 Plaintiffs further allege that each Airline has exercised this monopoly power in an anticompetitive manner by prohibiting the practice of hidden-city ticketing, and thereby defeating a mechanism through which consumers in the relevant city-pair markets could otherwise avoid the supra-competitive “hub premiums” imposed by the Airlines in these markets.

FN15. As noted earlier, Plaintiffs and their experts have identified seven hub airports and 234 city-pairs upon which their claims in this case are based. Their § 2 claims, however, exclude certain of these city-pairs that involve routes between two airlines’ hub airports.

These § 2 claims rest principally upon the expert testimony of economist John C. Beyer,

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Ph.D., and his colleague, Dr. Gary French, who have opined: (i) that the Defendant Airlines possess monopoly power in the relevant city-pair markets; (ii) that they have exercised this power to charge “hub premiums” for travel in these markets, thereby giving rise to the hidden-city fare phenomenon; and (iii) that the members of the various Plaintiff classes have been overcharged in an aggregate amount in excess of \$950 million, beyond what these air travelers would have paid if the Airlines had not prevented them from taking advantage of competitive hidden-city fares for travel on the desired hub-spoke routes.<sup>FN16</sup>

**FN16.** Defendants previously filed a motion to exclude the proposed testimony of Plaintiffs' experts as failing to satisfy the standards of [Fed.R.Evid. 702](#). In a recently issued Opinion and Order, the Court rejected this challenge, finding that Plaintiffs' expert testimony satisfied the Court's gatekeeping inquiry under [Rule 702](#), at least under the present evidentiary record. As discussed below, this ruling somewhat foretells the defeat of several of the Airlines' present arguments in support of their motion for summary judgment and in opposition to Plaintiffs' motion for class certification.

**\*188 III. THE DEFENDANT AIRLINES' MOTION FOR SUMMARY JUDGMENT**

**A. The Standards Governing Defendants' Motion**

In their present motion, the Defendant Airlines seek summary judgment in their favor on Plaintiffs' antitrust claims under both [Section 1](#) and [Section 2](#) of the Sherman Act. This motion, of course, is governed by the familiar standards set forth in [Federal Rule of Civil Procedure 56](#), under which summary judgment is proper “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to

judgment as a matter of law.” [Fed.R.Civ.P. 56\(c\)](#).

Three 1986 Supreme Court cases—[Matsushita Elec. Indus. Co. v. Zenith Radio Corp.](#), 475 U.S. 574, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986), [Anderson v. Liberty Lobby, Inc.](#), 477 U.S. 242, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986), and [Celotex Corp. v. Catrett](#), 477 U.S. 317, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986)—ushered in a “new era” in the federal courts' review of motions for summary judgment. These cases, in the aggregate, lowered the movant's burden in seeking summary judgment.<sup>FN17</sup>

As explained in [Celotex](#):

**FN17.** “[T]aken together, these three cases signal to the lower courts that summary judgment can be relied upon more so than in the past to weed out frivolous lawsuits and avoid wasteful trials.” 10A Charles Alan Wright, Arthur R. Miller & Mary Kay Kane, [Federal Practice & Procedure](#), § 2727, at 468 (1998) (footnote omitted).

In our view, the plain language of [Rule 56\(c\)](#) mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial.

[Celotex](#), 477 U.S. at 322, 106 S.Ct. at 2552. In considering a defendant's motion for summary judgment, then, the question is “whether a fair-minded jury could return a verdict for the plaintiff on the evidence presented,” and the “mere existence of a scintilla of evidence in support of the plaintiff's position” is insufficient to satisfy this test. [Anderson](#), 477 U.S. at 252, 106 S.Ct. at 2512. When performing this inquiry, “[t]he evidence of the non-movant is to be believed, and all justifiable inferences are to be drawn in his favor.” 477 U.S. at 255, 106 S.Ct. at 2513.

These same principles govern, of course, in cases brought under the Sherman Act. In fact, one

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of the Supreme Court's above-cited trilogy of summary judgment decisions, *Matsushita*, itself was an antitrust case. As in other complex fields, however, substantive antitrust law has placed a gloss upon the traditional standards for resolving a motion for summary judgment. The *Matsushita* Court observed that “antitrust law limits the range of permissible inferences from ambiguous evidence in a § 1 case,” and that, to withstand a motion for summary judgment, a plaintiff “must present evidence that tends to exclude the possibility that the alleged conspirators acted independently” *Matsushita*, 475 U.S. at 588, 106 S.Ct. at 1356 (internal quotations and citation omitted). Similarly, under § 2, if a defendant advances a legitimate business explanation for its allegedly anticompetitive conduct, the plaintiff must produce probative evidence tending to rebut this explanation in order to defeat a motion for summary judgment. See *Beard v. Parkview Hosp.*, 912 F.2d 138, 145 (6th Cir.1990). With these principles in mind, the Court turns to Defendants' motion.

## **B. Plaintiffs' Section 1 Antitrust Conspiracy Claim**

### **1. The Defendant Airlines Are Not Entitled to Summary Judgment Under the So-Called “Fraud Prevention” Exception to Sherman Act Liability.**

The cornerstone of Defendants' present challenge to Plaintiffs' Section 1 antitrust conspiracy claim is set forth with unmistakable clarity in the Airlines' brief, where they declare that the practice of hidden-city ticketing “is fraud.” (Defendants' Motion, Br. in Support at 11.) Defendants then explain:

[Hidden-city ticketing] is an intentional effort on the part of a passenger to trick an \*189 airline through false pretenses into selling transportation services at a price that the airline would not be willing to accept if the passenger had truthfully represented his intended itinerary. In doing so, the passenger also breaches his contract of

carriage with the airline. Misrepresenting one's intended itinerary to get air transportation services at a price the airline would not otherwise have charged is no different from lying to get a bereavement fare, misrepresenting one's age to get a senior citizen discount at the movies, or switching price tags on merchandise at a grocery store.

(*Id.*) Having thus stated their premise, Defendants appeal to decisions in which the Supreme Court recognized that certain exchanges of information among competitors do not run afoul of § 1 of the Sherman Act, where such exchanges are necessary to prevent fraud. It follows, in Defendants' view, that the Airlines' joint discussions of hidden-city ticketing at trade association meetings and on other occasions do not give rise to Sherman Act liability for an antitrust conspiracy.

In considering this contention, it is helpful to begin with the Supreme Court decision that first established a “fraud prevention” exception to antitrust liability. In *Cement Mfrs. Protective Ass'n v. United States*, 268 U.S. 588, 590–91, 45 S.Ct. 586, 587, 69 L.Ed. 1104 (1925), the Court addressed the antitrust implications of a trade association of cement manufacturers that was formed for the stated purpose of collecting and disseminating “such accurate information as may serve to protect each manufacturer against misrepresentation, deception and imposition, and enable him to conduct his business exactly as he pleases in every respect.” The Government brought suit against this trade association and its members, charging that certain of the association's practices violated § 1 of the Sherman Act, and requesting that it be enjoined from further such violations.

At the outset of its analysis, the Court observed that “[c]ement is a thoroughly standardized product,” that the manufacturers which comprised the membership of the defendant association were “competitors in the business of shipping the product in interstate commerce,” and that, even before this

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association was formed, “there was substantial uniformity of trade practices in the cement trade,” so that the adoption of such practices by cement manufacturers was not the product of any conspiracy among association members. 268 U.S. at 591, 593, 45 S.Ct. at 587. The Court then described the particular conduct challenged by the Government, relating to “specific job contracts”:

The specific job contract is a form of contract in common use by manufacturers of cement whereby cement is sold for future delivery for use in a specific piece of construction which is described in the contract. As was stated in the opinion of the court below, they are contracts “whereby a manufacturer is to deliver, in the future, cement to be used in a specific piece of work, such as a particular building or road, and the obligation is that the manufacturer shall furnish and the contractor shall take only such cement as is required for or used for the specific purpose.” These contracts have, by universal practice, been treated by cement manufacturers as, in effect, free options customarily made and acted upon on the understanding that the purchaser is to pay nothing until after the delivery of the cement to him; that he is not obligated in any event to take the cement contracted for unless he chooses to; that he is not held to the price named in the contract in the event of a decline in the market price; whereas the manufacturer may be held to the contract price if the market advances and may be held for the delivery of the full amount of cement required for the completion of the particular piece of construction described in the contract. The practical effect and operation of the specific job contract therefore is to enable contractors who are bidding upon construction work to secure a call or option for the cement required for the completion of that particular job at a price which may not be increased, but may be reduced if the market declines. It enables contractors to bid for future construction work with the assurance that the requisite cement will be available at a

definitely ascertained maximum price.

**\*190** In view of the option features of the contract referred to, the contractor is involved in no business risk if he enter into several specific job contracts with several manufacturers for the delivery of cement for a single specific job. The manufacturer, however, is under no moral or legal obligation to supply cement except such as is required for the specific job. If, therefore, the contractor takes advantage of his position and of the peculiar form of the specific job contract, as modified by the custom of the trade, to secure deliveries from each of several manufacturers of the full amount of cement required for the particular job, he in effect secures the future delivery of cement not required for the particular job, which he is not entitled to receive, which the manufacturer is under no legal or moral obligation to deliver, and which presumably he would not deliver if he had information that it was not to be used in accordance with his contract. The activities of the defendants complained of are directed toward securing this information and communicating it to members, and thus placing them in a position to prevent contractors from securing future deliveries of cement which they are not entitled to receive under their specific job contracts, and which experience shows they endeavor to procure especially in a rising market.

Members are required to make to the secretary of the association prompt reports of all specific job contracts, describing in detail the contract and giving the name and address of the purchaser; the amount of cement required, the price and delivery point; also the date of expiration of the contract .... The association also employs “checkers,” whose business it is, by actual inspection and inquiry, to ascertain, so far as possible, the amount of cement required for specific jobs referred to in specific job contracts, and whether cement shipped under specific job contracts is actually used or required for use under such

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contracts .... [W]e accept fully the government's contention that the defendants regularly take all practicable steps to ascertain whether cement contracted for under the specific job type of contract was actually being used for the job described in the contract, and that the fullest information with respect to such contracts and the use of cement shipped under said contracts is reported to the members of the association through the mediation of the secretary.

The government does not contend that the activities of the association with respect to specific job contracts diminished the number of such contracts, or that they diminished in any way the obligations of members of the association upon such contracts. There is, however, abundant evidence to show that there were actual cancellations of deliveries on the ground that contractors were not entitled, under the terms of their contracts, to receive such deliveries. In 1920, of 1,392 contracts investigated and found to be "padded" to the extent of more than 3,500,000 barrels of cement, 978 were partially canceled to the extent of 2,014,653 barrels.

268 U.S. at 594–97, 45 S.Ct. at 588–89.

While conceding that there was no "agreement or understanding between the defendants placing limitations on either prices or production," the Government nonetheless charged that "uniformity of prices and limitation of production [we]re necessary results" of the manufacturers' sharing of information concerning specific job contracts. 268 U.S. at 592, 45 S.Ct. at 587. Even assuming such indirect effects, however, the Supreme Court held that, under the circumstances, the dissemination of specific job contract information among association members did not constitute an unlawful conspiracy in restraint of trade:

That a combination existed for the purpose of gathering and distributing [specific job contract] information is not denied. That a consequence of

the gathering and dissemination of information with respect to the specific job contracts was to afford, to manufacturers of cement, opportunity and grounds for refusing deliveries of cement which the contractors were not entitled to call for, an opportunity of which manufacturers were prompt to avail themselves, is also not open to dispute. We do not see, however, in the activity of the defendants with respect to specific job contracts any basis for the contention that \*191 they constitute an unlawful restraint of commerce. The government does not rely on any agreement or understanding among members of the association that members would either make use of the specific job contract, or that they would refuse to deliver "excess" cement under specific job contracts. Members were left free to use this type of contract and to make such deliveries or not as they chose .... It may be assumed, however, if manufacturers take the precaution to draw their sales contracts in such form that they are not to be required to deliver cement not needed for the specific jobs described in these contracts, that they would, to a considerable extent, decline to make deliveries, upon receiving information showing that the deliveries claimed were not called for by the contracts.

Unless the provisions in the contract are waived by the manufacturer, demand for and receipt of such deliveries by the contractor would be a fraud on the manufacturer, and in our view the gathering and dissemination of information which will enable sellers to prevent the perpetuation of fraud upon them, which information they are free to act upon or not as they choose, cannot be held to be an unlawful restraint upon commerce, even though in the ordinary course of business most sellers would act on the information and refuse to make deliveries for which they were not legally bound.

.... [W]e cannot regard the procuring and dissemination of information which tends to

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prevent the procuring of fraudulent contracts or to prevent the fraudulent securing of deliveries of merchandise on the pretense that the seller is bound to deliver it by his contract, as an unlawful restraint of trade even though such information be gathered and disseminated by those who are engaged in the trade or business principally concerned.

268 U.S. at 603–04, 45 S.Ct. at 591.

In so ruling, the Court cited a case decided the same day, *Maple Flooring Mfrs. Ass'n v. United States*, 268 U.S. 563, 45 S.Ct. 578, 69 L.Ed. 1093 (1925), involving the activities of a trade association of corporations engaged in the business of selling wood flooring. The defendant association gathered from and disseminated to its members information concerning (i) the average cost to members of various dimensions and grades of flooring, (ii) standard freight rates for shipment of flooring, (iii) quantities and kinds of flooring sold, and (iv) the prices charged by members for these sales. In that case, the Government “neither alleged nor proved that there was any agreement among the members of the association either affecting production, fixing prices, or for price maintenance,” and the constituent members of the trade association remained “free to sell their product at any price they cho[ ]se and to conduct their business as they please[d].” 268 U.S. at 567, 45 S.Ct. at 579. “On the contrary, the defendants offered a great volume of evidence tending to show that the trend of prices of the products of the defendants corresponded to the law of supply and demand and that it evidenced no abnormality when compared with the price of commodities generally.” 268 U.S. at 567–68, 45 S.Ct. at 579.

Under these facts, the Court held that the defendant trade association's compilation and distribution of historical information regarding the activities of its constituent members did not, standing alone, violate the Sherman Act:

We realize that such information, gathered and

disseminated among the members of a trade or business, may be the basis of agreement or concerted action to lessen production arbitrarily or to raise prices beyond the levels of production and price which would prevail if no such agreement or concerted action ensued, and those engaged in commerce were left free to base individual initiative on full information of the essential elements of their business. Such concerted action constitutes a restraint of commerce and is illegal and may be enjoined .... But in the absence of proof of such agreement or concerted action having been actually reached or actually attempted, under the present plan of operation of defendants we can find no basis in the gathering and dissemination of such information by them or in their activities under their present organization for \*192 the inference that such concerted action will necessarily result ....

We decide only that trade associations or combinations of persons or corporations which openly and fairly gather and disseminate information as to the cost of their product, the volume of production, the actual price which the product has brought in past transactions, stocks of merchandise on hand, approximate cost of transportation from the principal point of shipment to the points of consumption as did these defendants and who, as they did, meet and discuss such information and statistics without however reaching or attempting to reach any agreement or any concerted action with respect to prices or production or restraining competition, do not thereby engage in unlawful restraint of commerce.

268 U.S. at 585–86, 45 S.Ct. at 585–86.

[1] Upon reviewing the decisions in *Cement Manufacturers* and *Maple Flooring*, the Court finds that they speak to some aspects of the present case, but not to others. In the former category, at least some of the information gathered and disseminated by airline industry groups, including the IATA and

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the ATA, concerned the airlines' individual, historical efforts at tariff enforcement. This activity falls within the rule of *Maple Flooring*—namely, while such information might conceivably be used as an aid to collective efforts, it is not unlawful, in itself, to gather and share such information as to past practices, so long as this activity is not a stepping stone to concerted anticompetitive measures.

Moreover, regarding Defendants' claim of “fraud prevention” within the rule of *Cement Manufacturers*, Plaintiffs apparently do not dispute that the practice of hidden-city ticketing requires a passenger to breach an airline's tariff rules and contract of carriage, which are incorporated by reference into the conditions of sale of each ticket purchased. In this sense, a passenger must “misrepresent” his intended itinerary, impliedly stating as he purchases the ticket that he wishes to travel the entire spoke-hub-spoke route, but knowing that he instead will discard the tickets for travel to and from the point beyond his true destination. To this extent, then, the situation here is like the one presented in *Cement Manufacturers*, where contractors breached their contracts with cement manufacturers by representing that several different purchases of cement all were earmarked for use in a single project.

However, there are a number of ways in which the rubric of “fraud prevention” does not precisely carry over from *Cement Manufacturers* to this case. First, in *Cement Manufacturers*, the contractual limitation upon a contractor's purchase of cement—namely, that the cement must be used on a specific job—presumably was a *quid pro quo* for the manufacturer's agreement to “lock in” the maximum price for that purchase, with the manufacturer bearing the full risk of any intervening price increases. When a contractor violated this contractual limitation, purchasing cement that would not be used on the job specified in the contract, the contractor received something *more* than the bargained-for benefit, thereby

disrupting the seemingly settled expectations of *both* contracting parties. It can be assumed, moreover, that the contractor was aware that “padded” purchases were contrary to the business arrangement as established and agreed to by the parties. Under these circumstances, there was no question as to the unlawful nature of the contractor's conduct in representing that each of several purchases of cement was intended for use in the same project.

This case, in contrast, involves the unilateral imposition by the Airlines of an additional condition of sale—a condition of which, it seems fair to say, many passengers are not even aware. Although Defendants suggest that a passenger's knowledge of the airlines' tariff rules is irrelevant, the very case they cite confirms that fraud requires a misrepresentation that is “calculated or intended to deceive” the injured party. *VanDenBroeck v. CommonPoint Mortgage Co.*, 210 F.3d 696, 701 (6th Cir.2000). Package discount pricing is commonplace in many industries—children's meals at fast food restaurants and automobile luxury packages are two examples that come to mind—and the average consumer presumably would not perceive that his purchase of such a package would \*193 serve as an implied “representation” that he intends to use each and every part of that package, much less that he might be accused of fraud or deception if he chooses to discard a particular portion. While the Airlines surely would prefer to know in advance whether a passenger intends to travel on each segment for which he purchased a ticket—so that, for instance, they can sell tickets for any unused seats, and can plan their operations based on a more accurate count of passengers—their business objectives do not automatically trigger a passenger's duty to disclose his true itinerary, nor do they transform his silence on the subject into an “intent to deceive.” In short, the question of “fraud” here involves a fact-intensive inquiry of a sort that was not needed in *Cement Manufacturers*.<sup>FN18</sup>

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FN18. Indeed, Plaintiffs point to evidence that the airlines have not always treated the practice of hidden-city ticketing as “fraud,” but that, to the contrary, some airlines publicly encouraged the practice in the past, and taught travel agents how to write such tickets at industry seminars. It would be difficult to establish the requisite “intent to deceive” where the purportedly injured party has propagated different views of what it considers “deception.”

Of course, a duty to disclose *may* be imposed by contract, and this arguably is what the Airlines have done. Even so, however, the situation here is different from the one presented in *Cement Manufacturers*, where, as noted, the contractors received a benefit in exchange for their agreement to a limiting contractual term. Here, the tariff rules incident to a passenger ticket are not the subject of negotiations, but instead are presented to the passenger on a take-it-or-leave-it basis, almost as in a contract of adhesion. It cannot be said here, as it could in *Cement Manufacturers*, that a contracting party expressly and knowingly agreed to a limiting condition in exchange for a particular benefit, and then, having received the benefit, refused to adhere to the condition. In addition, even accepting the enforceability of the Airlines' hidden-city prohibitions as a matter of contract law, it is well established that the breach of a contractual obligation cannot support a claim of fraud. *See, e.g., Brock v. Consolidated Biomedical Lab.*, 817 F.2d 24, 25–26 (6th Cir.1987).

More importantly, Defendants' appeal to “fraud prevention” begs one of the central questions in this case—namely, whether the Airlines' prohibition on hidden-city ticketing is an anticompetitive practice that violates the Sherman Act. In *Cement Manufacturers*, there was no claim that the underlying industry practice of using specific job contracts was itself anticompetitive, or that any manufacturer's use of this practice was the product of concerted action. Moreover, the Government did

not challenge the right of each individual manufacturer to adopt measures to enforce the terms of its own specific job contracts; indeed, the Government presumably would not have challenged even a *concerted* enforcement effort, but for its claim that “uniformity of prices and limitation of production [we]re necessary results” of this joint endeavor. *Cement Mfrs.*, 268 U.S. at 592, 45 S.Ct. at 587. In rejecting the Government's claim, the Court found that the only price and production effects that had resulted from the defendants' collective information-gathering effort were those that “would naturally flow from the dissemination of that information in the trade and its natural influence on individual action.” 268 U.S. at 606, 45 S.Ct. at 592.

Here, by contrast, Plaintiffs' § 2 claim expressly challenges the lawfulness of each Airline's individual prohibition on hidden-city ticketing, alleging that this represents the anticompetitive exercise of each Defendant's alleged monopoly power, with an attendant impact upon the price of travel to or from Defendants' hub airports. Clearly, an individual Airline could not immunize itself from Sherman Act liability merely by characterizing the prohibited practice as “fraudulent” and enacting rules to prevent it. Just as clearly, § 1 would forbid any collective effort by Defendants to prohibit a practice that each could not lawfully proscribe on its own.<sup>FN19</sup> Thus, while *Cement Manufacturers* \*194 did not address the propriety of an industry practice, but only the collective means of its enforcement, the present case implicates both questions, and the two are intertwined. The success of Defendants' appeal to “fraud prevention,” then, necessarily depends to a degree upon their success in defeating Plaintiffs' § 2 claims, and factual issues as to the latter—a question addressed below—would preclude summary judgment as to the former.

FN19. Notably, the converse is not necessarily true—*i.e.*, even if one Airline could act unilaterally against hidden-city

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ticketing, it does not necessarily follow that the Airlines collectively could agree to do so.

More generally, Defendants' "fraud prevention" argument misconceives the nature of Plaintiffs' complaint about the Airlines' prohibition on hidden-city ticketing. Plaintiffs do not claim any "entitlement" to purchase hidden-city tickets, but presumably would be pleased to purchase tickets reflecting their actual hub-spoke itineraries, so long as the price of these tickets did not include a hub "premium" imposed as a product of an Airline's alleged monopoly power. Likewise, Plaintiffs presumably would not balk at disclosing their true hub-spoke travel plans to the Airlines, provided that they were required to pay only the discounted price that reflected any hidden-city savings opportunity. Indeed, according to Plaintiffs' experts, if Defendants are enjoined from enforcing their prohibitions on hidden-city ticketing, the Airlines' eventual response will be to lower their hub-spoke fares, thereby defeating their passengers' incentive to "misrepresent" their itineraries in order to obtain a cheaper hidden-city fare. In sum, while misrepresentation was the lynchpin of the scheme employed by the contractors in *Cement Manufacturers*, and the means through which they sought to avoid paying the prevailing market price in effect at the time they actually needed additional cement, the species of "fraud" practiced by airline customers in this case is not an essential prerequisite to the achievement of the fare structure sought by Plaintiffs, but is only a byproduct of these customers' "self-help" efforts to circumvent an allegedly unlawful pricing scheme imposed by the Airlines.

In any event, even accepting Defendants' characterization of hidden-city ticketing as "fraud," the Court still would find that the rule of *Cement Manufacturers* does not apply here, at least not as a matter of law. In *Cement Manufacturers*, the Supreme Court observed that the defendants' collective effort to gather and disseminate

information about specific job contracts "enable[d] sellers to prevent the perpetration of a fraud upon them." *Cement Mfrs.*, 268 U.S. at 603–04, 45 S.Ct. at 591 (emphasis added). Absent this sharing of information, it would have been far more difficult, if not impossible, for any individual manufacturer to uncover a contractor's "padded" purchase of excess cement, beyond the amount needed to complete a specific project. Thus, *Cement Manufacturers* stands only for the limited proposition that the Sherman Act does not prohibit "the procuring and dissemination of information **which tends to prevent the procuring of fraudulent contracts.**" 268 U.S. at 604, 45 S.Ct. at 591 (emphasis added); see also *United States v. Container Corp. of America*, 393 U.S. 333, 335, 89 S.Ct. 510, 511, 21 L.Ed.2d 526 (1969) (explaining that *Cement Manufacturers* allowed the exchange of price information among competitors "as a means of protecting their legal rights from fraudulent inducements to deliver more cement than needed for a specific job").

Defendants can advance no such justification for any concerted efforts in this case. To the contrary, as part of a different challenge to Plaintiffs' § 1 claim, discussed in detail below, Defendants assert that each individual Airline has its own independent business reasons for prohibiting hidden-city ticketing. As proof of this point, Defendants offer evidence that each Airline separately adopted its prohibition at a different time and in a different form, and that each has taken a different approach to enforcing its separate prohibition. This argument belies the proposition that collective action "enabled" the Airlines to uncover and prevent any instances of hidden-city ticketing. Similarly, nothing in the record suggests that the Airlines must collectively gather or share information in order to enforce their respective prohibitions; rather, the practice of hidden-city ticketing involves only a single Airline, and any individual occurrence of the practice presumably may be uncovered solely by resort to information in the possession of the "defrauded" Airline. (See

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Defendants' \*195 Reply Br. at 12 n. 16 (“[Hidden-city] ticketing implicates only the fares of the airline being subjected to the misrepresentation.”).) FN20 In fact, the record indicates that Defendants *have* been able to unilaterally detect and penalize individual instances of hidden-city ticketing, through such counter-measures as cancellation of the remainder of a ticket when a passenger fails to travel one of its segments, and rules prohibiting the retrieval of checked baggage at the midpoint of a spoke-hub-spoke route. Consequently, *Cement Manufacturers*’ “rule of necessity” has no application here.

FN20. By way of contrast, the practice of “back-to-back” ticketing might require cooperative preventative measures, because the two tickets purchased to accomplish this result can be from two different airlines, so long as both fly between the passenger's point of origin and destination.

Finally, Plaintiffs' § 1 claim goes beyond the mere sharing of information, and charges that Defendants agreed to a concerted course of action. The Court in *Cement Manufacturers* was careful to point out that the manufacturers had *not* reached any agreement or understanding as to the *use* they would make of the information they had gathered, but instead remained “free to act upon [it] or not as they cho[ ]se.” *Cement Mfrs.*, 268 U.S. at 603–04, 45 S.Ct. at 591. In the present case, if the evidence shows only that Defendants collectively discussed the issue of hidden-city ticketing and shared information as to their respective prohibitions on the practice, but that they did not agree on a concerted policy or course of conduct with regard to this practice, Plaintiffs' § 1 claim will fail under the authority of *Maple Flooring*. And, in fact, this is the next of Defendants' challenges to the Section 1 claim in this case—namely, that the evidentiary record does not give rise to a reasonable inference of collusive action. Accordingly, having rejected

Defendants' claim that the “fraud prevention” rule of *Cement Manufacturers* precludes their liability as a matter of law, the Court now turns to this next challenge.

## 2. Plaintiffs Have Produced Sufficient Evidence of Concerted Action to Withstand Summary Judgment on Their Section 1 Claim.

As noted earlier, the courts have adopted fairly stringent standards for assessing claimed violations of § 1 of the Sherman Act. The *Matsushita* Court explained:

[A]ntitrust law limits the range of permissible inferences from ambiguous evidence in a § 1 case. Thus, in *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 104 S.Ct. 1464, 79 L.Ed.2d 775 (1984), we held that conduct as consistent with permissible competition as with illegal conspiracy does not, standing alone, support an inference of antitrust conspiracy. *Id.*, at 764, 104 S.Ct., at 1470. To survive a motion for summary judgment or for a directed verdict, a plaintiff seeking damages for a violation of § 1 must present evidence “that tends to exclude the possibility” that the alleged conspirators acted independently. 465 U.S., at 764, 104 S.Ct., at 1471. [The plaintiffs] in this case, in other words, must show that the inference of conspiracy is reasonable in light of the competing inferences of independent action or collusive action that could not have harmed [the plaintiffs].

*Matsushita*, 475 U.S. at 588, 106 S.Ct. at 1356–57. The Court also cautioned that “mistaken inferences” can be “especially costly” in antitrust cases, because they threaten to “chill the very conduct the antitrust laws are designed to protect.” 475 U.S. at 594, 106 S.Ct. at 1360.

[2][3][4] Following *Monsanto* and *Matsushita*, the Sixth Circuit has adopted a two-step inquiry for resolving a motion for summary judgment on a antitrust conspiracy claim. See *Riverview Investments, Inc. v. Ottawa Community Improvement Corp.*, 899 F.2d 474, 483 (6th Cir.),

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*cert. denied*, 498 U.S. 855, 111 S.Ct. 151, 112 L.Ed.2d 117 (1990). First, the Court must ask whether Plaintiffs' evidence of conspiracy is "ambiguous," meaning that it is "as consistent with the defendants' permissible independent interests as with an illegal conspiracy." 899 F.2d at 483. If so, the Court then must consider whether there is "any evidence that tends to exclude the possibility that the defendants were pursuing these independent interests." 899 F.2d at 483. "A plaintiff thus fails to demonstrate\*196 a conspiracy if, using ambiguous evidence, the inference of a conspiracy is less than or equal to an inference of independent action." 899 F.2d at 483; *see also Blomkest Fertilizer, Inc. v. Potash Corp.*, 203 F.3d 1028, 1032 (8th Cir.2000) ("[I]f it is as reasonable to infer from the evidence a price-fixing conspiracy as it is to infer permissible activity, then the plaintiff's claim, without more, fails on summary judgment."), *cert. denied*, 531 U.S. 815, 121 S.Ct. 50, 148 L.Ed.2d 19 (2000). Moreover, "a litigant may not proceed by first assuming a conspiracy, and then explaining the evidence accordingly." *Blomkest Fertilizer*, 203 F.3d at 1033.

[5] In their present motion, Defendants argue that Plaintiffs' evidence fails this test, as it is ambiguous and is just as consistent with an inference of independent action as with an inference of conspiracy. Principally, Defendants contend (i) that each Defendant Airline has an independent business interest in prohibiting hidden-city ticketing; (ii) that the record reflects disparate adoption of hidden-city prohibitions by each Airline and disparate enforcement of these measures, thereby undermining any inference of concerted action; and (iii) that Plaintiffs' evidence of discussions among airline representatives about hidden-city ticketing is insufficient as a matter of law to establish a § 1 violation, absent further evidence of an agreed-upon course of conduct. Upon reviewing the record in light of Defendants' assertions, the Court finds that Plaintiffs' evidence of a § 1 conspiracy, while considerably short of overwhelming, would nevertheless permit a

reasonable inference of collusive action.

It must be acknowledged, at the outset, that Plaintiffs have not produced any "smoking gun" evidence of an antitrust conspiracy. In *Cement Manufacturers*, for example, there was no doubt as to the existence of concerted action in gathering and disseminating information about specific job contracts; indeed, the constitution of the defendant trade association expressly called for this activity. Here, by contrast, there is no express agreement, in any form, as to a common course of action with regard to the practice of hidden-city ticketing. To the contrary, the initial impression upon surveying the record is one of independent action; the Airlines adopted their respective prohibitions on hidden-city ticketing at various times over a several-year period, and Plaintiffs do not contend that Defendants uniformly enforced these prohibitions through the same or similar measures or to the same or similar extents. In fact, as Defendants point out, Plaintiffs' evolving theory of the unlawful conspiracy in this case now includes the apparent concession that each Airline remained "free to prevent hidden-city ticketing" in "whatever manner or degree it saw fit." (Plaintiffs' Motion for Class Cert., Br. in Support at 4.) Plainly, there can be no conspiracy where each supposed participant is free to act in any way it chooses.

Next, as Defendants contend, and as evidenced by the fact that each of the Defendant Airlines had adopted tariff rules against hidden-city ticketing at some point (often years) *before* the commencement of the alleged conspiracy, each Airline arguably has an independent business interest in prohibiting this practice. This weakens any inference of conspiracy that might otherwise arise from uniformities or parallelisms in Defendants' conduct with respect to hidden-city ticketing, because Defendants' parallel approaches to proscribing the practice might just as well be the product of independent business decisions as of deliberate collusion. *See Wallace v. Bank of Bartlett*, 55 F.3d 1166, 1168 (6th Cir.1995) (observing that parallel conduct, "without more,

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does not itself establish a violation of the Sherman Act”), *cert. denied*, 516 U.S. 1047, 116 S.Ct. 709, 133 L.Ed.2d 664 (1996); *Blomkest Fertilizer*, 203 F.3d at 1032–33 (noting that the same is true even with conscious parallelism).

Yet, upon closer inspection, Defendants' evidence of independent interests and actions is more equivocal than they would have the Court believe. First, Defendants sweep too broadly in their claim that each airline is indifferent to the hidden-city ticketing policies of other airlines, and is wholly free to adopt (or not) a prohibition on this practice by reference solely to its own independent business interests, and without fear of competitive losses to another airline. Even Defendants concede, in their reply brief, that \*197 this analysis does not necessarily continue to hold true for routes between two carriers' hub airports. (See Defendants' Reply Br. at 12.) FN21 Similarly, Northwest's former Chief Accounting Officer, Mark Osterberg, pointed out that hub airports shared by two carriers give rise to different competitive considerations:

FN21. Interestingly, by distinguishing between hub-to-hub and other routes, Defendants seemingly have accepted the premise that each Airline is largely free to act as it pleases on hub-spoke routes involving its own hubs, without any concern about potential competition from other airlines. Yet, in their challenge to Plaintiffs' § 2 claim, Defendants deny that they have such competitive control on routes involving their hubs.

Let's take Dallas. Let's suppose in Dallas, Delta elects to enforce hidden-city ticketing and American elects not to. They are both hub carriers in Dallas. If I want to do hidden-city ticketing and I'm a customer, I'm a passenger, I'm going to go on the carrier that's not going to enforce it.

(Plaintiffs' Exhibits, Tab 95, Osterberg Dep. at 113.)

Thus, the relevant question, in terms of an airline's economic self-interest, would seem to be whether the financial gains from unilaterally enforcing a hidden-city prohibition on all hub-spoke routes would exceed the anticipated losses on hub-to-hub routes and at shared hubs if the airline's competitors chose *not* to prohibit hidden-city ticketing. FN22 Neither side's argument and evidence on this point is particularly compelling. Defendants note that only 12 of the 234 routes at issue in this case involve the hubs of two different carriers, and they surmise that losses on 12 routes could not possibly outweigh gains on 222 others. This “numbers game” loses much of its persuasive force, however, when it is recalled that the gains on the 222 routes are confined to the *difference* between the hub-spoke fare and the encompassing hidden-city fare, while the losses on the remaining 12 routes consist of the *entire fare* that otherwise would have been collected from each passenger who gives his business to the competing carrier with no hidden-city prohibition. FN23

FN22. This assumes an “all-or-nothing” approach to the prevention of hidden-city ticketing. Both Plaintiffs and Defendants seem to operate under this assumption, and the Airlines' tariff rules include such a blanket proscription. Apart from technical difficulties in implementation, however, there would seem to be no reason why an airline could not choose to prohibit hidden-city ticketing on hub-spoke routes, but allow it on routes between its and another carrier's hubs. And, so long as airlines are free to make this choice, this option seemingly would have to be factored into any determination of an airline's economically “optimal” response to the practice of hidden-city ticketing.

FN23. In addition, Defendants chide Plaintiffs for their “failure to offer evidence that any of the three defendant airlines ever weighed its potential common

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hub-hub revenue losses against its total [hidden-city] losses.” (Defendants' Reply Br. at 15.) This lack of evidence, however, strikes the Court as the proverbial “dog that didn't bark.” According to Defendants, each Airline independently concluded that its own self-interest favored a prohibition on hidden-city ticketing, and that competitive concerns did not dictate otherwise. (*See id.* at 13, 15.) To reach such a conclusion, each Airline presumably would have needed to perform some sort of cost/benefit analysis, under the assumption that the Airline might lose at least some of its customers to competitors that elected not to adopt such a prohibition. Yet, if each Airline were confident that the other Airlines would *also* prohibit this practice, no such analysis would be necessary. As noted, there is no evidence in the record of any such analysis having been undertaken.

Plaintiffs' evidence, likewise, is either inconclusive or rests upon questionable assumptions. Although they cite various testimony and memoranda evincing the Airlines' recognition of the potential competitive risks involved in unilateral action against hidden-city ticketing, Defendants point to other materials in the record reflecting the Airlines' ultimate conclusion that such risks were relatively modest and worth taking. [FN24](#)

Plaintiffs also cite the calculations of their expert, Dr. John Beyer, which indicate that each Airline's gain in revenue as a result of its hidden-city prohibition is dwarfed by the revenues achieved by that Airline on hub-to-hub \*198 routes. [FN25](#)

Yet, it cannot be assumed that an Airline would lose *all* of its hub-to-hub revenue if it continued to prohibit hidden-city ticketing while its competitors did not, and Plaintiffs have not suggested any basis for determining what percentage of this revenue might be at risk. Nonetheless, the Court cannot accept Defendants' contention that this questionable assumption

deprives Plaintiffs' position of all its weight. Rather, even if it were assumed, say, that an Airline faced only a 20-percent reduction in hub-hub revenue as a result of its unilateral stance against hidden-city ticketing, this loss still would exceed the gain posited by Dr. Beyer as a result of that Airline's enforcement of its prohibition. In short, questions of fact remain on the issue of each Airline's individual business interest in adopting a unilateral prohibition against hidden-city ticketing.

[FN24](#). Moreover, while Plaintiffs offer evidence that the airlines reached a different conclusion regarding back-to-back ticketing, determining that unilateral efforts would not be effective and that group concurrence was needed, Defendants correctly observe that back-to-back ticketing is not at issue in this case, and that hidden-city and back-to-back ticketing raise wholly different competitive concerns.

[FN25](#). For example, according to Dr. Beyer, Defendant Northwest realized additional revenues of approximately \$534 million in the period from 1992 to 1999 as a result of its hidden-city prohibition, but collected revenues of approximately \$3.02 billion in that same time period from business passengers traveling on hub-to-hub routes.

Next, the Court cannot concur in the dispositive weight Defendants would give to the evidence of each Airline's separate adoption and disparate enforcement of its tariff rules against hidden-city ticketing. As an initial matter, the evidentiary impact of the written rules against hidden-city ticketing is greatly diminished by the Airlines' apparent willingness, at some points in the past, to overlook—and, indeed, even to encourage—violations of these rules. In particular, Plaintiffs have produced fairly extensive evidence that several airlines, including those which had already adopted tariff rules against hidden-city

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ticketing, at least tolerated the practice through the late 1980's, and occasionally even promoted it. This evidence includes, for example: (i) testimony by Barbara Amster, a former Vice President of Pricing and Yield Management for American Airlines, as to her belief in 1989 that hidden-city ticketing—which, incidentally, she did not view as fraud—was a product of fare anomalies that the airline would “have to live with,” (Plaintiffs' Exhibits, Tab 72, Amster Dep. at 26–28, 36, 39); (ii) a 1988 edition of an Industry Agents' Handbook put out by the Airlines Reporting Corporation, which instructs travel agents in writing “point beyond” and “more distant point” tickets, (Plaintiffs' Exhibits, Tab 3, Industry Agents' Handbook at 11, 13); (iii) the affidavit of a former airline employee, Bruce Bishins, stating that he “used to work for the airlines teaching travel agents how to write” hidden-city and point-beyond tickets, (Plaintiffs' Exhibits, Tab 3, Bishins Aff. at ¶ 12); and (iv) various news articles quoting airline officials as stating that there was little or nothing that they could do about the practice, or that hidden-city fares were merely loopholes that the airline was not concerned with closing, (*see generally* Plaintiffs' Exhibits, Tab 4). Plainly, a tariff rule says little about an Airline's independent policy against hidden-city ticketing if the rule is not enforced.

More generally, Defendants' challenge to Plaintiffs' evidence of collusive action seems to rest on a questionable premise—namely, that a conspiracy cannot be established absent a complete “sea change” in each Airline's practices that results in a lock-step approach to hidden-city-ticketing. As readily as an Airline *adopts* a policy toward hidden-city ticketing, it can just as readily *change* it—as, indeed, is evidenced by the record of the Airlines' periodic amendments to their respective tariff rules. Thus, even if an Airline already had adopted a tariff rule against hidden-city ticketing prior to the onset of the conspiracy alleged by Plaintiffs, this would not preclude the conclusion that this Airline nevertheless joined the conspiracy, and thereby

agreed to *retain* its prior prohibition on hidden-city ticketing, or to enforce a previously dormant tariff rule. While it might well be more difficult to prove a conspiracy that involves only subtle changes in the conduct of its constituent members—and although, as discussed earlier, a given member's prior adoption of the supposed object of the conspiracy is strong evidence that this member's actions were independently motivated, and not the product of collusion—Defendants' evidence of prior prohibitions does not alone establish, as a matter of law, that the Airlines could not have conspired to \*199 deter the practice of hidden-city ticketing. Nor is Plaintiffs' claim of conspiracy fatally undermined by minor variances in the particular means of enforcement chosen by each individual Airline—an agreement need not dictate every conceivable aspect of each conspirator's behavior in order to violate § 1. FN26

FN26. In any event, the Court believes that Defendants have overstated the degree of variance in the Airlines' approaches to hidden-city ticketing. Counsel asserted at the November 14 hearing, for example, that Defendant Delta “is no longer enforcing” its hidden-city prohibition. (11/14/01 Hearing Tr. at 70.) Yet, it was quickly conceded that “everybody,” including Delta, automatically cancels the remainder of a passenger's itinerary if the passenger fails to travel one of its segments. (*Id.* at 71.) As the Court observed at the hearing, this clearly is an enforcement mechanism that strongly discourages the purchase of hidden-city tickets.

Nonetheless, to survive summary judgment, Plaintiffs still must offer sufficient evidence of an agreement to act collectively against hidden-city ticketing. In particular, beyond Plaintiffs' evidence of arguably parallel conduct—which, as noted, is far from conclusive, where the record reflects only general similarities in the actions taken by the

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various Airlines to deter hidden-city ticketing, and where Plaintiffs concede that each Airline remained free under the alleged conspiracy to oppose this practice in whatever manner and degree it saw fit—Plaintiffs must produce additional evidence, sometimes described as “plus factors,” which would permit an inference of “a unity of purpose or a common design and understanding, or a meeting of the minds in an unlawful arrangement.” *Wallace*, 55 F.3d at 1168 (internal quotations and citation omitted). The necessary “plus factors” can include “actions contrary to a defendant’s economic self-interest, product uniformity, exchange of price information and opportunity to meet, and a common motive to conspire or a large number of communications.” 55 F.3d at 1168 (citations omitted).

In an effort to make the requisite showing, Plaintiffs point to three ways in which the Defendant Airlines allegedly went beyond mere parallel but independent conduct, and instead chose to adopt a concerted course of action against the practice of hidden-city ticketing. First, Plaintiffs assert that the Airlines collectively adopted the position that hidden-city ticketing is a species of fraud. Next, Plaintiffs contend that industry meetings were used as forums, not merely to share information about their separate practices and experiences with regard to hidden-city ticketing, but to exhort each Airline to take further steps to deter the practice. Finally, Plaintiffs argue that the Airlines colluded to publicize their prohibitions on hidden-city ticketing and their ability and intention to enforce these rules. The Court will review each of these contentions in turn, with an eye toward determining whether each rests upon a tenable reading of the record and, if so, whether it serves as a “plus factor” that could sustain an inference of an unlawful conspiracy.

Regarding the Airlines’ position that hidden-city ticketing is tantamount to “fraud,” the Court notes that Plaintiffs’ claim of concerted action on this point has an initial ring of plausibility under a

broad view of the record. There is ample evidence that, in the late 1980’s, the airlines largely looked the other way with regard to hidden-city ticketing, viewing it as a potential basis for competition, an inevitable byproduct of their fare structures, or, at worst, an undesired “loophole” that was not worth the effort to plug. Yet, the Defendant Airlines now have come around to the point where they not only uniformly maintain that the practice is fraudulent, but have made this contention the centerpiece of their present motion for summary judgment, devoting fully half of their brief to variations on the theory that the Airlines were entitled to act as they did in a legitimate effort to stamp out fraud. The single-mindedness with which Defendants pursue this argument is striking, where it seemingly would suffice to cite fraud prevention as one of a number of legally permissible grounds upon which an airline might elect to take action against hidden-city ticketing—to facilitate better yield management, for example, or to stem the loss of revenue. And, of course, Defendants cannot make such an appeal to “fraud prevention” absent a shared view that hidden-city ticketing is, in fact, a \*200 fraudulent practice, and that it should be opposed on that basis.<sup>FN27</sup>

<sup>FN27</sup>. Indeed, to obtain protection under the rule of *Cement Manufacturers*, Defendants arguably must go further, and establish that, to the extent that they shared information and communicated among themselves regarding hidden-city ticketing, they did so for the purpose of preventing fraud.

In addition, Plaintiffs have produced some evidence that the Airlines’ views on this subject evolved as a result of direct discussions among their representatives at industry meetings. The record can be read to suggest, for instance, that the airlines’ international association, IATA, gradually arrived at the view that the analogous international practice of “cross-border” ticketing was counteracted most effectively by treating it as

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fraudulent. A 1989 IATA statement on the topic acknowledged that cross-border ticketing “is not fraud in the strict sense of criminal activity,” but instead represented “a prevalent form of revenue dilution” and a “potentially substantial threat to yield maximization.” (Plaintiffs' Exhibits, Tab 12, Dep. Ex. 206.) Over time, however, this practice was increasingly discussed in the context of fraud prevention, and was identified as an appropriate target for working groups and task forces that dealt with matters of fraud. Plaintiffs also point to an excerpt of the minutes of the March 17, 1993 meeting of the Joint ATA/IATA North American Fraud Prevention Task Force, whose membership included Northwest and U.S. Airways:

Concern was expressed at a number of manipulative practices carried out by ARC agents that were treated simply as tariff matters whereas it was a Member's belief that such practices were fraudulent in nature in that they contained elements of deception and dishonesty that were prejudicial to the airlines. Practices such as hidden-city ticketing ... were, in general, not categorized as fraud. Members agreed that there were indeed problems in this area and that there was a need for an increasing awareness of these practices as being fraudulent ....

(Plaintiffs' Exhibits, Tab 34, 3/17/93 Meeting Minutes at 6.) The Court finds that this evidence, among other materials in the record, could support an inference that the Airlines did not independently decide to treat hidden-city ticketing as fraud, but instead arrived at that conclusion as a “meeting of the minds” at industry gatherings.

The Court further concludes that this evidence serves as a “plus factor” which, if credited, would tend to exclude the possibility that the Airlines were acting independently. First, the labeling of hidden-city ticketing as fraud would tend to overcome any individual Airline's inclination to weigh the competitive advantages and disadvantages of allowing the practice, and would instead provide a common motive for all Airlines to

take action against it. Indeed, the record is replete with statements of the need for an industry-wide effort to combat fraud; Plaintiffs quote, for example, an airline representative's statement at a 1998 IATA Revenue Protection Forum that “I see that there is absolutely NO competition among airlines as far as fraud prevention is concerned.” (Plaintiffs' Exhibits, Tab 57, Dep. Ex. 130 at 3.)

In addition, this treatment of hidden-city ticketing as fraud arguably provided an opportunity for the Airlines to lawfully meet and communicate on the subject, whereas such discussions might have been more problematic if hidden-city ticketing were viewed as a competitive pricing issue. This distinction is effectively illustrated through Defendant Northwest's attempt in 1993 to enlist Defendant ARC in the effort to enforce the Airlines' hidden-city prohibitions. The record reflects Northwest's anticipation that ARC would cite antitrust concerns as a basis for resisting the Airline's proposal. Nevertheless, Northwest urged ARC to participate in the enforcement effort, stating that practices such as hidden-city and back-to-back ticketing “result in *theft*,” and arguing that, while “each airline could individually enforce” its tariff rules, ARC's involvement “would likely *deter* violations.” (Plaintiffs' Exhibits, Tab 34, Dep. Ex. 400 at ARC00124.) Northwest also provided a legal opinion to ARC, which stated that hidden-city ticketing “potentially amount[s] to fraud,” and then observed\*201 that “ARC routinely takes action ... against [travel] agencies that ... engage in fraudulent practices.” (Plaintiffs' Exhibits, Tab 34, Dep. Ex. 399 at ARC00317.)

More generally, the record is replete with evidence of occasions on which hidden-city ticketing was discussed at industry meetings in the guise of “fraud prevention.” If this practice were viewed as a matter of tariff enforcement, some evidence suggests that such joint discussions might have raised antitrust concerns. Northwest's Michael Levine, for example, testified that the airlines' antitrust immunity at IATA meetings extended only

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to discussions of international pricing issues, and that “the discussion of domestic tariff abuse would not have been, in my judgment, immunized by and therefore would have been exposed in an IATA meeting.” (Plaintiffs' Exhibits, Tab 90, Levine Dep. at 593.) Similarly, antitrust concerns have consistently been cited as a reason why ARC does not assist in the enforcement of the Airlines' tariff rules. For all of these reasons, then, the Court finds that the Airlines' consensus view of hidden-city ticketing as “fraud” is a “plus factor” that tends to exclude the possibility that the Airlines have independently elected to pursue similar policies of deterring hidden-city ticketing.

Plaintiffs' next suggested “plus factor”—the alleged exhortations at industry gatherings that airlines should do more to oppose hidden-city ticketing—dovetails somewhat with their first “plus factor.” In particular, the Court already has noted the evidence in the record that industry group meetings often served as forums for urging industry cooperation in response to fraudulent practices. Plainly, to the extent that hidden-city ticketing was included within the ambit of such “fraudulent” practices, these meetings went beyond the mere sharing of information regarding hidden-city ticketing and possible means for detecting and preventing it, and instead featured express exhortations to act collectively. Defendants' counsel agreed at the November 14, 2001 hearing that such exhortations to act would take this case outside the *Maple Flooring* situation of permissible information sharing. (See 11/14/01 Hearing Tr. at 47–48.)

Moreover, separate from these industry exhortations against hidden-city ticketing as “fraud,” Plaintiffs have produced evidence which suggests that the proactive discussions of “cross-border” ticketing at IATA meetings might have spilled over into the Airlines' views of hidden-city ticketing as a practice that also should be more aggressively targeted. There seems to be little doubt that IATA, through certain working groups and task

forces, affirmatively recommended steps that airlines could take to deter the practice of cross-border ticketing. Yet, it appears that IATA and its subgroups did not always scrupulously observe the distinction between cross-border and hidden-city ticketing, so that it is not unreasonable to infer that recommendations as to the former practice might have affected the airlines' behavior with respect to the latter one. As an example, IATA's director of fraud prevention, Mark Hawes, evidently made the proposal that led to the formation of the Joint ATA/IATA North American Fraud Prevention Task Force, and this task force apparently brought IATA's knowledge and expertise on matters of tariff abuse to bear upon the domestic concern of hidden-city ticketing. In addition, Plaintiffs point to the testimony of United's head of corporate security, Ken Gilbert, that his Airline's more active stance against hidden-city ticketing stemmed from discussions of these sorts of “abusive practices” at IATA or ATA meetings, and from the statements of airlines at these forums that “we think this is a big problem.” (Plaintiffs' Exhibits, Tab 82, Gilbert Dep. at 93.)

The Court finds that this evidence, viewed in a light most favorable to Plaintiffs, could support an inference of more than mere sharing of information, and that the activities and discussions at industry meetings could reasonably be construed as an instigating factor in the Airlines' arguably stepped-up efforts to deter hidden-city ticketing. First, it is somewhat striking that representatives of the Airlines found so many opportunities to at least “compare notes” on their responses to hidden-city ticketing where, as discussed earlier, cooperation among the Airlines was by no means necessary for any individual Airline to take effective action \*202 against this practice. Compare *Wilcox v. First Interstate Bank of Oregon, N.A.*, 815 F.2d 522, 527 (9th Cir.1987) (finding that meetings among competitors did not qualify as a “plus factor” because cooperation was “a necessary incident” to the practice challenged in that case). Indeed, the record suggests more than mere passing references

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to hidden-city ticketing on a few occasions, where task forces and working groups were convened to address this and other “fraudulent” practices.

Even less should it have been necessary for the Airlines to affirmatively *encourage* each other to act more aggressively against hidden-city ticketing, in light of Defendants' contention that it was in each Airline's economic self-interest to do so. Yet, there is evidence of such encouragement in the record. Indeed, Plaintiffs have produced evidence of at least two meetings—the March 17, 1993 session of the joint IATA/ATA task force on fraud prevention in North America, and the September 30, 1993 meeting of the ARC executive committee—at which an Airline's representative expressly advocated a common approach to the practice of hidden-city ticketing. Even if Plaintiffs have not been able to produce further “smoking gun” evidence that these proposals were explicitly adopted, the evidence of advocacy on this point tends to refute a claim of independent action, as it indicates that at least *some* Airline representatives viewed concerted action as superior to separate prohibitions. Plaintiffs need not conjure up a motive to conspire, where the Airlines themselves, or at least some of them, apparently perceived one.

Turning, finally, to Plaintiffs' claim of concerted efforts to publicize the Airlines' prohibitions against hidden-city ticketing, the Court finds that the evidence on this point does not serve as an additional “plus factor” in support of an inference of a common scheme to deter. Virtually all of the travel agent warning letters and Airline representative statements produced by Plaintiffs refer only to the individual Airline that issued them, and do not so much as hint at a collective decision to publicize the efforts against hidden-city ticketing. The lone exception is a statement at a travel agent conference, attributed to a Delta representative, warning that all of the airlines were adopting automated systems to audit tickets and detect practices such as hidden-city ticketing. Even this statement, however, does not necessarily

suggest a concerted plan of action, but is just as consistent with independent, parallel decisions to implement automated auditing systems. Likewise, Plaintiffs' citation to the testimony of Paul Ruden, an official of the American Society of Travel Agents, that the airlines “have been, for the most part, unrelenting in their determination to continue enforcing their penalties” on hidden-city tickets, (Plaintiffs' Exhibits, Tab 97, Ruden Dep. at 96), says nothing about a collective enforcement effort. More generally, despite their claims to the contrary, none of Plaintiffs' evidence on this issue establishes any sort of clear “point of demarcation,” before which the Airlines did not publicize their hidden-city prohibitions or issue warning letters regarding the practice, and after which they began to do so.

Nonetheless, the Court finds that the two “plus factors” put forward by Plaintiffs are sufficient to withstand a judgment against them as a matter of law on their § 1 claim. In light of the Airlines' apparent consensus that hidden-city ticketing is a species of “fraud,” and given the evidence that the Airlines discussed the practice and occasionally encouraged greater diligence at their industry gatherings, the Court finds that the present record would permit a reasonable inference that the Airlines' efforts to deter hidden-city ticketing are attributable to a common scheme or meeting of the minds, and do not simply reflect separate, legitimate business judgments as to a prudent course of action.

### **3. Defendants Are Not Entitled to Summary Judgment under a “Rule of Reason” Analysis of Their Alleged Conduct.**

Finally, even assuming that the Airlines' prohibitions against hidden-city ticketing reflect an agreement to oppose the practice, Defendants argue that their justifications for adopting these prohibitions would pass muster\*203 under a “Rule of Reason” analysis. The Court harbors substantial doubt, however, as to whether a full-scale Rule of Reason analysis is required under the circumstances presented here. Even if so, the present record does

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not permit the Court to declare the outcome of such an analysis as a matter of law.

In another recent case also involving airline policy—in that case, a policy regarding the use of baggage templates at Dulles Airport, in order to limit the size of carry-on baggage—the Fourth Circuit surveyed the three different levels of analysis that have been applied to determine whether an agreement among competitors, or a “horizontal restraint,” violates § 1 of the Sherman Act:

In determining whether a plaintiff has proved that a horizontal agreement violates Section 1, the Supreme Court has authorized three methods of analysis: (1) *per se* analysis, for obviously anticompetitive restraints, (2) quick-look analysis, for those with some procompetitive justification, and (3) the full “rule of reason,” for restraints whose net impact on competition is particularly difficult to determine. The boundaries between these levels of analysis are fluid; there is generally no categorical line to be drawn between restraints that give rise to an intuitively obvious inference of anticompetitive effect and those that call for more detailed treatment. Instead, the three methods are best viewed as a continuum, on which the amount and range of information needed to evaluate a restraint varies depending on how highly suspicious and how unique the restraint is. In all cases, however, the criterion to be used in judging the validity of a restraint on trade is its impact on competition.

The first approach, *per se* analysis, permits courts to make categorical judgments that certain practices, including price fixing, horizontal output restraints, and market-allocation agreements, are illegal *per se*. Practices suitable for *per se* analysis have been found over the years to be one[s] that would always or almost always tend to restrict competition and decrease output, and that are not designed to increase economic efficiency and render markets more,

rather than less, competitive. Such restrictions have such predictable and pernicious anticompetitive effect, and such limited potential for procompetitive benefit, that they are deemed unlawful *per se* without any need to conduct a detailed study of the markets on which the restraints operate or the actual effect of those restraints on competition.

At the other end of the spectrum, if the reasonableness of a restraint cannot be determined without a thorough analysis of its net effects on competition in the relevant market, courts must apply a full rule-of-reason analysis. In such cases a plaintiff must prove what market ... was restrained and that the defendants played a significant role in the relevant market because [a]bsent this market power, any restraint on trade created by [a] defendant's action is unlikely to implicate Section 1. The required analysis varies by case and may extend to plenary market examination, covering the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed, as well as the availability of reasonable, less restrictive alternatives.

Sometimes, the anticompetitive impact of a restraint is clear from a quick look, as in a *per se* case, but procompetitive justifications for it also exist. Such intermediate cases may involve[ ] an industry in which horizontal restraints on competition are essential if the product is to be available at all, or in which a horizontal restraint otherwise plausibly increase[s] economic efficiency and renders markets more, rather than less, competitive. For these cases, abbreviated or “quick-look” analysis fills in the continuum between *per se* analysis and the full rule of reason.

*Continental Airlines, Inc. v. United Airlines, Inc.*, 277 F.3d 499, 508–10 (4th Cir.2002) (internal quotations and citations omitted).

In *Continental*, a Dulles Airport management

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council, consisting of all airlines serving the airport, and defendant United, the primary carrier at Dulles, had instituted a policy of installing baggage templates at the airport's two security checkpoints, and requiring that all carry-on baggage must fit \*204 through these templates.<sup>FN28</sup> Plaintiff Continental dissented from this decision, alleging that it deprived the airline of its ability to compete on the basis of its more liberal carry-on baggage policy. In particular, Continental had expanded the overhead bin storage on its fleet of aircraft, and had increased its gate-checking services, so that carry-on bags could be quickly checked at the gate if the space on board had been exhausted.

**FN28.** Each airline was given a supply of “medallions” that it could provide to select passengers—typically, first-class, business-class, and full coach fare passengers—whose baggage was then exempt from the template limitation.

The District Court applied a quick-look Rule of Reason analysis to this policy, and concluded that the defendants' procompetitive justifications were wanting as a matter of law. See *Continental Airlines, Inc. v. United Air Lines, Inc.*, 126 F.Supp.2d 962, 974–81 (E.D.Va.2001). The lower court reasoned that a full Rule of Reason analysis was not necessary, where the baggage template policy “amount[s] to an agreement to provide a lower quality product and hence counts as an output restriction,” in that it “standardizes, and thereby eliminates open competition on, an element of the bargain between carriers and passengers.” 126 F.Supp.2d at 975. “In this regard, it is elementary economics that insofar as defendants' restriction standardizes an element of competition and prevents airlines like Continental from offering a better product and superior service to consumers with regard to carry-on baggage capacity and policies, the economic effect of the restriction is no different from the effect of a horizontal agreement among competitor airlines to fix the price of air carriage service for consumers.” 126 F.Supp.2d at

975–76. The District Court also found, however, that something more than *per se* analysis was required, because the airlines “operate out of shared airport facilities and thus must form agreements from time to time concerning the use of these facilities,” and because “[s]ome agreements of this sort may further procompetitive goals.” 126 F.Supp.2d at 977. The Court then rejected the defendants' three proffered procompetitive justifications—improved on-time performance, enhanced onboard safety, and improved passenger comfort and convenience—and awarded summary judgment in favor of Continental.

The Fourth Circuit reversed, and remanded the matter to the District Court for further assessment of the baggage template policy under a more fully developed record. In so ruling, the Court observed that the unique architectural configuration at Dulles—a “bottleneck” facility with two common security checkpoints, and with past experience indicating that these two checkpoints could not vary in their treatment of carry-on baggage—“force[s] all of its airlines to cooperate on a single decision as to the use of templates.” *Continental*, 277 F.3d at 512. “When the economic implications of physical or geographical limitations require coordination among competitors, the Supreme Court has long applied Section 1 of the Sherman Act with flexibility.” 277 F.3d at 512–13. The Court further reasoned:

Moreover, beyond the general need for greater cooperation at Dulles than at other airports, United and Continental each make a more specific claim, related to Dulles's unique configuration, as to why their respective preferred outcomes benefit competition. Each argues that only a uniform policy in accordance with its preference will make possible an entire service that would not otherwise be available at Dulles: assertedly, Continental must win to offer flights with carry-on largesse, and United must win to offer flights with carry-on rigor. The district court may ultimately have to choose

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between two procompetitive claims; either outcome would both help and hurt competition, and which helps competition more than the other may be far from plain.

277 F.3d at 513.

Under these circumstances, the Fourth Circuit found that additional analysis was necessary “to determine the nature of the challenged restraint's net effect on competition.” 277 F.3d at 513. The Court also held that the lower court had erred in determining\*205 that the defendants' procompetitive justifications were implausible as a matter of law. Accordingly, the case was remanded for further consideration of these issues under a more fully developed factual record. The Court did not decide, however, whether a modified quick-look analysis would suffice on remand, or whether a more extensive Rule of Reason analysis would be required to properly assess the lawfulness of the challenged restraint.

*Continental* provides valuable guidance in determining the proper level of analysis to apply in this case. In particular, by comparing that case to this one, the Court is fairly readily able to reject the extreme positions offered by the two sides here, and to conclude that the proper level of scrutiny lies somewhere in between *per se* and full-scale Rule of Reason analysis. Plaintiffs, not surprisingly, contend that the Airlines' alleged agreement to deter the practice of hidden-city ticketing is *per se* unlawful, as it prevents the alleged co-conspirators from competing on the basis of their hidden-city ticketing policies. Plaintiffs further maintain that this alleged agreement has a direct impact upon the prices paid by hub-spoke passengers for air travel, because it eliminates any opportunity for competition that might otherwise offer these passengers the option to purchase lower priced hidden-city tickets. Given these purportedly evident anticompetitive effects, Plaintiffs argue that *per se* analysis is appropriate.

In concluding otherwise, at least at this

juncture, the Court acknowledges that Plaintiffs here, unlike the plaintiff in *Continental*, have not sought a ruling in their favor on this point as a matter of law. To the contrary, Plaintiffs are the non-movants here, and therefore are entitled to the benefit of all justifiable inferences. Nevertheless, it is instructive to identify the propositions that must be established in order to find that *per se* treatment is suitable here. First, of course, Defendants must have actually entered into the agreement alleged by Plaintiffs—in contrast, there was no doubt about the existence of such an agreement in *Continental*. Next, it must be determined that, in the absence of Defendants' alleged agreement, there would be increased competition as to hidden-city ticketing, with at least some airlines electing to permit the practice. This issue is disputed, with the Airlines asserting that each has an independent economic self-interest in prohibiting hidden-city ticketing. FN29

Again, the situation was different in *Continental*, where the plaintiff airline was expressly seeking the opportunity to compete as to baggage policy, and undoubtedly would have done so if not for the defendants' contrary policy.

FN29. Indeed, there is an inherent tension between Plaintiffs' § 1 and § 2 claims on this point, where Plaintiffs have alleged, in support of their § 2 claims, that each Airline's hidden-city prohibition is an instrumental part of that Airline's own monopolistic strategy to impose “hub premiums” on its hub-spoke passengers. This seemingly would provide a motive—albeit an unlawful one—for each Airline to continue its prohibition, even in the absence of an agreement to do so.

Third, and most importantly, Plaintiffs' appeal to *per se* analysis turns upon the hotly disputed issue as to what the Airlines would do in the “but-for” world where hidden-city ticketing was permitted, or where at least some Airlines were free to allow the practice. In order to find that an agreement regarding hidden-city ticketing is

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inherently anticompetitive, it must be evident that the competitive situation would improve in the absence of this restraint. Defendants argue otherwise, contending that the practice of hidden-city ticketing jeopardizes the optimal performance of the Airlines' hub-spoke networks, and offering expert opinion that the Airlines' likely response if they could not prohibit hidden-city ticketing would be to reduce or cease service on certain routes, and to raise certain spoke-spoke fares. In this sense, this case presents a situation like the one addressed in *Continental*, where the parties offer diametrically opposed visions as to whether the “but-for” world would feature a more or less competitive environment.

[6] For many of the same reasons, however, the Court must reject Defendants' contentions that, as a matter of law, (i) a full Rule of Reason analysis is required here, and (ii) collective action against hidden-city ticketing passes muster under this analysis. Plainly, for purposes of deciding Defendants' \*206 motion, the Court must assume that the Airlines did, in fact, collectively agree to take action against the practice of hidden-city ticketing.<sup>FN30</sup> With this assumption in mind, the Court has no difficulty in identifying important distinctions between this case and *Continental*, and in concluding that these distinctions serve to illustrate why a more abbreviated analysis might be warranted here.

<sup>FN30</sup> Moreover, for the reasons discussed earlier, the Court does not find itself compelled as a matter of law to accept Defendants' “fraud prevention” justification for such an agreement.

First and foremost, the need for cooperation that was a lynchpin of the Fourth Circuit's analysis in *Continental* is utterly absent here, at least under Defendants' view of the case. The Airlines flatly deny that they have any reason to act collectively with respect to hidden-city ticketing, and instead contend that each Airline has separately prohibited the practice on independent business grounds. On

this point, the parties are largely in agreement, recognizing that hidden-city ticketing involves only a single airline's fares. Accordingly, because it is possible for one airline to choose to permit hidden-city ticketing while another elects to prohibit the practice, this case does not present the stark choice between two facially valid but mutually exclusive “all-or-nothing” policies that the Fourth Circuit confronted in *Continental*.

In light of the range of options that presumably would be available to each Airline here, absent their alleged agreement to adopt a uniform course of action, this case arguably involves a horizontal restraint on output, thereby warranting a less searching Rule of Reason analysis. Quite simply, even if a particular airline might deem it economically rational to prohibit hidden-city ticketing, it is difficult to see what is gained, from a competitive standpoint, by insisting that *all* airlines must do so. None of the various procompetitive justifications offered by Defendants in support of their hidden-city prohibitions would further serve to justify a joint effort against this practice. Rather, these justifications rest largely on the premise that, upon consideration of the myriad market forces on its various routes, each Airline has independently determined that, on balance, it is economically preferable to prohibit hidden-city ticketing than to allow it. This being the case, it would seem essential that each Airline remain free to make such a determination for each market in which it participates, something which plainly is not possible if the Airlines have agreed to a common, across-the-board policy.

Moreover, in the handful of situations where cooperative efforts might make a difference—shared hub airports, for example, or routes between one airline's hub and another's—it still is not evident what procompetitive benefits might flow from such cooperation. In any event, Defendants have not identified any. To the contrary, the Airlines state that they have never even considered allowing the practice of hidden-

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city ticketing on a limited basis or on particular routes, and so they presumably are in no position to identify the market benefits of such a limited policy.<sup>FN31</sup>

FN31. Nor does the record cast light on any other available, less restrictive alternatives to a blanket prohibition against hidden-city ticketing. Cf. *Continental*, 277 F.3d at 509 (noting that a full Rule of Reason analysis requires the examination of alternatives). An Airline might, for example, refuse to award frequent flier miles or withhold other perks where it detects that a passenger has used a hidden-city ticket.

Accordingly, while Plaintiffs have not offered conclusive proof that the competitive climate would improve in the absence of an agreement to act against hidden-city ticketing, Defendants have even less to offer in support of the proposition that such an agreement is competition-enhancing. This suggests that it might not be necessary to conduct a painstaking market analysis to confirm the likely anticompetitive effect of the alleged restraint at issue here. Instead, a quick-look approach might be warranted, with the focus on Defendants' proffered procompetitive justifications for a blanket prohibition on hidden-city ticketing.

As noted elsewhere in this Opinion, as well as in the Court's separate Opinion addressing the admissibility of Plaintiffs' proposed expert testimony, a number of material factual<sup>207</sup> disputes stand in the way of any determination as to the validity of the Airlines' claimed justifications for their prohibitions against hidden-city ticketing. Most fundamentally, it has yet to be determined whether the Airlines' hidden-city prohibitions serve, at least in part, as a bulwark against competitive market forces that otherwise would threaten the "hub premiums" they allegedly have imposed on their hub-spoke passengers. In addition, the parties and their experts offer dramatically different visions as to the state of the "but-for" world where

the practice of hidden-city ticketing would be permitted. In the face of such core issues of fact, it is hard to imagine how the Court could resolve a Rule of Reason inquiry, whether abbreviated or full-scale, as a matter of law one way or the other. See *Continental*, 277 F.3d at 511 ("Certainly courts have been wary of summary judgment in the context of quick-look analysis.").

In short, the present record does not dictate with any degree of certainty precisely what level of analysis should be applied, much less what the outcome of such an analysis would be. It follows that Defendants are not entitled to summary judgment in their favor on Plaintiffs' § 1 claim, and that the Court must await a full evidentiary record before deciding what sort of analysis should govern this claim.

### C. Plaintiffs' Section 2 Monopolization Claims

[7] Defendants also seek summary judgment in their favor on Plaintiffs' § 2 claims against each individual Defendant Airline. Most of the grounds for Defendants' motion do not warrant extended discussion here, as they already have been addressed in the Court's prior ruling regarding the opinions of Plaintiffs' experts. These include: (i) that Plaintiffs have failed to establish that their 234 hub-spoke city-pairs are appropriate markets upon which to base § 2 monopolization claims; (ii) that Plaintiffs have not demonstrated the existence of monopoly power in each of these markets; and (iii) that Plaintiffs and their experts have drawn unwarranted inferences—both as to the existence and exercise of monopoly power, and as to the existence and extent of damages suffered by members of the Plaintiff class—from the mere existence of some hidden-city savings opportunities for each hub-spoke market. Because the opinions of Plaintiffs' experts have been deemed admissible on these points, at least at the present juncture, this proffered expert testimony raises genuine issues of fact under the present record that preclude an award of summary judgment on these grounds. The battle of the parties' experts, in other words, must await

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resolution at trial.

[8][9] This leaves only a single remaining argument in support of Defendants' motion—namely, that each Airline's prohibition against hidden-city ticketing has purely “intra-brand” effects which cannot support a claim under § 2. As explained in the Court's initial published Opinion in this case:

In order to state a viable monopolization claim under § 2, an anti-trust plaintiff must allege: (1) the possession of monopoly power in the relevant market; and (2) the willful acquisition, maintenance, or use of that power by anti-competitive or exclusionary means. Section 2 requires both elements because the mere possession of monopoly power is not illegal.

*Chase*, 49 F.Supp.2d at 565 (internal quotations and citations omitted). Then, as now, Defendants challenged the second element of this standard, asserting that Plaintiffs had not identified any actionable anticompetitive conduct. The Court rejected this contention at the outset of this litigation, and finds an insufficient basis for concluding differently at this juncture.

Of course, given that the Court previously addressed this precise issue in these same proceedings, one might expect that Defendants would acknowledge the Court's prior ruling, but endeavor to show why it should no longer control upon the completion of discovery. Remarkably, Defendants did neither in their initial brief in support of their motion. Even when confronted with Plaintiffs' argument that this Court's prior decision should be deemed the “law of the case,” Defendants offered in reply only the unremarkable observations that (i) the law of the case doctrine applies solely to issues actually \*208 decided at an earlier stage of the proceedings, and (ii) that, in any event, the doctrine is discretionary, with the Court remaining free to reach a different conclusion. These propositions would carry considerably more force, however, if Defendants either (i) advanced a

plausible argument, based on careful analysis, that the Court's prior ruling did not, in fact, address the present issue, or (ii) pointed to specific instances where Plaintiffs' allegations have not been borne out through discovery. Defendants have done neither. Nor have they otherwise persuaded the Court that its prior ruling or supporting analysis should be abandoned.

In so concluding, the Court necessarily begins its present analysis by reviewing its earlier decision. Admittedly, this survey would be brief indeed, and perhaps even unnecessary, if the Court were to accept Defendants' cramped understanding of the second, “anticompetitive conduct” element of a § 2 claim. In particular, Defendants apparently assert that conduct is anticompetitive only if it is overtly directed at rivals, and expressly designed to exclude these rivals from the relevant market. Defendants observe that a given Airline's hidden-city prohibition is not directly “exclusionary” in this sense, as it is not aimed at the Airline's competitors, but is intended first and foremost to preserve each Airline's own fare structure. Defendants then cite passages in the record in which Plaintiffs and their expert, Dr. Beyer, seemingly acknowledge this proposition. Finally, Defendants advance this view of the law and the record as justifying their disregard of the Court's prior ruling, which, according to Defendants, “d[id] not discuss or analyze what constitutes exclusionary conduct.” (Defendants' Reply Br. at 23.)

In making this remarkable assertion, Defendants evidently failed to review the latter half of the Court's earlier Opinion, or perhaps thought it inconsequential to the present inquiry. The Court reads its decision far differently. For purposes of Defendants' initial motion to dismiss, the parties and the Court alike assumed that Plaintiffs had adequately alleged the first element of their § 2 claim, possession of monopoly power. Accordingly, the Court's *entire analysis* of Plaintiffs' § 2 claim was focused on the second element—*i.e.*, the

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anticompetitive exercise of this power, or “exclusionary” conduct as it is sometimes termed in antitrust law. See *Chase*, 49 F.Supp.2d at 565–69; cf. *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 482–83, 112 S.Ct. 2072, 2090–91, 119 L.Ed.2d 265 (1992) (speaking of this second element as variously requiring (i) “the use of monopoly power to foreclose competition, to gain a competitive advantage, or to destroy a competitor,” (ii) the “willful acquisition or maintenance of monopoly power,” or (iii) “exclusionary action” (internal quotations and citations omitted)).

In the event that Defendants did overlook this portion of the Court's earlier ruling, a brief recap is in order. In that decision, the Court held that Plaintiffs' allegations of anticompetitive conduct sufficed to state a viable § 2 claim. 49 F.Supp.2d at 568–69. In so ruling, the Court expressly acknowledged, and extensively addressed, Defendants' related contentions that “allegations of anti-competitive effects on intrabrand competition alone will not support a claim under § 2,” and that Plaintiffs “must also allege some negative effect on interbrand competition resulting from” an Airline's hidden-city prohibition. 49 F.Supp.2d at 566.<sup>FN32</sup> The Court found otherwise, largely on the authority of the Eleventh Circuit's decision in *Graphic Products Distributors, Inc. v. Itek Corp.*, 717 F.2d 1560, 1571–76 (11th Cir.1983). In particular, the Court quoted with approval the following passage from *Itek*:

FN32. As explained in the earlier Opinion, “[i]nterbrand competition is the competition among the manufacturers of the same generic product,” while “intrabrand competition is the competition between the distributors—wholesale or retail—of the product of a particular manufacturer.” *Chase*, 49 F.Supp.2d at 566 n. 20 (quoting *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 52 n. 19, 97 S.Ct. 2549, 2558 n. 19, 53 L.Ed.2d 568

(1977)).

The argument, pressed by [defendant] at length here, that the reduction or elimination of intrabrand competition is, by itself, never sufficient to show that a trade restraint is anticompetitive must rest, at bottom, on the view that intrabrand competition\*209—regardless of its circumstances—is never a significant source of consumer welfare. This view is simply not supported by economic analysis, or by the cases. A seller with considerable market power in the interbrand market—whether stemming from its dominant position in the market structure or from the successful differentiation of its products—will necessarily have some power over price. In that situation, intrabrand competition will be a significant source of consumer welfare because it alone can exert downward pressure on the retail price at which the good is sold.

*Chase*, 49 F.Supp.2d at 567 (quoting *Itek*, 717 F.2d at 1572 n. 20). Following *Itek*, this Court concluded that Plaintiffs' allegations of diminished intrabrand competition, combined with their allegations of a dominant market position in the relevant interbrand market, sufficed to state a claim under § 2. See *Chase*, 49 F.Supp.2d at 568–69.

Defendants' present argument is merely a restatement of the intrabrand/interbrand challenge mounted at the initial stage of this litigation. Now, as before, Defendants submit that each Airline's hidden-city prohibition affects only that Airline's own fare structure, and does not inhibit competition among the various Airlines in the relevant product market of passenger air travel service. As Defendants point out, there is nothing inherent in one Airline's refusal to sell a hidden-city ticket for hub-spoke travel that would prevent another Airline from offering competitive service on this hub-spoke route. Indeed, to the extent that hidden-city prohibitions result in higher fares, Defendants assert that these prohibitions are presumptively *procompetitive* in the interbrand market, as higher

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prices generally encourage entry into a market. Yet, all of this just as surely could have been (and was) said at the outset of these proceedings—which brings the Court to ask, once again, why it should deviate from its earlier conclusion that anticompetitive conduct directed at the intrabrand level alone can, in the proper circumstances, sustain a § 2 claim.

One possible ground for departing from this ruling, of course, would be the absence of evidence in support of Plaintiffs' § 2 allegations. Nothing in the course of discovery, however, has altered the parties' or the Court's basic understanding of the nature of hidden-city ticketing. Nor have Plaintiffs alleged some sort of anticompetitive or exclusionary conduct or impact that they are now unable to support through the materials produced in discovery. To the contrary, Plaintiffs' discovery responses, as cited in Defendants' motion, illustrate their consistent intrabrand-based theory of liability in this case:

The exclusionary practices challenged in this case are not primarily directed at [Defendants'] airline competitors. Rather, Plaintiffs challenge Defendants' individual and collective interference with, and foreclosure of, the natural (intra-brand) price arbitrage that would occur as a result of the inherent pricing anomalies present in the airlines' present fare structure. In the absence of Defendants' conspiracy and monopolization, it is the travel agents/agencies who would “enter the market” to “compete” with Defendants, by actively publicizing and selling hidden-city, back-to-back and similar types of tickets .... While travel agents/agencies strive to provide the lowest possible air fare to their customers ..., they collectively have been prevented from providing such services to Plaintiffs and the putative class as a direct result of Defendants' conspiratorial and monopolistic rules, policies and practices.

(Defendants' Motion, Ex. 11, Plaintiffs' Interrogatory Responses at 48.) Plainly, to support this theory, Plaintiffs need not produce evidence of

“exclusionary conduct” as Defendants would define that term.

Further, many of the purported “revelations” identified in Defendants' motion surely were evident to all throughout this litigation, and so provide no basis for reconsideration of the Court's prior ruling. Defendants state, for instance, that “exclusionary conduct” directed at travel agents cannot sustain Plaintiffs' § 2 claims, where travel agents and the Airlines do not compete in the relevant market of passenger air travel service. This point is rather obvious, however, and Defendants may rest assured that the Court made no contrary assumption in rendering its earlier\*210 decision. Likewise, Dr. Beyer's purported “concession” that he does not consider hidden-city prohibitions to be “exclusionary conduct,” (*see* Beyer Dep. at 60), is wholly consistent with Plaintiffs' stated position that the unlawfulness of a hidden-city prohibition lies not in any direct purpose to exclude competitor airlines from hub-spoke markets, but in such a prohibition's tendency to impede the competitive forces that otherwise would operate to constrain fares for hub-spoke travel. FN33

FN33. In any event, to the extent that Dr. Beyer's testimony is viewed as expressing a legal conclusion as to what constitutes actionable “exclusionary conduct” under § 2, such an opinion cannot overcome the Court's duty to say what the law is.

Consequently, there being no apparent evidentiary shortfall that Defendants may seize upon to distinguish the Court's earlier ruling, Defendants are left to argue, in essence, that the Court wrongly denied their initial motion to dismiss. In considering this contention, the Court notes that the decisional law provides very little direct guidance on the question whether intrabrand conduct alone may support a § 2 claim. Indeed, the Court's earlier ruling rested principally on the authority of a single decision, *Itek*, and the subsequent case law has little to add on the subject. Nonetheless, upon surveying the limited case law

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on this and related issues, the Court adheres to its prior ruling.

In considering anew the nature of the Airlines' hidden-city prohibitions, the Court initially observes that they can best be characterized as “vertical restraints” which impose limitations upon the sale of passenger air travel services.<sup>FN34</sup>

Absent these restraints, a hub-spoke passenger would be able to choose among hub-spoke and encompassing spoke-hub-spoke fares in purchasing a ticket. Even if an Airline itself did not wish to publicize the availability of hidden-city fares or sell hidden-city tickets to its customers, a passenger could seek the assistance of a travel agency in identifying and purchasing such tickets. The record indicates that this has occurred in the past, with various airlines and Defendant ARC's handbook instructing travel agents how to write hidden-city tickets. Plaintiffs charge that the Airlines have largely eliminated this opportunity through their enforcement of vertical restraints against the purchase and use of hidden-city tickets.

<sup>FN34</sup>. As noted earlier, a horizontal restraint entails action by competitors at the same market level. In this case, for example, Plaintiffs' § 1 claim rests upon allegations of a horizontal agreement among the Airlines to deter the practice of hidden-city ticketing. In contrast, a vertical restraint operates in the distribution chain between supplier and customer—in this case, an Airline and its passengers. Given the vertical nature of an individual Airline's hidden-city prohibition, Defendants' protestations that the Airlines and travel agents do not compete in the relevant market—namely, passenger air travel service—are utterly unremarkable and lack legal significance. Likewise, because Plaintiffs here are not “jilted distributors,” and do not otherwise claim that they have been excluded from the relevant market, Defendants' various

citations to antitrust cases in which a plaintiff failed to show that it competed with the defendant in a relevant market, *see, e.g., Intergraph Corp. v. Intel Corp.*, 195 F.3d 1346, 1353–55 (Fed.Cir.1999); *Ad-Vantage Telephone Directory Consultants, Inc. v. GTE Directories Corp.*, 849 F.2d 1336, 1348 (11th Cir.1987), are simply inapposite. Much as Defendants might prefer that Plaintiffs' § 2 claims rested on a fundamentally flawed view of the marketplace, Plaintiffs have stubbornly refused to cast their claims in such terms. Any legal defects in these claims lie well below the surface, and will not be disclosed through Defendants' superficial apples-to-oranges comparisons.

[10][11] Yet, the mere existence of such a vertical restraint, without more, cannot sustain a monopolization claim under § 2. “[A] manufacturer cannot be charged with antitrust violations if it monopolizes its own brand,” *International Logistics Group, Ltd. v. Chrysler Corp.*, 884 F.2d 904, 908 (6th Cir.1989), *cert. denied*, 494 U.S. 1066, 110 S.Ct. 1783, 108 L.Ed.2d 784 (1990), and “in many cases, a refusal to deal designed to accomplish vertical integration, without more, should not be a basis for imposing liability,” *Byars v. Bluff City News Co.*, 609 F.2d 843, 861 (6th Cir.1979). Thus, even if an Airline altogether eliminated travel agents as an alternate source of ticket sales, such a vertical integration of the chain of distribution would not be *per se* unlawful; rather, the totality of the circumstances would have to be carefully examined to assess the possible anticompetitive effects of such a scheme. \*211 *See Byars*, 609 F.2d at 861–62; *see also Continental T.V.*, 433 U.S. at 51–57, 97 S.Ct. at 2558–61 (addressing the “complex” market impact of vertical restrictions). It follows that careful analysis also is required here, where something less than full-scale vertical integration is at issue: travel agents continue to sell tickets for air travel, but have been prohibited from writing hidden-city

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tickets.

Unfortunately, neither side has provided much assistance in this analysis. Plaintiffs are largely content to rest on the Court's prior ruling.<sup>FN35</sup> As noted, this reliance is well placed, where the Court's earlier decision squarely held that the market conditions alleged by Plaintiffs, if established, would sustain a § 2 claim based on purely intrabrand anticompetitive conduct. See *Chase*, 49 F.Supp.2d at 568–69. As indicated elsewhere in this Opinion, Plaintiffs have produced sufficient evidence of these market conditions to withstand summary judgment. In particular, Plaintiffs point to expert testimony and government studies suggesting that the Airlines possess dominant market strength on many routes to and from their respective hub airports, and that substantial barriers to entry exist at these hub airports.

**FN35.** Plaintiffs' only other argument on this point is that hidden-city prohibitions have interbrand as well as intrabrand effects, in light of the Airlines' alleged collective adoption of these prohibitions. Yet, this contention inappropriately elides the distinction between Plaintiffs' § 1 and § 2 claims. If there were such an agreement among the Airlines to prohibit hidden-city ticketing, then Plaintiffs' § 2 claims would be mere surplusage, as all of the relief they seek could be obtained through their § 1 claim. If their § 2 claim adds anything, then, it can only be in the event that each Airline's separate hidden-city prohibition is found to be an anticompetitive exercise of its own alleged monopoly power, without regard for what the other Airlines might be doing with respect to this practice. For present purposes, then, the Court believes it appropriate to view each Airline's conduct in isolation.

The Court concludes, as it did before, that such market conditions can serve to tip the balance

between the pro- and anti-competitive effects of a vertical restraint. Absent market power in the interbrand hub-spoke market, an Airline could not employ vertical restrictions as a means of driving up the fares for hub-spoke travel, because competitors could defeat this attempt by offering lower fares. See *Continental T.V.*, 433 U.S. at 52 n. 19, 97 S.Ct. at 2558 n. 19 (“[W]hen interbrand competition exists, ... it provides a significant check on the exploitation of intrabrand market power because of the ability of consumers to substitute a different brand of the same product.”); *Itek*, 717 F.2d at 1568–69 & n. 11 (explicating this rationale for its “insist[ence], at the threshold, that a plaintiff attacking vertical restrictions establish the market power of the defendant”). Even with a substantial share of the hub-spoke market, but with low barriers to entry, an Airline could not achieve supracompetitive hub-spoke fares through vertical restraints, because higher fares would provide an incentive for competitors to enter the hub-spoke market.

If neither of these disciplining factors is present, however, an otherwise lawful vertical restriction can threaten consumer welfare, and is therefore subject to scrutiny as an anticompetitive measure forbidden by the Sherman Act. As observed in *Itek*:

[I]n situations of manufacturer market power, intrabrand restrictions on distributor competition can have a substantial adverse effect on consumer welfare by eliminating an important source of competitive pressure on price. Rather than promoting nonprice competition, vertical restraints in this context may enable a manufacturer to retain monopoly profits arising from an interbrand competitive advantage.

*Itek*, 717 F.2d at 1572 n. 20; see also *Tunis Brothers Co. v. Ford Motor Co.*, 696 F.Supp. 1056, 1061 (E.D.Pa.1988) (recognizing that “a diminution in intrabrand competition in an oligopolistic market exercised by one with considerable market power” can produce anticompetitive effects that violate the

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Sherman Act). Plaintiffs here have produced evidence suggesting that the Airlines' dominant market shares and barriers to entry at their hub airports leave them largely free to impose supracompetitive fares on their hub-spoke routes, without having to account for competitive pressures that otherwise would keep prices in check. The Court again holds, as it did previously, that the vertical nature \*212 of the mechanism through which the Airlines allegedly achieved this result does not shield Defendants from liability under § 2 of the Sherman Act.

By failing to acknowledge the import of the Court's prior ruling, Defendants have surrendered their opportunity to challenge its reasoning head-on. Nevertheless, they indirectly call into question one of the assumptions made in the Court's earlier decision—namely, that travel agents may be counted upon as a competitive force in the intrabrand market of ticket sales. Specifically, in a footnote in their brief, and at greater length at oral argument, Defendants have pointed to cases holding that it is not unlawful for a principal to insist upon the price that its agent charges for its product. *See, e.g., Ad-Vantage*, 849 F.2d at 1346; *Illinois Corporate Travel, Inc. v. American Airlines, Inc.*, 806 F.2d 722, 724–26 (7th Cir.1986). Indeed, in the latter of these cases, the District Court expressly found that “[a]s their title indicates, travel agencies are agents” of the airlines. *Illinois Corporate Travel v. American Airlines, Inc.*, 700 F.Supp. 1485, 1492 (N.D.Ill.1988), *aff'd*, 889 F.2d 751 (7th Cir.1989). “The implicit assumption behind [the principal/agent] cases is there can be no antitrust violation without a competitor, and agents do not compete with those whom they represent.” *Ad-Vantage*, 849 F.2d at 1346. Moreover, Judge Posner has identified an economic rationale for this rule, observing that agents typically lack the information and expertise to make pricing decisions, so that they should not be consulted in determining what constitutes a “competitive” price for a product. *See Morrison v. Murray Biscuit Co.*, 797 F.2d 1430, 1437 (7th Cir.1986).

Applying these principles here, Defendants insist that travel agents do not truly compete with the Airlines in the market of ticket sales, because the agents are bound to adhere to the price and other terms and conditions dictated by the Airlines. Consequently, when an Airline raises its fares, a travel agency must pass this increase along to its customers, and does not engage in a “price-fixing conspiracy” by doing so. It follows, in Defendants' view, that an Airline may insist upon its travel agencies' allegiance to a hidden-city prohibition without violating the Sherman Act.

The Court finds Defendants' argument on this point illuminating, but not dispositive. First, as a matter of brute fact, it appears that travel agents have served in the past as a disciplining force against elevated hub-spoke fares. Specifically, while most of the airlines have long had tariff rules against hidden-city ticketing, some of them nevertheless have acquiesced, at least, in the sale of such tickets by travel agents. Regardless of whether this is viewed as “competition” within the meaning of the Sherman Act, it is clear that the Airlines' present enforcement of their hidden-city prohibitions has foreclosed this previously existing avenue of price relief. In this respect, then, Defendants' appeal to agency principles is weakened by their failure to scrupulously observe the rules that govern a typical principal/agent relationship.

The Court also notes that the principal/agent nature of a travel agency's relationship with a given Airline is complicated by the agency's corresponding obligations to its customers, including its duty to identify the lowest possible fare. If a travel agency fails to aggressively pursue low fares on behalf of its customers, it is likely to lose business to other agencies. In this respect, a travel agency's interests are not aligned with those of any specific Airline “principal,” making it arguably capable of conspiring with or competing against this Airline. *See Morrison*, 797 F.2d at 1438 (“Some cases hold that if the agent is acting for his

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own purposes rather than those of the principal he may be capable of conspiring with the principal.”).

Moreover, the agency rule cited by Defendants cannot be divorced from the legal context in which it was developed. In particular, this principle generally is invoked as a defense to a charge of unlawful conspiracy in violation of § 1 of the Sherman Act. *See, e.g., Illinois Corporate Travel*, 889 F.2d at 752; *Morrison*, 797 F.2d at 1431. In its most direct application, then, this agency rule would preclude only a § 1 claim that the Airlines had conspired with travel agents to eliminate the practice of hidden-city ticketing. Indeed, this Court relied on related agency principles in dismissing Plaintiffs' \*213 claim of a § 1 conspiracy between Defendants Northwest and ARC to adopt and enforce a hidden-city prohibition. *See Chase*, 49 F.Supp.2d at 561–63. In contrast, under § 2, Plaintiffs need not identify a separate entity with which the Airlines are capable of conspiring. Further, even in the context of § 1, a vertical arrangement between a principal and agent is not always and invariably *per se* lawful, but generally is subject to assessment under the Rule of Reason. *See Illinois Corporate Travel*, 889 F.2d at 754, 806 F.2d at 727–29.

Nevertheless, the Court recognizes that it is somewhat problematic to rest a § 2 claim of anticompetitive conduct solely upon allegations of restrained “competition” between a principal and its agent, where such parties have, at best, only a limited capacity to compete. Here, for instance, it is not as though a discounted fare offered by a travel agent could be said to reflect an economic judgment by the agent as to the suitability of this fare. Likewise, when travel agents were permitted to write hidden-city tickets, they did not do so based on an assessment that the lower hidden-city fare was a proper or “competitive” price for hub-spoke travel; rather, agents wrote such tickets merely as the lowest-fare option for their customers to travel on the desired hub-spoke route.

There is nothing inherently anticompetitive,

then, in the Airlines' withdrawal of the travel agents' prior authority to issue hidden-city tickets. If there were, one could just as readily argue that an Airline would violate § 2 by mistakenly propagating a discounted fare for one of its routes, and then discovering the error and removing the fare after travel agents had already issued some tickets at the too-low price. In either case, a source of fare discounting would be removed from the marketplace, but it could not be said that these discounts were the product of market competition. In this regard, Defendants make a persuasive case that an Airline's actions *viz-a-viz* travel agents provide a slender reed upon which to rest a showing of anticompetitive conduct.

Yet, the Court is unwilling, under the present record, to take the final step urged by Defendants—to accept the “mistaken fare” analogy *in toto*, and to deem it *per se* lawful for the Airlines to close the hidden-city “loophole” in their fare structures. The Court cannot escape the element of question-begging in Defendants' position. If, in fact, Defendants' hub-spoke fares are determined by competitive forces, then the Airlines do not act anticompetitively in foreclosing hidden-city fares that threaten their legitimate fare structures. If, on the other hand, Plaintiffs and their experts carry the day with their assertion that lower hidden-city fares are the product of supracompetitive hub premiums imposed by the Airlines on their hub-spoke passengers, then Plaintiffs seemingly would have established one of the hallmarks of monopoly power—namely, “the power to control prices,” *Intergraph Corp.*, 195 F.3d at 1353—and the exercise of this power in the setting of hub-spoke fares. To close a “loophole” under these circumstances would foreclose the opportunity of consumers to obtain the competitive fares which, in Plaintiffs' view, are reflected in hidden-city tickets.

This is precisely the anticompetitive “intra-brand” effect accepted in the Court's prior ruling as sufficient to sustain a § 2 claim. In particular, the Court characterized Plaintiffs' § 2

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claims as based on Defendants' creation of an "anti-competitive barrier" that "interferes with how the relevant market would operate in the absence of" the Airlines' hidden-city prohibitions. *Chase*, 49 F.Supp.2d at 566. While this earlier Opinion also spoke of reduced competition among the various distributors of tickets for air travel, *see Chase*, 49 F.Supp.2d at 569, the Court does not view the existence of such competition as the lynchpin of its ruling. If it were, this would mean that a fully vertically-integrated monopolist would be wholly immunized from § 2 liability for any actions it might take within its monopolized market that threaten consumer welfare. Such actions, after all, could not jeopardize intrabrand competition—by assumption, there is none. Moreover, in Defendants' view, any negative impact upon consumers must be deemed procompetitive in the interbrand market, as it enhances the opportunity for rivals to capture the business of disgruntled customers. Yet, this assumes that entry is \*214 possible, and, as noted, Plaintiffs have introduced issues of fact on this question.

In any event, even leaving aside intrabrand considerations for the moment, the Court is not persuaded as a matter of law that an individual Airline's hidden-city prohibition has no conceivable anticompetitive effect in the interbrand market of passenger air travel service. Defendants simplistically argue that it cannot, because it merely results in increased prices in hub-spoke markets, thereby encouraging entry into these markets. This view is incomplete, however, as it ignores the barriers to entry identified by Plaintiffs, and overlooks the possible competitive benefits that might accrue to an Airline that is able to successfully impose supracompetitive hub premiums while maintaining its monopoly share of hub-spoke passengers. Under the present, summary judgment posture of this case, the Court must accept as true Plaintiffs' evidence and expert testimony that such competitive imperfections are present in the relevant hub-spoke markets.

In these circumstances, there is a potential for mischief in the interbrand marketplace. First, as suggested by Plaintiffs' counsel at the November 14 hearing, an Airline's supracompetitive pricing on its allegedly monopolized hub-spoke routes could operate to subsidize its pricing on its competitive spoke-spoke routes. Such a fare structure would raise the specter of monopoly leveraging. The Sixth Circuit has recognized that a plaintiff can make the requisite showing of anticompetitive conduct under § 2 by pointing to the defendant's exploitation of monopoly power in one market to gain a competitive advantage in another. *See Kerasotes Michigan Theatres, Inc. v. National Amusements, Inc.*, 854 F.2d 135, 137–38 (6th Cir.1988), *cert. denied*, 490 U.S. 1087, 109 S.Ct. 2461, 104 L.Ed.2d 982 (1989).<sup>FN36</sup>

FN36. While some courts have required a showing that the defendant either attained or attempted to attain a monopoly in the leveraged market, *see, e.g., Alaska Airlines, Inc. v. United Airlines, Inc.*, 948 F.2d 536, 547 (9th Cir.1991), *cert. denied*, 503 U.S. 977, 112 S.Ct. 1603, 118 L.Ed.2d 316 (1992), the Sixth Circuit declined to adopt this standard in *Kerasotes*, stating:

We expressly reject the district court's reasoning that leverage or the abuse of monopoly power is not actionable when the offender has not yet acquired a dominant position in the affected market .... Products that may be inferior should not be allowed to prosper in a particular market as a result of [their] producer's exploitation of its monopoly position in a second market. Under such situations, potential economic or competitive gains are not identifiable. This is, of course, most clearly so where the alleged offender has used coercion in the market where it validly possesses monopoly power to further extend that power to a second market. Finally, we observe that

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the antitrust laws prohibit not just the possession of monopoly power but also attempts to restrain trade and impede competition. Thus, it is not determinative that [the defendant] may not presently enjoy a dominant market power position in ... the affected market.

*Kerasotes*, 854 F.2d at 137–38.

Indeed, given the interdependent nature of an Airline's hub-spoke network, there is reason for concern that an Airline's monopoly leveraging on its spoke-spoke routes might also serve to further enhance its dominant position at its hub airport. In positing the state of the “but-for” world where Defendants could not prohibit hidden-city ticketing, Plaintiffs have pointed to evidence that changes in operations at one spoke of an Airline's hub-spoke network can produce a ripple effect throughout the network. If this can occur negatively, with a reduction in service at one or more spokes jeopardizing the profitability of the hub airport fed by those spokes, it stands to reason that the opposite could occur as well—that is, that increased service at “feeder” spokes could produce a thriving hub. In this way, an Airline's leveraging of its alleged hub monopoly to enhance its position on spoke-spoke routes could, in turn, redound to the benefit of its alleged market dominance at its hub airport. If so, such conduct could be deemed anticompetitive under § 2, as it would signify the willful maintenance of monopoly power (and supracompetitive pricing) at an Airline's hub, “as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.” *Re/ Max International, Inc. v. Realty One, Inc.*, 173 F.3d 995, 1016 (6th Cir.1999) (internal quotations and citations omitted).

Similarly, there is a suggestion in the record of price discrimination, which also is recognized in this Circuit as a form of anticompetitive conduct that can establish a § 2 \*215 violation.<sup>FN37</sup> In particular, the Sixth Circuit observed in *Byars*,

*supra*, that vertical integration is not *per se* unlawful, but that it may be deemed so where it “facilitates price discrimination so that the monopolist can reap the maximum monopoly profit from different consumers.” *Byars*, 609 F.2d at 861. In this case, an Airline's hidden-city prohibition is precisely designed to ensure that two different classes of passengers pay different fares, even though they are sitting alongside each other on the very same airplane traveling the same hub-spoke route. Plaintiffs assert that this fare differential is attributable to the Airlines' market dominance at their hub airports, giving them the power to impose higher fares on their hub-spoke passengers. Defendants respond that their fare structures, with their hidden-city pricing anomalies, are the product of legitimate competitive considerations. This, of course, is a core factual question in this case, and must be resolved by the trier of fact on a complete evidentiary record.

FN37. “Price discrimination occurs when a firm obtains different rates of return from different groups of customers.” III Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law*, ¶ 721a, at 262 (2d ed.2002).

To be sure, a leading treatise of antitrust law advises the judiciary to proceed with caution in cases of alleged price discrimination, opining that this practice “has ambiguous effects on consumer welfare and entry by competitors.” Areeda & Hovenkamp, *supra*, ¶ 721e, at 270. Even where a court might be reasonably confident of the anticompetitive effects of such a practice, there is the difficulty of fashioning appropriate relief, which generally would entail a determination of the appropriate “competitive” price. *See id.*, ¶ 721e, at 268–70. Here, however, Plaintiffs have produced evidence that hub-spoke passengers have been compelled to pay supracompetitive fares, and that barriers to entry have thwarted the usual market forces that would correct this situation. They further submit that the appropriate competitive fares for hub-spoke travel are estimable by resort to

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the Airlines' hidden-city fares, which encompass the same hub-spoke travel but are set under competitive conditions. Once again, the Court need not decide at this juncture whether Plaintiffs' economic model is correct. It is enough that it provides a plausible basis for finding anticompetitive conduct, and that it enjoys sufficient support in the record. The Court finds that Plaintiffs have met these threshold requirements.<sup>FN38</sup>

<sup>FN38</sup>. In its earlier Opinion addressing the proposed testimony of Plaintiffs' experts, the Court expressed serious reservations about the use of hidden-city fares as a measure of the purported hub premiums imposed by the Airlines on their hub-spoke passengers. Nevertheless, the Court found that the experts' testimony on this point satisfied the threshold standards for admissibility under [Fed.R.Evid. 702](#).

Admittedly, these concerns of leveraging and price discrimination rest largely upon economic theory at this point, and their existence has yet to be established. Plaintiffs, however, are not the moving party—they need not prove their case here, but need only identify factual disputes as to the issues raised by Defendants. In this context, Plaintiffs' heavy reliance on the Court's prior Opinion, and their failure to offer much in the way of concrete evidence regarding anticompetitive effects in the interbrand market, appear to be in-kind responses to the broad-brush arguments put forward in Defendants' motion. By citing bright-line (and often inapposite) rules and advancing a superficial view of the marketplace, Defendants have done little to elicit a more thorough and sophisticated market analysis, much less to show that any such analysis must be resolved in their favor as a matter of law. The Court is confident that none of the broad principles relied upon by Defendants establishes the *per se* lawfulness of their hidden-city prohibitions. Moreover, the Court's tentative assessment of the marketplace, undertaken with little assistance from

the parties, fails to lead to a firm conclusion, as a matter of law, that the Airlines' prohibitions raise no anticompetitive concerns. Accordingly, Defendants are not entitled to summary judgment in their favor on Plaintiffs' § 2 claims.

#### **IV. PLAINTIFFS' MOTION FOR CLASS CERTIFICATION**

##### **A. The Standards Governing Plaintiffs' Motion**

As noted at the outset, Plaintiffs filed a motion on November 15, 2000, requesting \*216 certification of three classes under [Fed.R.Civ.P. 23](#), with one of these classes, in turn, encompassing three subclasses. First, with regard to Plaintiffs' request for an order enjoining Defendants from enforcing their prohibitions on hidden-city ticketing, Plaintiffs seek certification of a class consisting of all persons or entities who will purchase a ticket from one of the Airline Defendants for travel originating or terminating at one of these Airlines' hub airports. Second, Plaintiffs move for certification of a class under their [Section 1](#) antitrust conspiracy theory, with this class consisting of all persons or entities who purchased an unrestricted full-fare ticket from one of the Airline Defendants for travel on an “Affected City–Pair” route—namely, some (but not all) of the routes originating or terminating at one of Defendants' hub airports. Third, for each of Plaintiffs' [Section 2](#) antitrust claims against the three individual Airline Defendants, Plaintiffs request certification of a subclass of persons or entities who purchased an unrestricted full-fare ticket from the relevant Airline for travel on an “Affected City–Pair” route, excluding any shared hub-to-hub routes.<sup>FN39</sup>

<sup>FN39</sup>. Membership in the latter two classes is limited to those who purchased tickets within a defined “class period,” which began on (i) October 10, 1992 with respect to Defendant Northwest, (ii) May 18, 1995 for Defendant U.S. Airways, and (iii) June 11, 1995 for Defendant Delta.

Plaintiffs' motion is governed by [Federal Rule](#)

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of Civil Procedure 23, which provides in pertinent part:

**(a) Prerequisites to a Class Action.** One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

**(b) Class Actions Maintainable.** An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition:

\* \* \* \* \*

(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or

(3) the courts finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The matters pertinent to the findings include: (A) the interests of members of the class in individually controlling the prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; (D) the difficulties likely to be encountered in the management of a class action.

Fed.R.Civ.P. 23.

[12] As is clear from the text and structure of Rule 23 itself, a proposed class action must satisfy each of the four prerequisites of subsection (a), and must then qualify under at least one of the three categories set forth in subsection (b). *See In re American Medical Systems, Inc.*, 75 F.3d 1069, 1079 (6th Cir.1996); *Fuller v. Fruehauf Trailer Corp.*, 168 F.R.D. 588, 594 (E.D.Mich.1996). Plaintiffs, as the parties seeking class certification, bear the burden of establishing that these requirements are satisfied; “[a] class is not maintainable as a class action by virtue of its designation as such in the pleadings.” *In re American Medical Systems*, 75 F.3d at 1079. Further, the Supreme Court has cautioned that a class action “may only be certified if the trial court is satisfied, after a rigorous analysis, that the prerequisites of Rule 23(a) have been satisfied.” *General Telephone Co. v. Falcon*, 457 U.S. 147, 161, 102 S.Ct. 2364, 2372, 72 L.Ed.2d 740 (1982).

**\*217 B. Plaintiffs Have Satisfied the Four Prerequisites of Rule 23(a).**

The four elements of Rule 23(a) “have been given the shorthand designations of ‘numerosity, commonality, typicality, and adequacy of representation.’ ” *Fuller*, 168 F.R.D. at 595 (citation omitted). In challenging Plaintiffs’ showing under Rule 23(a), Defendants devote little or no discussion to the issues of numerosity and commonality, and instead focus on adequacy and, especially, typicality. Consequently, the Court, too, will move rather quickly through the first two elements of Rule 23(a), and then will examine in depth the more controversial issues.

**1. Numerosity**

[13][14] Rule 23(a) requires that the proposed class be “so numerous that joinder of all members is impracticable.” There is “no strict numerical test for determining impracticability of joinder,” *In re American Medical Systems, supra*, 75 F.3d at 1079, and “[t]he mere allegation that the class is too numerous to make joinder practicable, by itself, is not sufficient to meet this prerequisite.” *Fleming v.*

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*Travenol Laboratories, Inc.*, 707 F.2d 829, 833 (5th Cir.1983). Instead, “a plaintiff must ordinarily demonstrate some evidence or reasonable estimate of the number of purported class members.” *Zeidman v. J. Ray McDermott & Co.*, 651 F.2d 1030, 1038 (5th Cir.1981). In general, the numerosity inquiry “requires examination of the specific facts of each case,” *In re American Medical Systems, supra*, 75 F.3d at 1079 (internal quotations and citations omitted), and turns upon such factors as the dispersion of class members across a wide geographic area and the ease of identifying class members, see *Andrews v. Bechtel Power Corp.*, 780 F.2d 124, 131–32 (1st Cir.1985), cert. denied, 476 U.S. 1172, 106 S.Ct. 2896, 90 L.Ed.2d 983 (1986).

[15] Plaintiffs readily satisfy this prerequisite here. They estimate that the proposed classes number in the hundreds of thousands, if not millions, and it is fair to assume that the class members are located across the nation, as the purported “Affected City–Pairs” span from coast to coast. Under these circumstances, joinder is impracticable, and the numerosity requirement is established.

## 2. Commonality

[16] Next, the “commonality” element of [Rule 23\(a\)](#) requires that there be “questions of law or fact common to the class.” Complete identity of issues is not required; rather, it is enough if the resolution of one particular issue will affect all or a significant number of the members of the putative class. *Fuller*, 168 F.R.D. at 595–96. For example, “[w]here the party opposing the class has engaged in some course of conduct that affects a group of persons and gives rise to a cause of action, one or more of the elements of that cause of action will be common to all of the persons affected.” 168 F.R.D. at 595 (internal quotations and citation omitted). Yet, “not every common question ... will suffice,” because “at a sufficiently abstract level of generality, almost any set of claims can be said to display commonality.” *Sprague v. General Motors*

*Corp.*, 133 F.3d 388, 397 (6th Cir.), cert. denied, 524 U.S. 923, 118 S.Ct. 2312, 141 L.Ed.2d 170 (1998). “What we are looking for is a common issue the resolution of which will advance the litigation.” 133 F.3d at 397.

[17] Here, there are many such common issues. Regarding Plaintiffs' [Section 1](#) claim, an obvious commonality is the question whether the Defendant Airlines agreed upon a common course of action to eliminate hidden-city ticketing. The resolution of this issue will either defeat Plaintiffs' [Section 1](#) claim, if there was no such agreement, or will go far toward establishing a Sherman Act violation, if there was such collusive conduct.

Similarly, as to Plaintiffs' [Section 2](#) claims against the individual Airlines, the Court has no trouble in identifying common issues. For example, Plaintiffs' antitrust claims against the individual Defendant Airlines rest heavily upon a hub-based approach to market definition and analysis, under which an Airline's purported monopoly power in a given city-pair market allegedly may be determined largely through consideration of market conditions at the hub point of origin or destination. If Plaintiffs cannot establish the \*218 validity of this approach, and if Defendants instead prevail on their counter-theory that each route emanating from the same hub is subject to distinct competitive forces, Plaintiffs' [Section 2](#) claims will fail for want of proof of the existence of monopoly power in each of the relevant city-pair markets. As another example, Plaintiffs' [Section 2](#) claims will rise or fall on the question whether hidden-city savings opportunities are a product of the Defendant Airlines' exercise of monopoly power at their hubs, as Plaintiffs and their experts contend, or are, as Defendants maintain, simply a side effect of economically rational fare structures that reflect legitimate considerations such as supply and demand and quality of service. Accordingly, the Court finds that the prerequisite of commonality is satisfied.

## 3. Typicality

To satisfy the “typicality” prong of [Rule 23\(a\)](#),

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Plaintiffs must show that “the claims or defenses of the representative parties are typical of the claims or defenses of the class.” “The premise of the typicality requirement is simply stated: as goes the claim of the named plaintiff, so go the claims of the class.” *Sprague*, 133 F.3d at 399. While the “commonality” and “typicality” inquiries overlap to a degree, this Court previously has explained that these prerequisites “focus[ ] on two distinct questions”:

Under the commonality prong, a court must ask whether there are sufficient factual or legal questions *in common* among the class members' claims to make class certification economical and otherwise appropriate. In contrast, under the typicality prong, a court must ask whether, despite the presence of common questions, each class member's claim involves so many *distinct* factual or legal questions as to make class certification inappropriate .... In short, commonality focuses on similarities, while typicality focuses on differences.

*Fuller*, 168 F.R.D. at 597–98.

This prerequisite, and the related requirement of predominance under Rule 23(b)(3), is at the heart of the parties' dispute as to the propriety of class certification. Defendants' brief in opposition to Plaintiffs' motion is replete with examples of the “individualized proof” that purportedly will be needed for each class member to establish his or her entitlement to relief. Thus, according to Defendants, the evidence in support of a given class representative's claim would do little or nothing to demonstrate that anyone else has suffered an antitrust injury. Specifically, Defendants assert that individualized inquiry is required to resolve the following issues: (i) whether Plaintiffs' “Affected City–Pairs” properly delineate the product and geographic markets in which a particular ticket purchase occurred; (ii) whether a Defendant Airline possesses monopoly power in each relevant city-pair market; (iii) whether (and which) hidden-city fares may serve as appropriate benchmarks for

determining a truly “competitive” fare, thereby constituting cognizable evidence of an Airline's alleged exercise of monopoly power, and of the impact of this alleged exercise upon the members of the class; (iv) whether each individual class member suffered injury as a result of a Defendant's allegedly illegal conduct; (v) what damages, if any, can be proven by each class member; and (vi) whether a class member was fully reimbursed for his or her travel, and therefore would be ineligible to collect damages.

The Court will address each of these matters in turn. Before doing so, however, the Court wishes to offer two general observations which, as will be seen, bear heavily on most or all of the several issues raised by Defendants. First, while it is evident that Defendants have a number of problems with the analysis offered by Plaintiffs' experts, and that the two sides' experts reach diametrically opposed conclusions on a number of points, it is equally clear that, “[a]t this stage, the Court should not delve into the merits of an expert's opinion or indulge ‘dueling’ between opposing experts.” *In re Cardizem CD Antitrust Litigation*, 200 F.R.D. 297, 311 (E.D.Mich.2001); *see also Caridad v. Metro–North Commuter Railroad*, 191 F.3d 283, 293 (2d Cir.1999), *cert. denied*, 529 U.S. 1107, 120 S.Ct. 1959, 146 L.Ed.2d 791 (2000); \*219 *In re Disposable Contact Lens Antitrust Litigation*, 170 F.R.D. 524, 531 (M.D.Fla.1996); *In re Domestic Air Transp. Antitrust Litigation*, 137 F.R.D. 677, 692 (N.D.Ga.1991) (“It is not the function of the Court at this time to determine whether Dr. Beyer is correct.”). Rather, it is enough that Plaintiffs and their experts have put forward a “colorable method” of establishing their antitrust claims through generalized, class-wide proof. *Disposable Contact Lens Antitrust Litigation*, 170 F.R.D. at 531. FN40

FN40. As noted earlier, Defendants argued in a separate motion that the methodology of Plaintiffs' experts is so flawed, and that the fit is so poor between their expert opinions and the facts of this case, that

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their conclusions must be discounted for purposes of resolving the present motions. The Court recently addressed this question in a separate Opinion and Order, holding that the opinions of Plaintiffs' experts survive gatekeeping scrutiny under Fed.R.Evid. 702.

Next, while Defendants make much of the complexity of the economics of the airline industry, and contend that the determination of each fare involves myriad context-specific considerations, Plaintiffs remind the Court that this precise argument has been made, and emphatically rejected, in the past:

It is now the task of the Court to determine the propriety of class certification in this action. While the determination requires consideration of many issues, the overriding question before the Court today is whether participants in a massive, nationwide industry are exempted from the purview of the civil antitrust laws of the United States because of their ability to portray the class as so large and the industry as so complex and complicated that an action to hold the participants accountable for the injuries they have caused cannot possibly be brought as a class action.

*Domestic Air Transp. Antitrust Litigation*, 137 F.R.D. at 683. Although the issues involved in *Domestic Air Transp. Antitrust Litigation* are by no means identical to those presented here, Judge Shoob's analysis nevertheless carries much persuasive force in this case, where the Airlines again seek to avoid class certification in an antitrust action challenging an aspect of their hub-and-spoke systems. Like Judge Shoob, this Court finds that the Airlines have dramatically overstated the idiosyncracies of the claims and defenses in this case.

**(a) Plaintiffs' Hub-Based Market Analysis**

In arguing that their antitrust claims are amenable to generalized, class-wide proof, and that their individual claims are typical of those of the

class as a whole, Plaintiffs advance a market analysis that focuses upon the Defendant Airlines' hub airports. Specifically, they and their experts posit (i) that the relevant product market is air travel, and that other modes of transportation need not be considered in light of the 150-mile minimum used to identify the relevant city-pairs; (ii) that the relevant geographic markets are city-pairs emanating from or terminating at a hub airport, with each "city" encompassing all airports within a single metropolitan area; and (iii) that the existence of monopoly power in each city-pair market can be determined largely by reference to conditions at the hub end of the route. Defendants argue that these generalizations are unwarranted, and that the proper inquiry, focusing on each individual city-pair, would lead to the conclusion that a given Plaintiff's claim is typical only of, at best, those claims involving precisely the same city-pair.

[18] Initially, as Plaintiffs point out, Defendants' challenges to Plaintiffs' market analysis do not affect the question of class certification with respect to Plaintiffs' Section 1 claims. As explained earlier, the agreement alleged by Plaintiffs, if proven, likely would be subject to only an abbreviated or "quick look" form of Rule of Reason analysis, and Plaintiffs would not be called upon to produce a detailed market-by-market analysis of the anticompetitive effects of Defendants' alleged agreement. See *California Dental Ass'n v. Federal Trade Comm'n*, 526 U.S. 756, 769–70, 119 S.Ct. 1604, 1612–13, 143 L.Ed.2d 935 (1999). In any event, any weakness in Plaintiffs' analysis of a particular city-pair market seemingly would have no bearing on their § 1 claim, where there is no evidence that any Airline has ever even considered a partial prohibition on hidden-city ticketing, depending on the conditions in a particular market. Even under a full-blown Rule of Reason analysis, then, there is no \*220 reason to think that the outcome will turn upon market-to-market distinctions; rather, in this regard, Plaintiffs and Defendants alike seemingly are proceeding under the assumption that the economics of the industry

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are largely driven by the nature and characteristics of a hub-spoke network. In short, any alleged defects in Plaintiffs' market analysis are of no consequence to their request for class certification of their antitrust conspiracy claim.

Next, regarding the product and geographic scope of Plaintiffs' market definition, the Court already has concluded in a prior Opinion that Defendants' challenges go only to the evidentiary weight of Plaintiffs' expert opinions and the correctness of the conclusions drawn by those experts, but do not provide a basis for altogether excluding these opinions. Moreover, Defendants' quibbles do not render Plaintiffs' claims any less susceptible to class-wide or generalized proof. Whether, for example, the interchangeability of ground and air travel extends 150 or 300 miles, or whether certain markets (*e.g.*, Cleveland and Akron) are so close together that they create the possibility of substitution between city-pairs, the outcome of such inquiries still would result in a largely global set of rules through which one could, as a matter of common proof, ascertain the proper set of city-pair markets. As Plaintiffs note, any broader attack on the use of city-pairs surely cannot succeed, where the airlines themselves, as well as numerous government and academic reports, have adopted this same general approach to analyzing the air travel industry. In short, while Defendants' challenges might lead to a *shorter list* of city-pairs than the one offered by Plaintiffs' experts, they do not call into question Plaintiffs' overall city-pair approach to market analysis, nor do they require anything approaching 234 separate "trials" to determine the relevant markets.

Finally, Defendants accuse Plaintiffs' experts of making an unwarranted leap from hub-based to market-wide findings of monopoly power, and they argue that it is necessary to separately examine each of Plaintiffs' 234 city-pairs for the presence of such power. Again, however, the Court has already held that Plaintiffs will be permitted to present their somewhat "hub-skewed" market analysis to the

trier of fact. More generally, in their contention that individualized proof will be necessary to establish the requisite monopoly power in each city-pair market, Defendants overlook the core premise of Plaintiffs' [Section 2](#) claims. Plaintiffs' entire [Section 2](#) case rests upon the allegation that, by virtue of each Defendant's alleged monopoly power at its hub airports, Defendants are able to impose "hub premiums" on many passengers traveling to or from their hubs, thereby giving rise to hidden-city savings opportunities. Plaintiffs do not contend that this is an isolated city-specific phenomenon, but a generalized occurrence on many of the routes emanating from Defendants' hub airports. In other words, a hub monopoly, and its attendant effect on the bulk of city-pair fares involving a hub, is the lynchpin of Plaintiffs' [Section 2](#) claims. If Plaintiffs are unable to persuade the trier of fact that each Defendant possesses such power at its hub airports, then Plaintiffs' claims must fail, irrespective of whether a given Airline might be found to possess monopoly power on this or that city-pair route.

Consequently, if Defendants believe that Plaintiffs and their experts are guilty of sweeping generalization, or that they have overlooked contrary data, in their haste to claim broad monopoly power, it should be a relatively easy matter for Defendants to disprove Plaintiffs' core thesis at trial, and Defendants certainly are entitled to introduce market-specific evidence in their effort to do so. Notwithstanding such defenses, however, Plaintiffs' claims, as alleged, surely are amenable to generalized, class-wide proof, and any traveler on a city-pair route involving a particular hub is just as "typical" as any other for purposes of proving these claims.<sup>FN41</sup> Indeed, under the present record, \*221 it is clear that Plaintiffs can *only* succeed if this is so, because, as Defendants correctly point out, Plaintiffs and their experts have not undertaken any sort of route-by-route market analysis that might support a narrower species of [Section 2](#) claim.

FN41. For this reason, the Court rejects Defendants' related "standing" argument—

*i.e.*, that each named Plaintiff can serve as the representative for only those class members who traveled on precisely the same city-pair route. Under the hub-based market theory advanced by Plaintiffs and their experts, the antitrust injury allegedly suffered by any particular named Plaintiff would be precisely the same as that purportedly suffered by any other passenger who flew into or out of the same hub—namely, the deprivation, by virtue of the exercise of a Defendant's alleged monopoly power, of the opportunity to purchase a hidden-city ticket at a lower fare that would provide the same “product” as a hub-spoke ticket reflecting the passenger's true itinerary. Given the highly similar nature of the claims of all passengers traveling to or from the same hub, minor factual distinctions— *e.g.*, different fares over time—do not defeat typicality. *See Domestic Air Transp. Antitrust Litigation*, 137 F.R.D. at 699.

Having said that, the Court is concerned that the named Plaintiffs might not have purchased tickets involving all seven of the hub airports at issue here. While it might not be necessary in this case to undertake a detailed market analysis for each and every city-pair, such an analysis seemingly is needed for each hub, and all class members who traveled to or from a given hub presumably should be able to look to a particular representative to pursue their claims. Accordingly, the Court leaves this matter open for further consideration.

**(b) Plaintiffs' Use of Hidden–City Fares as Benchmarks for Allegedly Supracompetitive Hub–Spoke Fares**

As their next challenge to Plaintiffs' showing of typicality, as well as predominance, Defendants question the “triple duty” purposes for which

Plaintiffs and their experts propose to offer evidence of hidden-city savings opportunities. As observed by Defendants, Plaintiffs point to these savings opportunities as (i) further evidence that Defendants possess monopoly power at their hub airports; (ii) the requisite proof, under both [Section 1](#) and [Section 2](#), of the anticompetitive effect of Defendants' actions; and (iii) evidence of the existence and extent of the injury suffered by each member of the class. According to Defendants, each one of these purposes opens the door to individualized proofs that defeat any claim of typicality or predominance of common issues.

[19] Defendants' first challenge, to the use of hidden-city savings opportunities as evidence of monopoly power, merits little discussion. As observed in the Court's prior Opinion addressing the admissibility of the expert testimony proffered by Plaintiffs, Plaintiffs and their experts point to hidden-city savings opportunities merely as “confirm[ing] defendants' exercise of monopoly power,” (Plaintiffs' Exhibits, Tab 71, Beyer Expert Report at ¶ 17), and not as conclusive proof of the existence of such power. Defendants are free to offer evidence— *e.g.*, instances of so-called “negative” hidden-city savings, where a spoke-hub-spoke fare is higher than the fare for traveling the included hub-spoke route—to rebut these claims of monopoly power.

Defendants' remaining two challenges are related, for a simple reason. In particular, given that the crux of Plaintiffs' claims of anticompetitive conduct, under both [Section 1](#) and [Section 2](#), is the denial of any opportunity to capture the hidden-city savings opportunities that would be available but for the Airlines' prohibition on hidden-city ticketing, it is hardly surprising that Plaintiffs would point to these savings opportunities *both* (i) as proof of Defendants' anticompetitive conduct, *and* (ii) as establishing the existence and extent of each class member's injury as a result of that conduct. Defendants, of course, need not acknowledge the merit of Plaintiffs' theories of

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liability, but they surely must recognize, at this late date in these proceedings, that Plaintiffs' claims rest upon the premise that hidden-city savings opportunities are a reflection of supracompetitive hub premiums imposed by the Defendant airlines. Similarly, though Defendants might strongly disagree with the expert analysis through which Plaintiffs seek to support this proposition, there is no question that the opinions offered by Plaintiffs' experts *do* support their contentions as to the significance of hidden-city savings opportunities.

Thus, it appears, once again, that Defendants wish the Court to weigh the respective opinions of the parties' experts. This the Court cannot do. The Court fully appreciates that, in the view of Defendants and their experts, the fares for a given spoke-hub-\*222 spoke route and its included hub-spoke route are determined by two wholly distinct sets of competitive factors, so that one route cannot readily be compared to the other.<sup>FN42</sup> Yet, accepting as true Plaintiffs' contrary premise that, in light of Defendants' monopoly power at their hub airports, hub-spoke fares are relatively immune from competitive pressures, it is not wholly irrational to look to (purportedly competitive) fares on the spoke-hub-spoke routes that encompass these allegedly monopolized hub-spoke route as providing some indication of the existence and extent of the "hub premiums" charged by the airline. Moreover, this proposed measure achieves greater probative value if one accepts Plaintiffs' further contention—again, challenged by Defendants—that, if the Airlines' hidden-city prohibitions were lifted, their likely response would be to lower their hub-spoke fares to eliminate any hidden-city savings opportunities. The fare that would be paid by a class member but for a Defendant's alleged antitrust violation seemingly provides a good benchmark for measuring the extent of the injury caused by such a violation.

<sup>FN42</sup>. Indeed, in its recent Opinion addressing Defendants' various challenges to the opinions of Plaintiffs' experts, the

Court discussed this point at length, and acknowledged that such comparisons raise a number of legitimate concerns.

The Court previously has recognized that the hidden-city benchmark analysis put forward by Plaintiffs' expert, Dr. Beyer, must confront a number of difficult questions, including: (i) how it can be that considerably fewer than all of the spoke-hub-spoke "hidden-city" routes offer opportunities for savings;<sup>FN43</sup> and (ii) how a widely disparate set of hidden-city fares, averaged together, can serve as a good estimate of the "hub premium" that the Airlines have imposed through their prohibitions against hidden-city ticketing.<sup>FN44</sup> Obviously, the explanations offered by Plaintiffs and their experts on these and other points must survive across-the-board scrutiny, and Defendants, of course, are free to offer evidence that tends to undermine Plaintiffs' attempt to establish unlawful overcharges through generalized proofs. Under the present record, however, the Court finds that Plaintiffs' benchmark analysis appears amenable to class-wide treatment, and that it poses no particular obstacle to Plaintiffs' satisfaction of the prerequisites of typicality and predominance.

<sup>FN43</sup>. Dr. Beyer has endeavored to explain this phenomenon, attributing it to such factors as differences in travel distances and natural monopolies on certain spoke-spoke routes. As to the latter, for example, if the hub-spoke route at issue is Detroit to Cincinnati, Ohio, it would not necessarily be surprising that a Seattle–Detroit–Cincinnati route did not offer a hidden-city savings opportunity.

<sup>FN44</sup>. Defendants note, for example, that Dr. Beyer has proposed 29 routes (with 128 separate fares) as benchmarks for the allegedly supracompetitive fare charged by Defendant Delta in a *single* market, Albany–Atlanta. Obviously, some of these benchmarks achieve higher savings, and

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some lower. The question becomes, then, how to isolate the portion of this savings that represents a “hub premium” due to the Airlines' hidden-city prohibitions, and how to explain the remaining differences among all the various savings opportunities once this premium is removed.

Dr. Beyer apparently endeavors to resolve these issues by applying a “minimum average” method of computation, under which the average hidden-city savings percentage is calculated for each fare code on a quarterly basis. Dr. Beyer then chose the fare code that achieved the smallest average savings percentage as his benchmark for the alleged anticompetitive overcharge for that quarter. For example, upon reviewing the Albany–Atlanta market on the date of September 19, 1995, Dr. Beyer found that the average savings percentages under the six applicable fare codes ranged from 11.5 to 14 percent. He used the smallest of these averages—11.5 percent—as the alleged overcharge imposed by Defendant Delta on its passengers traveling between Albany and Atlanta during this quarter in 1995.

#### (c) Plaintiffs' Proof of Antitrust Injury

Next, Defendants argue that Plaintiffs' proposed common proof of antitrust injury glosses over or ignores several individualized elements of each class member's relevant ticket purchases. In particular, Defendants contend that each class member would need to show (i) that he would have purchased a hidden-city ticket if such a practice was not prohibited by Defendants; (ii) that, despite possible issues of limited seat availability and inventory management, he could have located and purchased a hidden-city ticket for the desired date and time of travel that achieved \*223 the

benchmark level, or at least some level, of savings; and (iii) that, in the “but for” world in which the Airlines could not prohibit hidden-city ticketing, he would have paid a lower fare for his travel on an affected city-pair route.

[20][21] The Court finds the latter issue largely dispositive, and thus addresses the first two points only briefly. The courts have recognized that, for purposes of determining whether to certify a class, the “impact” element of an antitrust claim need not be established as to each and every class member; rather, it is enough if the plaintiffs' proposed method of proof promises to establish “widespread injury to the class” as a result of the defendant's antitrust violation. See *In re NASDAQ Market-Makers Antitrust Litigation*, 169 F.R.D. 493, 523 (S.D.N.Y.1996). In other words, “at the class certification stage, Plaintiffs must show that antitrust impact *can be proven* with common evidence on a classwide basis; Plaintiffs need not show antitrust impact *in fact occurred* on a classwide basis.” *In re Polypropylene Carpet Antitrust Litigation*, 178 F.R.D. 603, 618 (N.D.Ga.1997). The evidence offered by Plaintiffs and the opinions propounded by their experts, if credited, would establish, as a general matter amenable to common proof, that many class members would have sought out and purchased hidden-city tickets, and that the practice would have become widespread, if the Airlines had not acted to prohibit it.

Next, regarding the near-endless parade of scenarios advanced by Defendants as to the state of the “but for” world if hidden-city ticketing could not be prohibited, the Court again declines Defendants' invitation to weigh in on the battle of the experts. Plaintiffs' experts have offered a variety of explanations why, in their view, the Airlines likely would respond by lowering their hub-spoke fares to eliminate any hidden-city savings opportunities. Principally, these experts contend (i) that raising spoke-spoke fares to accomplish the same result would threaten to

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undermine the viability of the Airlines' hub-spoke networks by decreasing the crucial flow of passengers through the hubs; and (ii) that a do-nothing response, allowing the practice of hidden-city ticketing to become more widespread, would inject an unacceptable degree of chaos into Defendants' inventory control efforts as the Airlines were confronted with ever-increasing numbers of "phantom" passengers. As stated in the Court's prior Opinion addressing Plaintiffs' expert testimony, Defendants and their experts have by no means conclusively proved that these hypotheses are irrational, or that they rest upon an untenable methodology. Rather, Defendants merely claim an entitlement to prove, through market-specific evidence and otherwise, that the "but-for" world would be a great deal more complicated, with a great deal more variation in the airlines' market-by-market responses, than posited by Plaintiffs' experts.

To be sure, Plaintiffs' approach on this issue is yet one more example of the simplification that is achieved through a largely hub-based outlook on the air travel industry. But, as stated above, Plaintiffs have thoroughly demonstrated their commitment to this theory, and it is clear that their antitrust claims will rise or fall with the trier of fact's acceptance or rejection of their hub-dominated view of the marketplace. All that matters, at this stage, is that Plaintiffs' theory of liability rests upon a colorable analytical method that is susceptible to generalized proof. The Court finds that this threshold is achieved here with regard to Plaintiffs' claims of antitrust impact.

#### (d) Plaintiffs' Proof of Damages

Defendants next identify various damage-related issues which, in their view, will require individualized proofs, and which, therefore, threaten to undermine the typicality of any given named Plaintiff's claims. Each of these issues has been addressed or noted above, including (i) that the lifting of the Airlines' hidden-city prohibitions would produce responses that vary from market to

market, so that it is not possible to establish through generalized proofs the amount of savings that each class member would have achieved; (ii) that the benchmarking methodology of Plaintiffs' experts inappropriately incorporates an averaging technique, rather than purporting to determine with certainty the extent of damage suffered by each class \*224 member; and (iii) that Defendants are entitled to scrutinize each proposed benchmark that goes into this averaging computation, in an attempt to show that a given hidden-city savings opportunity reflects competitive considerations (e.g., low fare due to great inconvenience) rather than a "hub premium."

[22] By this time, the Court's response to these arguments will come as no surprise. Certain of these issues—for example, questions about the state of the "but for" world—could only be resolved by weighing the respective opinions of the parties' experts. Others—for example, the suitability of particular benchmarks—implicate individualized *defenses* to the generalized proofs that Plaintiffs propose to offer. Again, Defendants will prevail if they are able to persuade the trier of fact that the airline industry is not so simple as suggested by Plaintiffs' hub-based market analysis. Further, to the extent that Plaintiffs' proposed method of computing damages might overstate the "hub premiums" paid by the members of the class, it should be left to the trier of fact to decide whether, and by how much, to discount any monetary award. Plaintiffs need not establish their losses to a certainty; rather, in cases like this one, "[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, 101 S.Ct. 1923, 1929, 68 L.Ed.2d 442 (1981).

In any event, Plaintiffs have cited ample authority for the proposition that individualized damage inquiries, standing alone, do not warrant the denial of class certification, at least as to issues

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of liability. See *Sterling v. Velsicol Chem. Corp.*, 855 F.2d 1188, 1196–97 (6th Cir.1988); see also *In re American Medical Systems*, 75 F.3d at 1084; *In re Visa Check/Mastermoney Antitrust Litigation*, 280 F.3d 124, 139–40 (2d Cir.2001). “District courts have correctly recognized that any other rule would eliminate antitrust class actions.” *Visa Check/Mastermoney Antitrust Litigation*, 280 F.3d at 139–40 (citing cases). For purposes of resolving Plaintiffs’ present motion, then, the Court need not determine precisely the procedure through which it will resolve any individualized issues of damages that might remain after the common questions of liability and antitrust impact have been addressed. It is enough to conclude, as the Court now does, that any such individualized inquiries do not sufficiently detract from the typicality of the named Plaintiffs’ claims to preclude the certification of a class.

**(e) Reimbursement of the Ticket Purchase Price Paid by a Class Member or Named Plaintiff**

Finally, Defendants maintain that individual proofs will be required to eliminate any “windfall” recoveries by named Plaintiffs or class members who were reimbursed—e.g., by an employer—for any alleged overcharge imposed by a Defendant airline. This concern is not merely hypothetical, as, for example, Plaintiff Norman Volk has testified that he was fully reimbursed for all of the air travel for which he seeks to recover in this case. If, as Defendants contend, such reimbursement means that a class member lacks standing under the Clayton Act or Article III of the Constitution, it follows that individualized proofs will be required as to whether each class member was reimbursed for his or her relevant air travel.

As part of their debate on this issue, the parties devote considerable energy to wrangling over the significance of the Supreme Court’s rulings in *Hanover Shoe, Inc. v. United Shoe Machinery Corp.*, 392 U.S. 481, 88 S.Ct. 2224, 20 L.Ed.2d 1231 (1968), and *Illinois Brick Co. v. Illinois*, 431 U.S. 720, 97 S.Ct. 2061, 52 L.Ed.2d 707 (1977). At

best, however, these cases bear only tangentially upon the issues of reimbursement and standing raised by Defendants. In these decisions, the Court addressed, and largely rejected, the defensive and offensive use of a “pass-on” theory to, respectively, cut off a defendant’s antitrust liability to a direct purchaser plaintiff or expand the universe of antitrust plaintiffs to include indirect purchasers. As to the former, Defendants do not claim that some class members have merely “passed on” their antitrust injuries in the form of, for example, higher prices to customers. As to the latter, Plaintiffs need not seek to expand the universe of antitrust \*225 plaintiffs, as their proposed classes include only direct purchasers. In short, the complex questions of proof and policy judgments at issue in *Hanover Shoe* and *Illinois Brick* are not implicated here.

[23] Rather, the issue here is more straightforward, albeit individual to each class member—namely, whether a given class member sustained an out-of-pocket loss as a result of a Defendant’s antitrust violation, or whether this class member was made whole through reimbursement. Whatever can be said about the standing of a class member in the latter category, the case law cited by Plaintiffs uniformly confirms that this inquiry goes to the merits of each class member’s claim and, therefore, is not an appropriate basis for denying class certification. See, e.g., *Rozema v. Marshfield Clinic*, 174 F.R.D. 425, 444 (W.D.Wis.1997) (distinguishing between common issues of liability, which are necessary for certification of a class, and the rights of individual class members to recover, which are not); *Domestic Air Transp. Antitrust Litigation*, 137 F.R.D. at 696.<sup>FN45</sup> More specifically, it is not necessary, at the class certification stage, for Plaintiffs to show that each and every class member could satisfy an individualized standing inquiry. *Rozema*, 174 F.R.D. at 444.

FN45. In this regard, it is noteworthy that Defendants have not moved for summary judgment in their favor on the ground of

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lack of standing of any named Plaintiff who has been fully reimbursed for his air travel expenses.

To be sure, if Plaintiffs prevail on the common issues of liability, the remaining question of standing could present a formidable challenge to the Court's resources, as the Court can find no principled basis for denying Defendants the opportunity to at least explore whether each individual class member incurred any out-of-pocket losses as a result of a Defendant's overcharge. *Cf. In re Domestic Air Transp. Antitrust Litigation*, 148 F.R.D. 297, 318 (N.D.Ga.1993) (observing, as a basis for approving a settlement, that “the passing-on defense represented one of the major obstacles to plaintiffs' recovery,” where “individual determinations of the issue of reimbursement, whether at the liability or claims administration stage, would be not only impracticable but impossible, given judicial resources”). At this juncture, however, the Court need not reach the issue, and need not yet determine how to effectively and efficiently safeguard Defendants' entitlement to insist that each class member establish a right to recovery.<sup>FN46</sup>

<sup>FN46</sup>. The Court does observe, though, that individual “mini-trials” are not inevitable here, and that various procedural mechanisms—*e.g.*, detailed questionnaires or sworn affidavits—might assist in streamlining the requisite individualized inquiries.

#### 4. Adequacy of Representation

[24] The fourth and final prerequisite of [Rule 23\(a\)](#) is that “the representative parties will fairly and adequately protect the interests of the class.” To satisfy this prong of the inquiry, it must be shown that the representatives have interests in common with, and not antagonistic to, the interests of the unnamed members of the class, and that the representatives will vigorously prosecute these interests through qualified counsel. *In re American Medical Systems*, 75 F.3d at 1083.

[25] Defendants do not challenge the qualifications of Plaintiffs' chosen counsel. Rather, they argue only that there is a very real possibility of antagonistic interests among the members of the class and their named representatives, where (i) the class members must compete among themselves for a presumably limited supply of hidden-city tickets; and (ii) some passengers might be worse off if Plaintiffs succeed, as this potentially could result in an increase in at least some spoke-spoke fares and the elimination of some routes altogether. These contentions, however, implicate the conditions in the “but for” world, and therefore fall within the “battle of the experts” rubric. More generally, it is a fundamental premise of Plaintiffs' claims that each class member, as a hub passenger, has been required to pay a “hub premium” as a result of Defendants' antitrust violations. While other categories of passengers might shoulder portions of the financial burden in the event these alleged “hub premiums” are eliminated, the Court is **\*226** satisfied that Plaintiffs have reasonably defined their proposed classes to ensure that their membership is limited to those who stand to benefit in the event that Plaintiffs prevail.

#### C. Class Certification Is Appropriate Under [Rule 23\(b\)\(3\)](#).

[26] Having met the threshold requirements of [Rule 23\(a\)](#), Plaintiffs next must show that their proposed classes satisfy the conditions of at least one of the subdivisions of [Rule 23\(b\)](#). Plaintiffs propose that their “injunctive class” be certified under [Rule 23\(b\)\(2\)](#), and that the remaining classes be certified under [Rule 23\(b\)\(3\)](#). The Court finds, however, that Plaintiffs' proposed “damage” classes can serve as appropriate vehicles for the award of both monetary and injunctive relief, and that it is unnecessary to certify a separate, not to mention broader, class for purposes solely of determining whether to award the latter form of relief.

As Defendants observe, certification under [Rule 23\(b\)\(2\)](#) generally has been held to be inappropriate where the principal relief sought is

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money damages. See, e.g., *Visa Check/Mastermoney Antitrust Litigation*, 280 F.3d at 146–47; *Lemon v. International Union of Operating Eng'rs*, 216 F.3d 577, 580–81 (7th Cir.2000). As explained by the Seventh Circuit:

[T]he problem is that Rule 23(b)(2) provides for binding litigation on all class members without guarantees of personal notice and the opportunity to opt out of the suit. By virtue of its requirement that the plaintiffs seek to redress a common injury properly addressed by a class-wide injunctive or declaratory remedy, Rule 23(b)(2) operates under the presumption that the interests of the class members are cohesive and homogenous such that the case will not depend on adjudication of facts particular to any subset of the class nor require a remedy that differentiates materially among class members. A suit for money damages, even if the plaintiffs seek uniform, class-wide equitable relief as well, jeopardizes that presumption of cohesion and homogeneity because individual claims for compensatory or punitive damages typically require judicial inquiry into the particularized merits of each individual plaintiff's claim.

Indeed, in recognition of the potential divergence of interests within the class, each class member in actions for money damages is entitled as a matter of due process to personal notice and an opportunity to opt out of the class action. Accordingly, Rule 23(c)(2) guarantees those rights for each member of a class certified under Rule 23(b)(3). However, the Federal Rules of Civil Procedure do not provide comparable procedural guarantees of those rights for a class certified under subsections (b)(1) or (b)(2), and as a result, Rule 23(b)(2) certification does not ensure personal notice or opportunity to opt out even if some or all the plaintiffs pray for monetary damages.

*Lemon*, 216 F.3d at 580 (citations omitted). These concerns are implicated here, where Plaintiffs seek substantial monetary damages (on

the order of \$950 million) on behalf of hundreds of thousands of air travelers, but where, as noted, there are significant hurdles in the way of Plaintiffs' attempt to establish these damages through generalized proofs.

Consequently, if Plaintiffs are able to satisfy the dictates of Rule 23(b)(3), the Court sees no need to determine whether they also might satisfy subsection (b)(2) with regard to a separate class seeking only injunctive relief. See *Visa Check/Mastermoney Antitrust Litigation*, 280 F.3d at 147 (declining to determine the correctness of the District Court's ruling that a class could be certified under Rule 23(b)(2), where the Court already had upheld the certification of the class under subsection (b)(3)). This additional inquiry seems particularly unnecessary where the injunctive relief sought by the proposed separate class could just as easily be pursued by the various "damages" classes, and where such equitable relief, if awarded, would accrue to the benefit of all members of the proposed "injunctive only" class. Further, where the questions of liability significantly overlap, and indeed appear to be virtually identical, it would disserve judicial economy to certify separate "injunction" and "damage" classes.

\*227 [27] Accordingly, the Court next inquires whether Plaintiffs have satisfied subsection (b)(3). To do so, Plaintiffs must demonstrate (i) that "questions of law or fact common to the members of the class predominate over any questions affecting only individual members," and (ii) that "a class action is superior to other available methods for the fair and efficient adjudication of the controversy." Fed.R.Civ.P. 23(b)(3). The issue of predominance has been thoroughly addressed and resolved above, as Defendants' various challenges on the Rule 23(a) requirement of typicality—*i.e.*, that the claims of the individual named Plaintiffs are replete with individualized issues, and hence are not typical of the claims of class members generally—are merely the flip-side of their challenges to predominance—*i.e.*, that each class

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member's claims, like those of the named Plaintiffs, are replete with individualized inquiries. Thus, without in any way diminishing the opportunity of Defendants to show that Plaintiffs' and their experts' assertions of predominance are flawed, the Court nevertheless finds, for present purposes, that Plaintiffs' proposed method of proving liability rests upon predominantly common questions of law and fact.

[28] This leaves only the question whether a class action is superior to other methods of adjudicating Plaintiffs' claims. As was held in *Domestic Air Transp. Antitrust Litigation*, this Court finds, similarly, that “a class action [is] the only fair method of adjudication for plaintiffs,” as the “individual claims of many class members are so small that the cost of individual litigation would be far greater than the value of those claims.” *Domestic Air Transp. Antitrust Litigation*, 137 F.R.D. at 693–94. Moreover, assuming the validity of Plaintiffs' hub-based analysis of the airline industry, a class action properly reflects that each passenger who travels into or out of the same hub airport is in the “same boat,” so to speak, at least as to most issues.

Regarding Defendants' suggestion that a class action would be unmanageable, and hence not “superior,” this rests upon the proposition that “this case would require separate full-blown trials on the elements of violation for each of the hundreds of alleged markets in this case, and on injury and damages for each of the millions of members of the proposed class.” (Defendants' Response Br. at 44.) These various contentions have already been addressed, and the Court need not revisit its analysis or conclusions. It is enough to point out, once again, that the Airlines' success in persuading the trier of fact to reject Plaintiffs' hub-dominated market analysis will largely determine the fate of each and every class member's claim, because Plaintiffs clearly are not in a position to offer additional, market-by-market evidence in the event that their hub-based evidence is discounted. Indeed,

far from providing a basis for denying class certification, Defendants merely have identified a *common defense* to the claims of all class members, albeit one that rests upon a substantial volume of evidence as to allegedly differing conditions among the various city-pair markets. Consequently, the Court finds that Plaintiffs have established the prerequisites for class certification under Fed.R.Civ.P. 23(b)(3). FN47

FN47. This general ruling leaves a number of subsidiary procedural matters yet to be resolved. As noted earlier, for instance, it could be argued that each hub airport presents a sufficiently distinct set of circumstances to warrant the creation of subclasses. In addition, there are questions as to precisely the sort of notice Plaintiffs must provide to potential class members, and the degree to which this notice should attempt to anticipate the individualized “standing” concern alluded to earlier. Counsel should be prepared to discuss these and other outstanding procedural issues at a forthcoming status conference to be set by the Court.

## V. CONCLUSION

For the reasons set forth above,

NOW, THEREFORE, IT IS HEREBY ORDERED that Plaintiffs' November 15, 2000 Motion for Class Certification is GRANTED IN PART, with the exception of Plaintiffs' request for certification of a separate class under Fed.R.Civ.P. 23(b)(2) seeking purely injunctive relief. IT IS FURTHER ORDERED that the Airline \*228 Defendants' November 15, 2000 Motion for Summary Judgment is DENIED.

E.D.Mich.,2002.

In re Northwest Airlines Corp.

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146 Fed.Appx. 783, 2005 WL 2009178 (C.A.6 (Tenn.)), 2005-2 Trade Cases P 74,940, 2005 Fed.App. 0734N  
**(Not Selected for publication in the Federal Reporter)**  
**(Cite as: 146 Fed.Appx. 783, 2005 WL 2009178 (C.A.6 (Tenn.)))**

**C**

This case was not selected for publication in the Federal Reporter.

Not for Publication in West's Federal Reporter See Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. See also Sixth Circuit Rule 28. (Find CTA6 Rule 28)

United States Court of Appeals,  
Sixth Circuit.  
Richard RODNEY, Jr., on behalf of himself and all others similarly situated, Plaintiff-Appellant,  
v.  
NORTHWEST AIRLINES, INC.; and Northwest Airlines Corp., Defendants-Appellees.  
  
No. 04-5752.  
Aug. 22, 2005.

**Background:** Passenger brought action against airline, alleging monopoly in three hubs. The United States District Court for the Western District of Tennessee denied passenger's motion to certify action as a class action. Passenger appealed.

**Holding:** The Court of Appeals, [Batchelder](#), Circuit Judge, held that common issues did not predominate over any questions, and thus, certification of class was not appropriate.

Affirmed.

West Headnotes

**[1] Federal Civil Procedure 170A**  **172**

170A Federal Civil Procedure  
170AII Parties  
170AII(D) Class Actions  
170AII(D)2 Proceedings  
170Ak172 k. Evidence; pleadings and supplementary material. [Most Cited Cases](#)  
Court performing inquiry into whether

common issues predominated, warranting certification of class in antitrust action, could consider not only evidence presented in plaintiff's case-in-chief but defendant's likely rebuttal evidence. [Fed.Rules Civ.Proc.Rule 23\(b\)\(3\)](#), 28 U.S.C.A.

**[2] Federal Civil Procedure 170A**  **181.5**

170A Federal Civil Procedure  
170AII Parties  
170AII(D) Class Actions  
170AII(D)3 Particular Classes Represented  
170Ak181.5 k. Antitrust plaintiffs.

[Most Cited Cases](#)

Individual questions predominated on issue of market definition in antitrust action alleging that airline exercised monopoly power in three hubs, and thus, class certification was not warranted, as cross-elasticity analysis would be specific to each of 74 routes going into and out of the three hubs. [Fed.Rules Civ.Proc.Rule 23\(b\)\(3\)](#), 28 U.S.C.A.

**[3] Federal Civil Procedure 170A**  **181.5**

170A Federal Civil Procedure  
170AII Parties  
170AII(D) Class Actions  
170AII(D)3 Particular Classes Represented  
170Ak181.5 k. Antitrust plaintiffs.

[Most Cited Cases](#)

District court could consider an antitrust plaintiff's failure to define the market as part of its class certification analysis without violating procedural requirements of class action rule. [Fed.Rules Civ.Proc.Rule 23](#), 28 U.S.C.A.

**[4] Federal Civil Procedure 170A**  **181.5**

170A Federal Civil Procedure  
170AII Parties  
170AII(D) Class Actions  
170AII(D)3 Particular Classes

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Represented

170Ak181.5 k. Antitrust plaintiffs.

Most Cited Cases

Antitrust plaintiff's failure to properly define a market weighed against finding that certification of a class was proper. Fed.Rules Civ.Proc.Rule 23, 28 U.S.C.A.

[5] Federal Civil Procedure 170A 181.5

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

Most Cited Cases

Because presence of entry barriers was unique to each airline route in and out of three hubs, proof that airline exercised monopoly power over the route that plaintiff took did not establish that airline exercised monopoly power over the other 73 routes, and this factor weighed against granting class certification. Fed.Rules Civ.Proc.Rule 23(b)(3), 28 U.S.C.A.; Sherman Act, § 2, 15 U.S.C.A. § 2.

[6] Federal Civil Procedure 170A 181.5

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

Most Cited Cases

Issues unique to each of 74 of airline's routes into and out of three hubs predominated on questions of antitrust injury, and thus, certification of class action was not warranted. Fed.Rules Civ.Proc.Rule 23(b)(3), 28 U.S.C.A.

[7] Federal Civil Procedure 170A 181.5

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak181.5 k. Antitrust plaintiffs.

Most Cited Cases

Common issues did not predominate as to damages from airline's alleged monopoly in three hubs, and thus, certification of class was not appropriate in antitrust action; different variables that would be plugged into formula for computing damages were specific to the individual routes insofar as formula required court to calculate a "base fare," which was the fare charged by airline's competitors for a route of similar mileage. Fed.Rules Civ.Proc.Rule 23(b)(3), 28 U.S.C.A.

\*784 On Appeal from the United States District Court for the Western District of Tennessee. Merrill G. Davidoff, Ruthanne Gordon, Jerome Marcus (Argued), Berger & Montague, Philadelphia, PA, Patrick E. Cafferty, Miller, Faucher, Chertow, Cafferty & Wexler, Ann Arbor, MI, for Plaintiff-Appellant.

James P. Denvir, Alfred P. Levitt (Argued), Paul Kunz, Boies, Schiller & Flexner LLP, Washington, DC, Leo M. Bearman, Jr., Baker, Donelson, Bearman, Caldwell & Berkowitz, Memphis, TN, for Defendants-Appellees.

Before KEITH, BATCHELDER, and COLE, Circuit Judges.

BATCHELDER, Circuit Judge.

\*\*1 Plaintiff-Appellant Richard Rodney appeals the district court's order denying his motion to certify his antitrust suit as a class action. Because the district court did not abuse its discretion in concluding that questions of law or fact common to the members of the class do not predominate over any questions affecting only Rodney, we will AFFIRM the district court's order denying class certification.

I.

146 Fed.Appx. 783, 2005 WL 2009178 (C.A.6 (Tenn.)), 2005-2 Trade Cases P 74,940, 2005 Fed.App. 0734N

(Not Selected for publication in the Federal Reporter)

(Cite as: 146 Fed.Appx. 783, 2005 WL 2009178 (C.A.6 (Tenn.)))

On March 6, 2001, Rodney filed a two-count complaint against Northwest Airlines, Inc. and Northwest Airlines Corp. (“Northwest”) seeking damages and injunctive relief under Sections 4 and 16 of the Clayton Act, 15 U.S.C. §§ 15 and 26 and Section 2 of the Sherman Act, 15 U.S.C. § 2. The complaint alleges that Northwest made efforts “to illegally dominate and control the market for passenger air travel into and out of Memphis Airport (the ‘Memphis Hub’), Detroit Metropolitan Airport (the ‘Detroit Hub’), and Minneapolis/St. Paul Airport (the ‘Minneapolis Hub’)....” Rodney claims that he was harmed by Northwest’s monopolistic practices in 1996, when he took a Northwest flight from the Minneapolis Hub to Los Angeles.

On July 25, 2001, Rodney moved the court for class certification on behalf of a damages class pursuant to FED. R. CIV. P. 23(a) and (b)(3) and an injunctive relief class pursuant to FED. R. CIV. P. 23(a) and (b)(2). Rodney’s motion asked the court to name himself and Phillip Sax, another antitrust plaintiff who was represented by the same counsel, as lead plaintiffs. The motion defined the class as,

All members of Northwest Airlines’ WorldPerks frequent flyer program who purchased and used (i.e., flew those routes) airline tickets from Northwest Airlines or through its authorized agents on either a “Y” fare, or other unrestricted or fully refundable fare, and/or any other airline ticket purchased 14 days or less prior to departure, for non-stop travel into or out of Detroit-Wayne County International Airport [ ], Minneapolis-St. Paul International Airport [ ], and/or Memphis International Airport [ ], on one-way tickets or round trip tickets, on [ ] “supracompetitive price” routes....

On March 31, 2004, the district court issued an order and memorandum denying the motion for class certification. Because Rodney spent little energy addressing the certification of the injunctive relief class and did not identify a specific activity for the court to enjoin, the court refused to certify

the class under Rule 23(b)(2); Rodney does not appeal this decision. The district court denied Rodney’s request for certification of a damages class under Rule 23(b)(3) on two independent grounds. First, the court held that the plaintiffs \*785 failed to demonstrate that questions common to the class members predominate over any questions affecting only individual members. In reaching this conclusion, the court stated that individualized evidence could well predominate over common evidence on the issues of monopoly power, antitrust injury, and damages. Alternatively, the district court ruled that Rodney could not adequately represent the class because he flew only one of the many allegedly monopolized routes. The court also held that Sax was not a proper member of the class. Rodney appealed and on June 25, 2004, a panel of this court granted permission to take an interlocutory appeal pursuant to Rule 23(f).

\*\*2 Rodney’s case relies almost exclusively on a report prepared by two professors, Dr. Clinton Oster, Jr. and Dr. John S. Strong, both of whom are experts in the economics of the airline industry. The report concludes that Northwest exercises monopoly power for air services originating in each of its three hubs. On appeal, Rodney contends that Northwest monopolizes 74 separate routes as a result of its domination of the three hubs.

## II.

We review for abuse of discretion a district court’s decision to deny class certification. *Alkire v. Irving*, 330 F.3d 802, 810 (6th Cir.2003). An abuse of discretion occurs when the district court relies upon clearly erroneous findings of fact, improperly applies the proper legal standard, or employs an erroneous legal standard. *Miami Univ. Wrestling Club v. Miami Univ.*, 302 F.3d 608, 613 (6th Cir.2002). We will not find an abuse of discretion without “a definite and firm conviction that the trial court committed a clear error of judgment.” *Id.*

The party seeking certification of a class under Rule 23(a) must show that,

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(1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

In addition to the prerequisites of [Rule 23\(a\)](#), a party seeking class certification must show that the class action is maintainable under [Rule 23\(b\)](#). Rodney contends that his class action is maintainable under [Rule 23\(b\)\(3\)](#) because “questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy.”

“There are no hard and fast rules ... regarding the suitability of a particular type of antitrust case for class action treatment. Rather, the unique factors of each case will generally be the determining factor governing certification.” [Bell Atlantic Corp. v. AT&T](#), 339 F.3d 294, 301 (5th Cir.2003) (internal quotation omitted). [Rule 23](#) does not give the court “any authority to conduct a preliminary inquiry into the merits of a suit in order to determine whether it may be maintained as a class action.” [Eisen v. Carlisle & Jacquelin](#), 417 U.S. 156, 177, 94 S.Ct. 2140, 40 L.Ed.2d 732 (1974). A district court cannot deny certification based upon its belief that the plaintiff cannot prevail on the merits. [Castano v. American Tobacco Co.](#), 84 F.3d 734, 744 (5th Cir.1996). However, a court is allowed to look beyond the pleadings on a class certification motion to determine what type of evidence will be presented by the parties. See [General Telephone Co. v. Falcon](#), 457 U.S. 147, 160, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982). “Under [Rule 23\(f\)](#), this court can review \*786 the merits of an appeal only insofar as they bear upon the propriety of class certification, that is, whether the proposed class satisfies the prerequisites of [Rule 23](#).” [In re Lorazepam & Clorazepate Antitrust](#)

[Litigation](#), 289 F.3d 98, 105 (D.C.Cir.2002).

\*\*3 [Rule 23\(b\)\(3\)](#)'s “predominance” inquiry tests “whether the proposed classes are sufficiently cohesive to warrant adjudication by representation.” [Amchem Products, Inc. v. Windsor](#), 521 U.S. 591, 623, 117 S.Ct. 2231, 138 L.Ed.2d 689 (1997). In analyzing the predominance requirement, courts “take care to inquire into the substance and structure of the underlying claims without passing judgment on their merits.” [Robinson v. Texas Automobile Dealers Assoc.](#), 387 F.3d 416, 421 (5th Cir.2004). “Determining whether the plaintiffs can clear the predominance hurdle set by [Rule 23\(b\)\(3\)](#) also requires us to consider how a trial on the merits would be conducted if a class were certified.” [Bell Atlantic](#), 339 F.3d at 302 (internal quotation omitted). Though not a determination on the merits, the [Rule 23\(b\)\(3\)](#) analysis helps “prevent [ ] the class from degenerating into a series of individual trials.” *Id.* (internal quotation omitted).

To prevail in an antitrust action, a plaintiff must prove several elements, including that: 1) the defendant possessed monopoly power in a properly defined market; 2) the defendant engaged in anti-competitive or exclusionary conduct with respect to each properly defined market; 3) the plaintiff was actually injured; 4) the defendant's conduct caused antitrust injury; and 5) the plaintiff suffered damages. See [Atlantic Richfield Co. v. USA Petroleum Co.](#), 495 U.S. 328, 334-35, 110 S.Ct. 1884, 109 L.Ed.2d 333 (1990); [Brunswick Corp. v. Pueblo Bowl-O-Mat](#), 429 U.S. 477, 485-91, 97 S.Ct. 690, 50 L.Ed.2d 701 (1977); [Conwood Co., L.P. v. U.S. Tobacco Co.](#), 290 F.3d 768, 782 (6th Cir.2002) (“[a] claim under § 2 of the Sherman Act requires proof of two elements: 1) the possession of monopoly power in a relevant market; and 2) the willful acquisition, maintenance, or use of that power by anti-competitive or exclusionary means....”). We will first examine Rodney's argument that a court analyzing whether common issues will predominate under [Rule 23\(b\)\(3\)](#) is

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confined to the evidence contained in the plaintiff's case-in-chief and then consider, in turn, whether each element of an antitrust action would be established with proof common to the class.

[1] Rodney argues that the district court's application of Rule 23(b)(3) was erroneous because "in deciding whether common issues predominate, a court should assess only the plaintiff's proffered method of proving his case-in-chief." We have held, however, that "the parties should be afforded an opportunity to present evidence on the maintainability of the class action." *In re American Medical Systems, Inc.*, 75 F.3d 1069, 1079 (6th Cir.1996) (emphasis added) (quotation omitted) (considering "evidence in the record presented by the nonmoving party" in reversing the district court's order granting class certification); see also *Waste Mgmt. Holdings v. Mowbray*, 208 F.3d 288, 295 (1st Cir.2000) ("we regard the law as settled that affirmative defenses should be considered in making class certification decisions"). Indeed, we have noted, albeit in an unpublished opinion, that "the Advisory Committee Notes to Rule 23(b)(3) advise against class certification where a defendant has a defense to liability that will vary with each individual class member." *Butler v. Sterling, Inc.*, No. 98-3223, 2000 WL 353502 at \*6 (6th Cir. March 31, 2000). Because a defendant's evidence may be probative of class cohesiveness and may be such as to cause the class to degenerate into a series of individual\*787 trials, we hold that a court performing a "predominance" inquiry under Rule 23(b)(3) may consider not only the evidence presented in the plaintiff's case-in-chief but the defendant's likely rebuttal evidence. Considering both Rodney's evidence and the evidence that Northwest is likely to present in response to Rodney's claims, we proceed to our examination of whether each element of Rodney's antitrust case would be established with proof common to the class.

#### Market Definition

\*\*4 [2] Establishing relevant markets is the

first step in every monopolization claim. *Conwood Co., L.P.*, 290 F.3d at 782. Rodney defines the market as all non-stop scheduled flights into and out of each of Northwest's Hubs. At issue then, is whether questions of law or fact common to the members of the class predominate in determining whether Rodney has properly defined the market. "In considering what is the relevant market for determining the control of price and competition, no more definite rule can be declared than that commodities reasonably interchangeable by consumers for the same purposes make up that 'part of the trade or commerce', monopolization of which may be illegal." *Worldwide Basketball and Sports Tours, Inc. v. NCAA*, 388 F.3d 955, 961 (6th Cir.2004) (quoting *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 395, 76 S.Ct. 994, 100 L.Ed. 1264 (1956)). This "reasonable interchangeability" standard, which is the essential test for determining the relevant product market, "may be gauged by (1) the product uses, *i.e.*, whether the substitute products or services can perform the same function, and/or (2) consumer response (cross-elasticity); that is, consumer sensitivity to price levels at which they elect substitutes for the defendant's product or service." *Worldwide Basketball*, 388 F.3d at 961 (quoting *White & White, Inc. v. American Hosp. Supply Corp.*, 723 F.2d 495, 500 (6th Cir.1983)). The plaintiff carries the burden of proving that no such substitutes are available. *Int'l Logistics Group v. Chrysler Corp.*, 884 F.2d 904, 908 (6th Cir.1989).

We think that individual questions predominate on the issue of market definition because cross-elasticity analyses will be specific to each of the 74 routes. For example, an analysis of whether bus travel from Detroit to Toledo is reasonably interchangeable with a flight between those two cities will not help to define the market for travel between Minneapolis and Los Angeles. Drs. Strong and Oster's analysis of whether a competing airline's flight offerings differs from Northwest's offerings suggests that individual issues will predominate over the question of market definition.

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The report states,

The extent to which a flight with different characteristics is a substitute for another airline's flight offerings depends on both the nature of the trip and the nature of the traveler. For a short-distance trip, a one-stop flight or a connecting flight is likely to have a substantial time and circuitry penalty compared to a nonstop flight, so that a traveler will be less likely to such flight offerings as acceptable substitutes, even if they are priced somewhat lower. On a long-distance trip, the time penalty and added circuitry are less noticeable and one-stop or connecting flights are more likely to be considered substitutes.

Dr. Oster testified that factors including flight frequencies, flight times, size of airports, the existence of a layover, and duration of the flight are all factors that must be considered in an analysis of whether substitute products can perform the same function as the Northwest flights. He further testified that this analysis would have to be performed on a route-by-route basis. When asked whether markets with fewer \*788 than 20,000 passengers per year are natural monopolies, Dr. Oster responded “[n]ot necessarily,” and later elaborated that this analysis would have to be performed on a market-by-market basis. Shortly thereafter, the following exchange occurred,

\*\*5 Question: And would you agree with me that even with high market shares that there are other factors that must be examined to determine whether monopoly power exists?

Answer: Yes.

Question: And would you agree with me that the factors that must be examined have to be examined on a route-specific basis?

Answer: Yes.

We also note that the report of Northwest's expert witness indicates that the company would present route-specific evidence in support of its

argument that Rodney has failed to define the market. Because market definition will involve an analysis of the alternatives available in each of the 74 different routes, this factor weighs against certification.

[3] Even assuming that questions of law or fact common to the members of the class predominate over the issue of whether Rodney has properly defined the market, we think that his definition of the market as all non-stop scheduled flights into and out of each of Northwest's hubs fails as a matter of law. At the outset we must consider whether Rule 23(f) allows a court to deny class certification based upon an antitrust plaintiff's failure to define the market. While our circuit has not spoken to this issue, in *Unger v. Amedisys Inc.*, the Fifth Circuit vacated the district court's certification of a securities fraud class action based on the “fraud on the market” theory, which requires proof that the security at issue is traded in an “efficient market.” 401 F.3d 316, 322 (5th Cir.2005) (quotation omitted). Stating that “[q]uestions of market efficiency cannot be treated differently from other preliminary certification issues,” the court of appeals vacated the class certification and remanded because the district court devoted insufficient attention to evaluating the market efficiency factors. *Id.* at 325. Similarly, the Fourth Circuit has held that “while an evaluation of the merits to determine the strength of plaintiffs' case is not part of a Rule 23 analysis, the factors spelled out in Rule 23 must be addressed through findings, even if they overlap with issues on the merits.” *Gariety v. Grant Thornton LLP*, 368 F.3d 356, 366 (4th Cir.2004) (vacating the certification of a class on the ground that a district court does not comply with the procedural requirements of Rule 23 by accepting a plaintiff's allegation that an “efficient market” exists). We think that the reasoning of the *Unger* and *Gariety* courts, which we find to be persuasive, applies with equal force in instances where an antitrust plaintiff, who has not properly defined the market, seeks class certification. Accordingly, we hold that a

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court may consider an antitrust plaintiff's failure to define the market as part of its class certification analysis without violating the procedural requirements of [Rule 23](#).

[4] As explained above, interchangeable commodities are part of the same market, [Worldwide Basketball](#), 388 F.3d at 961, and an antitrust plaintiff carries the burden of proving that no reasonable substitutes are available. [International Logistics Group, Ltd. v. Chrysler Corp.](#), 884 F.2d 904, 908 (6th Cir.1989). Drs. Oster and Strong's report does not contain a cross-elasticity analysis of whether bus or train travel is a reasonable substitute for flights on Northwest and Dr. Oster himself testified that he did not analyze whether ground transportation is a substitute for air transportation. Moreover, Dr. Oster testified that he did not do a specific analysis\*789 to determine whether connecting service is a substitute for non-stop service. Rodney's failure to properly define a market also weighs against a finding that certification is proper. FN1

FN1. We note that our conclusion that Rodney has not defined the market is only relevant to the issue of whether a class should be certified and does not preclude the factfinder from ultimately concluding otherwise. [Garity](#), 368 F.3d at 366 (“The jury or factfinder can be given free hand to find all of the facts required to render a verdict on the merits, and if its finding of any fact differs from a finding made in connection with class action certification, the ultimate factfinder's finding on the merits will govern the judgment”).

#### Monopoly Power

\*\*6 [5] To make a successful claim under § 2 of the Sherman Act, Rodney must prove that Northwest possessed monopoly power in the relevant market. [Re/ Max Intern., Inc. v. Realty One, Inc.](#), 173 F.3d 995, 1016 (6th Cir.1999). A plaintiff can do this either directly, by “showing the exercise of actual control over prices or the actual

exclusion of competitors,” or circumstantially, by showing that the defendant has a high market share within a defined market. *Id.* (internal quotation omitted). To prove that Northwest exercised monopoly power, Rodney's experts composed a series of “data screens” designed to identify those routes that were monopolized. The district court held that individualized information would predominate over the monopoly power element because Northwest would probably impeach Rodney's methodology “by showing that the data screens do not credibly produce routes where Northwest had monopoly power.” “This type of evidence,” wrote the district court “could easily involve voluminous individualized information for each specific route, rather than just evidence tending to discredit plaintiff's method as a whole.” We are not firmly convinced that the district court was wrong.

Rodney's use of “data screens” does little to assuage our concern that proving monopoly power will cause the class action to degenerate into a series of mini-trials inasmuch as Rodney's own experts describe the “data screens” as a “Market-By-Market Analysis of Market Power.” Even assuming that Rodney's “data screens” prove that Northwest has a disproportionately high market share in a manner that will not result in a series of mini-trials, an analysis of other factors probative of monopoly power, like the absence of entry barriers, *see Am. Council of Certified Podiatric Physicians and Surgeons v. Am. Board of Podiatric Surgery*, 185 F.3d 606, 623 (6th Cir.1999), will necessarily be done on a route-by-route basis. “Entry barriers are ‘additional long-run costs that were not incurred by incumbent firms but must be incurred by new entrants,’ or ‘factors in the market that deter entry while permitting incumbent firms to earn monopoly returns.’ ” [Rebel Oil Co., Inc. v. Atlantic Richfield Co.](#) 51 F.3d 1421, 1439 (9th Cir.1995) (quoting [Los Angeles Land Co. v. Brunswick Corp.](#), 6 F.3d 1422, 1427-28 (9th Cir.1993)). Sources of entry barriers include licensing agreements, buyer preference for established brands, and capital market evaluations

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imposing higher capital costs on new entrants. *Rebel Oil*, 51 F.3d at 1439. The report of Janusz A. Ordober, the defense's expert, indicates that Northwest will rebut Rodney's data screens by citing these sorts of entry barriers, the presence or absence of which will be specific to each of the 74 individual routes. Because the presence of entry barriers is unique to each route, proof that Northwest exercised monopoly power over the route that Rodney took does not establish that Northwest exercised monopoly power over the other 73 routes. This factor weighs against granting class certification.

#### **\*790 Anti-competitive Conduct and Injury In Fact**

\*\*7 The district court thought that the elements of anti-competitive conduct and injury in fact weighed in favor of granting class certification and we are inclined to agree. "Anticompetitive conduct is conduct designed to destroy competition, not just to eliminate a competitor." *Richter Concrete v. Hilltop Concrete*, 691 F.2d 818, 823 (6th Cir.1982). Rodney seeks to satisfy this element not through proof of specific anti-competitive acts, but rather through the "predation by reputation" theory. According to this theory, Northwest's reputation for aggressive competition at its hubs deterred entry into those markets,<sup>FN2</sup> and evidence to support this theory would seem to span all of the 74 markets and apply to all of the class members. We do not think that such proofs are likely to cause the class action to degenerate into a series of mini-trials.

**FN2.** Because we affirm the district court's order on the ground that Rodney has failed to show that common issues of law and fact will predominate, we do not address Rodney's claim that "predation by reputation" theory can give rise to antitrust liability.

#### **Antitrust Injury**

[6] In addition to showing anti-competitive conduct and cause in fact, an antitrust plaintiff must also show an "antitrust injury," which is "(1)

'injury of the type that the antitrust laws were intended to prevent' and (2) injury 'that flows from that which makes defendants' acts unlawful.' " *In re Cardizem*, 332 F.3d 896, 909 (6th Cir.2003) (applying § 1 of the Sherman Act) (quoting *Brunswick Corp.*, 429 U.S. at 489, 97 S.Ct. 690); see also *Atlantic Richfield*, 495 U.S. at 342-43, 110 S.Ct. 1884. This requirement "ensures that a plaintiff can recover only if the loss stems from a competition-reducing aspect or effect of the defendant's behavior." *Cardizem*, 332 F.3d at 910 (quoting *Atlantic Richfield*, 495 U.S. at 342-43, 110 S.Ct. 1884).

Rodney argues that his "data screens provide a common method of proving widespread injury to the class." He adds that "in selecting the damaged routes, Plaintiff's experts applied a set of data screens designed to filter out any discrepancy *not* caused by anti-competitive conduct." Even assuming that Rodney's "data screens" do filter out injuries not caused by anti-competitive conduct, we do not think that they could do so in a manner that would preserve class cohesion in view of his experts' statement that the data screens would have to be applied on a "Route-By-Route" basis. Nor do we agree that Rodney's use of the "predation by reputation" theory to prove that passengers on each of the 74 different routes suffered an antitrust injury would avoid the degeneration of the class action into a series of mini-trials. As the district court correctly observed, "it is not readily apparent how a 'reputation for predation' directly damages individual passengers."

In any event, Northwest would likely be forced to rebut Rodney's claims with evidence that competing carriers chose not to enter particular routes for reasons other than Northwest's reputation. According to Michael Mooney, an executive employed by Midwest Express who testified for Rodney, factors that influence a competing carrier's decision to enter a market include the profitability of the route and the strategic fit of the route *vis-a-vis* the carrier's

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business plan. Dr. Strong also testified that a competing carrier's pilot contracts may prevent that carrier from entering a specific market. In short, the record reveals that there are any number of reasons, other than Northwest's "reputation," why Northwest's competitors declined to enter a given route and these reasons would likely be different from one route to \*791 the next. If we were to certify Rodney's class, Northwest would be forced to prove that competitors declined to enter the route that Rodney actually took for reasons other than Northwest's reputation and then make the same showing for each of the 73 other routes at issue. Clearly, issues unique to each of the 74 different routes predominate on the question of antitrust injury.

#### Damages

**\*\*8 [7]** A plaintiff seeking class certification must present a damages model that functions on a class-wide basis. See *Bell Atlantic*, 339 F.3d at 303. "Class treatment, however, may not be suitable where the calculation of damages is not susceptible to a mathematical or formulaic calculation, or where the formula by which the parties propose to calculate individual damages is clearly inadequate." *Id.* at 307. A plaintiff need not calculate a specific damage figure so long as he proposes an acceptable method for calculating damages. See *In re Visa Check/MasterMoney Antitrust Litigation*, 280 F.3d 124, 138-39 (2d Cir.2001).

The district court found that the damages factor counseled against certifying the class because Rodney's experts "have admitted that they have not yet identified any methodology for computing damages." Drs. Oster and Strong's report contains a section titled "methodology for the calculation of damages." According to Rodney's brief, "[t]his methodology compares the prices paid by class members who paid for tickets (the 'fares average fare') in the 74 Northwest 'damage' markets ... to benchmark prices that have been charged by all other 'major' or 'national' airlines in similar markets (the 'base fare'), which are constructed

from the U.S. Department of Transportation's Databank 1A." Dr. Oster testified, however, that this calculation is not a methodology for computing damages but is instead a mechanism for identifying the markets in which to calculate damages. When asked "[s]o you have not identified a methodology for computing damages other than to identify the markets; is that correct?" Dr. Oster responded "[t]hat's' correct because we've not been asked to calculate the damages in those markets." Dr. Oster also testified that "if our task were to calculate damages for all passengers in the market, this would be one way you could proceed." He added that "[w]hether we would use some method [to calculate damages] that resulted in the involved fares average fare or not, I really don't want to say because [Dr. Strong] and I have not sat down and said, okay, if we're going to calculate damages, how should we do it, because we haven't been given that task."

In recognition of this testimony, Rodney argues that his experts' methodology *could* be used to calculate damages and that such a calculation would satisfy the requirements of Rule 23(b)(3). At first blush, it seems that Rodney cannot prove that class issues predominate the damages element because his experts have not agreed on a formula for computing damages. Even assuming that Rodney's experts would use the model appearing in his experts' report, the element of damages doesn't favor certification. The different variables that would be plugged into that formula are specific to the individual routes insofar as the formula requires us to calculate a "base fare," which is the fare charged by Northwest's competitors for a route of similar mileage. Moreover, as evidenced by the Report of Janusz A. Ordovery, Northwest's expert, Northwest intends to rebut Rodney's evidence by arguing that the routes that Northwest flies are not comparable to the "benchmark" prices used in Rodney's proposed damage formula. This would involve analysis of the distinct characteristics of various Northwest routes. The damages element certainly does not favor class certification.

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**\*792 Conclusion**

**\*\*9** Considering all of the elements of Rodney's antitrust case, we do not have a definite and firm conviction that the district court committed a clear error of judgment when it concluded that issues of fact common to the class would predominate over any questions affecting only Rodney. If Rodney's class were certified, the proofs would include evidence specific to each of 74 different routes and the class action would inevitably degenerate into 74 mini-trials. Accordingly, we **AFFIRM** the order of the district court denying Rodney's motion to certify the class. Because we affirm the district court on the ground that Rodney has failed to satisfy the requirements of [Rule 23\(b\)\(3\)](#), we need not, and will not, address the district court's alternative holding that Rodney is not an adequate representative of the class as required by [Rule 23\(a\)\(3\)](#).

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**(Not Selected for publication in the Federal Reporter)**  
**(Cite as: 385 Fed.Appx. 423, 2009 WL 87510 (C.A.6 (Tenn.)))**



This case was not selected for publication in the Federal Reporter.

Not for Publication in West's Federal Reporter See Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. See also Sixth Circuit Rule 28. (Find CTA6 Rule 28)

United States Court of Appeals,  
Sixth Circuit.  
Edmundo M. ROMBERIO, Theresa Keir, Michelle Lynn Washington, Karen M. Gately, Thomas Rocco, Thomas P. Davis, and Marvina Jenkins, individually and on behalf of all others similarly situated, Plaintiffs-Appellees,  
v.  
UNUMPROVIDENT CORPORATION, ERISA Benefit Denial Actions, Defendant-Appellant.

No. 07-6404.  
Jan. 12, 2009.

**Background:** Insureds under group long-term disability benefit policies/plans brought consolidated suits against disability insurer and its subsidiaries alleging that defendants devised and implemented a scheme to illegally deny or terminate their long-term disability claims in violation of Employee Retirement Income Security Act (ERISA). The United States District Court for the Eastern District of Tennessee, [Collier, C.J., 245 F.R.D. 317](#), granted insureds class certification. Insurer and its subsidiaries appealed.

**Holdings:** The Court of Appeals, [Stafford](#), District Judge, held that:

- (1) proposed class definition was not sufficiently definite, thereby precluding certification of class;
- (2) typicality requirement was not satisfied, thereby precluding certification of class; and
- (3) lack of homogeneity and cohesion of interests of class members precluded certification of class.

Reversed.

[Clay](#), Circuit Judge, filed dissenting opinion.

West Headnotes

**[1] Federal Civil Procedure 170A ↪184.5**

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak184 Employees

170Ak184.5 k. In general. **Most**

**Cited Cases**

Proposed class definition was not sufficiently definite, thereby precluding class certification in action by insureds under group long-term disability benefit policies/plans alleging that disability insurer and its subsidiaries devised and implemented a scheme to illegally deny or terminate their long-term disability claims in violation of ERISA; insureds challenged group of loosely-defined practices in connection with denying benefit claims that were not applied uniformly to discrete, easily-defined class of individuals, proposed definition would necessarily include many individuals whose claims were properly denied for medical reasons, definition did little to distinguish between set of individuals whose claims were properly denied and set of individuals whose claims were improperly denied for profit-driven reasons, and thus, only way to distinguish between two sets of individuals was to engage in individualized fact-finding which made class definition unsatisfactory. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.; Fed.Rules Civ.Proc.Rule 23(a)(2), (b)(2), 28 U.S.C.A.

**[2] Federal Civil Procedure 170A ↪184.5**

170A Federal Civil Procedure

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170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak184 Employees

170Ak184.5 k. In general. Most

Cited Cases

Typicality requirement was not satisfied, thereby precluding class certification in action by insureds under group long-term disability benefit policies/plans alleging that disability insurer and its subsidiaries devised and implemented a scheme to illegally deny or terminate their long-term disability claims in violation of Employee Retirement Income Security Act (ERISA); potential class members worked in different jobs, had different vocational skills, had different impairments, and experienced different disability review procedures managed by different claim representatives, and fact that all of insureds might have been subjected to some or all of insurer's alleged wrongful practices did not eliminate need for individualized assessment as to ultimately propriety of benefits decisions affecting each and every class member. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.; Fed.Rules Civ.Proc.Rule 23(a)(2).

[3] Federal Civil Procedure 170A ↪184.5

170A Federal Civil Procedure

170AII Parties

170AII(D) Class Actions

170AII(D)3 Particular Classes

Represented

170Ak184 Employees

170Ak184.5 k. In general. Most

Cited Cases

Lack of homogeneity and cohesion of interests of class members precluded certification of class in action by insureds under group long-term disability benefit policies/plans alleging that disability insurer and its subsidiaries devised and implemented a scheme to illegally deny or terminate their long-term disability claims in violation of Employee

Retirement Income Security Act (ERISA); although insureds sought imposition of constructive trust as well as entry of order requiring insurer to provide full and fair review of claims for benefits under plan that were denied, insureds did not explain how constructive trust could be imposed without individualized review of every denied claim, or how court could avoid exposing insurer to relief, re-review of every claim, in order to determine whether any individual was, in first instance, a class member, and, in second instance, entitled to relief for improper denial or termination of benefits. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.; Fed.Rules Civ.Proc.Rule 23(b)(2), 28 U.S.C.A.

\*424 On Appeal from the United States District Court for the Eastern District of Tennessee at Chattanooga.

BEFORE: CLAY and GRIFFIN, Circuit Judges; and STAFFORD, District Judge. FN\*

FN\* The Honorable William H. Stafford, Jr., Senior United States District Judge for the Northern District of Florida, sitting by designation.

STAFFORD, District Judge.

\*\*1 With leave of this court, the defendant-appellant, UnumProvident Corporation (“Unum”), appeals from the district court's interlocutory order certifying the plaintiffs' breach-of-fiduciary-duty action as a class action. We now REVERSE.

BACKGROUND

The case was begun when fifteen individual claimants filed seven class actions in six federal district courts FN1 located in six different circuits. FN2 The plaintiffs sued Unum, six of Unum's insuring subsidiaries, FN3 and two of Unum's corporate officers, asserting breach-of-fiduciary-duty claims under section 503(a)(3) of the Employment Retirement Security Act of 1974

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(“ERISA”). 29 U.S.C. § 1132(a)(3). With one exception, the plaintiffs were covered by group long-term disability insurance policies purchased by their individual employers either from Unum or one of its subsidiaries.<sup>FN4</sup> Some of the plaintiffs \*425 claimed that they were wrongfully denied long-term disability benefits; others claimed that their long-term disability benefits were wrongfully terminated.

**FN1.** The Southern District of New York, the District of Massachusetts, the Northern District of California, the Eastern District of Pennsylvania, the Eastern District of Tennessee, and the Southern District of Illinois.

**FN2.** The First, Second, Third, Sixth, Seventh, and Ninth Circuits.

**FN3.** The insuring subsidiaries are The Paul Revere Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, First Unum Life Insurance Company, Unum Life Insurance Company of America, and Colonial Life & Accident Insurance Company.

**FN4.** The one exception is Thomas Davis. It is alleged that Davis was insured under a group long-term disability policy issued by The Prudential Insurance Company, thereafter The Hartford, neither of which is alleged to be a subsidiary of Unum.

In 2003, the cases were consolidated in the Eastern District of Tennessee by the Judicial Panel on Multidistrict Litigation. Seven of the plaintiffs thereafter settled their claims, and an eighth plaintiff ultimately received the benefits she was seeking. Those eight plaintiffs have been dismissed from the action, leaving seven plaintiffs who seek to proceed with this consolidated action.

**A. The Allegations:**

The plaintiffs allege that Unum<sup>FN5</sup> devised and implemented a corporate-wide scheme to illegally deny or terminate the long-term disability claims of thousands of disabled Americans, all in violation of ERISA. Specifically, in their Consolidated Amended Class Action Complaint, the plaintiffs allege that Unum engages in the following practices:

**FN5.** Unum is appealing on behalf of itself and the other corporate defendants. We refer to the group of corporate defendants as Unum.

- a. Instituting targets, budgets, or goals for cost-savings to be attained through the denial and termination of claims; the claims do not receive a proper review by a fiduciary and are denied or terminated based upon UnumProvident's financial targets rather than the medical and vocational evidence concerning claimants' disabilities;
- b. Providing financial incentives to in-house physicians who will “rubber stamp” previously made business decisions; the physicians thus ignore their appropriate ethical obligations and overlook strong medical evidence that would ordinarily require a disability claim to be approved.
- c. Implementing of compensation and/or bonus plans that reward Company management for denying or terminating as many claims as possible to meet special financial goals set by the Company.
- d. Authorizing more senior in-house doctors to alter the written reports of other “uncooperative” in-house doctors in order to justify a claim denial or termination;
- e. Creating secret documents for each claim, at the time that claims are filed, that, upon information and belief, sets [sic] a target date for cutting off future disability payments; these “Duration Management” documents reflect

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business decisions made by non-medical claims personnel as to when the company believes claim payments should stop in the future; physicians are not involved in creating these secret documents which are kept outside of the claims file and withheld from claimants, their attorneys, and reviewing courts, and are not produced in discovery during litigation;

**\*\*2** f. Encouraging a game among the in-house physicians called the practice of “insurance medicine;” these in-house physicians are prompted, encouraged, and pressured into (1) changing their valid medical opinions as to a claimant's disability in order to justify a business-driven claim denial; (2) closing their eyes to numerous sources of medical evidence that support a claimant's disability; (3) remaining quiet about their personal medical opinions that require further analysis, review, testing, and follow up that would reveal the claimant's obvious disability; and (4) putting “canned” statements into their written reports that, on the surface, appear to validate a previous decision by claims **\*426** personnel to terminate ongoing disability payments to a claimant or to deny a claim in the first instance.

g. Recruiting claims personnel who have a reputation for “closing claims” (cutting off the ongoing monthly benefits of disabled individuals);

h. Designing a system in which claimants who have multiple disabling conditions will never receive an integrated overview as to how all of the disabling conditions combine to disable the claimant; by deliberately fragmenting the claim into a number of pieces and preventing a comprehensive review of individuals with “co-morbid” conditions, the Company ensures that the claimant will not receive a comprehensive and fair review of the claim; and

i. Employing numerous other practices that pressure claims handling personnel into causing

claims to be denied or terminated without receiving a proper review.

Allegations regarding the seven plaintiffs who remain in the case include the following:

Theresa Keir worked as a financial systems analyst for a real estate company when she became insured under a group long-term disability policy issued by Unum to her employer. In March of 2000, Keir claimed disability arising out of **breast cancer** surgeries in her left and right breasts, **spinal fusions** in her low back, removal of a precancerous ovarian cyst, dermatomyocitis, two **herniated discs** in her neck, and **fibromyalgia**. Based on an in-house review of her medical records, Unum denied Keir's claim to disability benefits in December of 2000. On appeal, Unum upheld the adverse benefits decision.

Michelle Lynn Washington was employed as an attorney when she became insured under a group long-term disability policy issued by Unum. On May 29, 1998, Washington claimed disability arising from **mitral valve prolapse**, **iron deficiency**, **anemia**, **hypothyroidism**, cervical discogenic disease, cervical myofascial pain, L-5 **radiculopathy**, **fibromyalgia**, and depression. Unum paid Washington disability benefits for almost three years before terminating those benefits in 2001 based upon an in-house medical review that purportedly revealed that Washington could resume her full-time employment as an attorney. On Washington's appeal, Unum upheld the termination of benefits.

Karen Gately was employed as a registered nurse when she became insured under a group long-term disability policy issued by Unum. Gately claimed disability on or about August 1, 1995, arising from fatigue, loss of balance, joint pain and swelling, **short term memory loss**, and confusion, all arising from **lyme disease**. After paying disability benefits to Gately for seventy months, Unum terminated her benefits in November of 2001, allegedly because her file contained no

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objective data regarding her “Epstein Barr virus, lyme disease, chronic fatigue, and cognitive dysfunction.” On review, Unum upheld its decision to terminated Gately's benefits.

**\*\*3** Thomas Rocco was employed by the Canadian Imperial Bank of Commerce when he became insured under a group long-term disability policy issued by Unum. On or about February 2, 2000, Rocco claimed disability arising from symptoms associated with Meniere's disease, chronic obstructive pulmonary disease, diabetes mellitus II, hearing loss, and anxiety disorder. Rocco received disability benefits for approximately nine months before his benefits were terminated in May of 2001. On review, Unum upheld its decision to terminate Rocco's benefits.

Thomas P. Davis was employed as a product safety reporting associate when he became insured under a group long-term disability policy issued by The Prudential \*427 Insurance Company, thereafter The Hartford. Davis claimed disability in July of 1991 arising from labyrinth dysfunction, which produced balance and reading disabilities. The Prudential/Hartford paid Davis long-term disability benefits until February of 2001, when Unum-as substituted administrator-terminated his benefits. Those benefits were reinstated by Unum before the plaintiffs filed their Consolidated Amended Class Action Complaint in early 2004. Unum contends that Davis has received all benefits to which he was/is entitled.

Marvina Jenkins was employed as a bank loan officer when she became insured under a group long-term disability policy issued by Unum. In April of 1999, Jenkins claimed disability arising from cognitive injury due to oxygen deprivation to the brain and anoxic encephalopathy, producing an IQ of 62. Jenkins received disability benefits until September of 2000, when Unum terminated her benefits, claiming that she was fit to return to work. It is not alleged that Jenkins sought review of Unum's decision to terminate her disability benefits.

Edmundo M. Romberio was employed as a mechanical technician by a communications company when he became insured under a group long-term disability policy issued by Unum. On or about May 16, 2000, Romberio claimed disability arising from the debilitating effects of diabetes, including permanent diabetic neuropathy, blurred vision, dizziness, severe fatigue, and nerve damage. Unum denied Romberio's request for disability benefits, then informed him that coverage under his policy would be terminated. It is not alleged that Romberio sought review of Unum's decision. On or about October 29, 2001, Unum terminated Romberio's coverage.

In their Consolidated Amended Class Action Complaint, the plaintiffs requested injunctive and declaratory relief pursuant to 29 U.S.C. § 1132 (a)(3).<sup>FN6</sup> In particular, the plaintiffs requested an order directing Unum to (a) cease the offending practices of wrongfully denying, terminating, or suspending plan benefits; (b) institute, under appropriate judicial supervision, new procedures that fully comply with ERISA; and (c) provide a full and fair review-by a receiver and/or special master appointed to serve as a neutral claims adjustor-“for all claims for benefits under the plan that have been affected by the offending claims practices and thus wrongly denied.” In the alternative, the plaintiffs requested imposition of a constructive trust over any trust assets controlled by Unum.

**FN6.** ERISA section 1132(a)(3) is a catchall remedial provision that authorizes a civil action “by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.”

#### **B. Class Certification Proceedings:**

**\*\*4** The plaintiffs requested certification of a

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class defined as follows:

All plan participants and beneficiaries insured under ERISA[-] governed long-term disability insurance policies/plans issued by UnumProvident and the insuring subsidiaries of UnumProvident throughout the United States who have had a long-term disability claim denied, terminated, or suspended on or after June 30, 1999 by UnumProvident or one or more of its insuring subsidiaries after being subjected to any of the practices alleged in the Complaint.

Unum opposed the motion for class certification, arguing, among other things, that

**\*428** (1) the existence of individualized issues on both liability and remedy precludes any finding of the homogeneity and cohesiveness required for certification under Rule 23(b)(2); (2) the immature tort doctrine precludes certification because of the very novelty of this [§ ] 502(a)(3) claim; (3) each class member who believes his or her claim was wrongfully denied has both an economically viable cause of action, and a means of bringing it; (4) any payments of benefits they expect as a result of this case are not plainly incidental to the declaratory and injunctive relief that they claim is the focus of their claims; and (5) the incompatibility between these claims and Rule 23 certification is highlighted by the defective nature of the class definition

*In re UnumProvident Corp. ERISA Benefits Denial Actions*, 245 F.R.D. 317, 322 (E.D.Tenn.2007) (internal quotation marks and citation omitted).

The district court conducted a hearing on the plaintiffs' motion for class certification on July 18, 2007. The district court thereafter issued a memorandum opinion, explaining that, among other things, (1) the plaintiffs' proposed class definition is sufficiently definite to determine who is or is not a class member; (2) typicality is present because the plaintiffs' allegations "will involve a determination

of whether Unum implemented a uniform, profit-driven scheme to deny all claims based on financial concerns, rather than based on the actual merits of the applications for benefits;" (3) the plaintiffs are representative of the class, all having allegedly been subject to an improper uniform policy of denying claims based on the company's profits; (4) the plaintiffs' counsel are qualified and capable of handling the litigation; and (5) the plaintiffs have satisfied the requirements of Rule 23(b)(2) because the common claim is subject to a single injunctive remedy—namely an injunction to end or ameliorate Unum's alleged unlawful claims review policy. Consistent with its findings and conclusions, the district court certified the class, using the class definition proposed by the plaintiffs.

#### STANDARD OF REVIEW

This court reviews a district court's grant of class certification for abuse of discretion. *Coleman v. Gen. Motors Acceptance Corp.*, 296 F.3d 443, 446 (6th Cir.2002). A district court abuses its discretion when it "applies the wrong legal standard, misapplies the correct legal standard, or relies on clearly erroneous findings of fact." *Schachner v. Blue Cross & Blue Shield of Ohio*, 77 F.3d 889, 895 (6th Cir.1996) (internal quotation marks and citation omitted). This court will not find an abuse of discretion unless it has a "definite and firm conviction that the trial court committed a clear error of judgment." *Miami Univ. Wrestling Club v. Miami Univ.*, 302 F.3d 608, 613 (6th Cir.2002) (internal quotation marks and citation omitted). When ruling on a motion for class certification, the district court must exercise its discretion within the framework of Rule 23.

#### DISCUSSION

**\*\*5** Before certifying a class action, a district court must conduct a "rigorous analysis" into whether the requirements of Rule 23 have been satisfied. *Gen. Tel. Co. v. Falcon*, 457 U.S. 147, 161, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982); *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 397 (6th Cir.1998) (en banc). Under Rule 23(a), a party

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seeking class certification must show that (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) \*429 the representative parties will fairly and adequately protect the interests of the class. In addition to the prerequisites of Rule 23(a), a party seeking class certification must satisfy one of the three subsections of Rule 23(b). Here, the plaintiffs have moved for certification under Rule 23(b)(2), which demands a showing that “the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole.” Fed.R.Civ.P. 23(b)(2).

According to Unum, the district court failed in its responsibility to conduct the rigorous analysis required for class certification, failing-in particular-in its analysis of the typicality requirement under Rule 23(a)(2) and the element of cohesiveness under Rule 23(b)(2). Citing *Sprague* and *Reeb v. Ohio Dep't of Rehabilitation and Correction*, 435 F.3d 639 (6th Cir.2006), Unum contends that, as part of its rigorous analysis, the district court was required to examine the precise nature of the plaintiffs' claims as well as the proof required to establish those claims. *Reeb*, 435 F.3d at 644-45 (explaining that allegations of a “general policy” of discrimination are inadequate to establish entitlement to class certification; instead, “rigorous analysis” requires precise information about the incidents, people involved, motivations, and consequences regarding each of the named plaintiffs' claims); *Sprague*, 133 F.3d at 397-98 (noting that certification was not proper merely because the plaintiffs challenged General Motors' system-wide general policy that changed retirees' health benefits; instead, the district court was required to examine what the plaintiffs would have to prove to establish their individual claims); see also Fed.R.Civ.P. 23(c)(1)(B) (requiring a district

court, when certifying a class, to define not only the class but also the “class claims, issues, or defenses”).

While acknowledging that *Reeb* called for a searching examination of the precise nature of the plaintiffs' claims, the district court suggested that the lessons of *Reeb* were limited to cases involving generalized claims of employment discrimination. Without explaining why those lessons would be inapplicable in a case involving the denial of disability benefits, the district court declined to perform a rigorous analysis of the plaintiffs' claims, merely stating: “[T]he Court will not need to confront such individual determinations here.” The district court's refusal to look more closely at the plaintiffs' claims, and also to the defenses that Unum might raise in response to those claims, is puzzling.

\*\*6 To prevail on a breach-of-fiduciary-duty claim under ERISA, a plaintiff must generally prove that the defendant not only breached its fiduciary duty but also caused harm by that breach. *Kuper v. Iovenko*, 66 F.3d 1447, 1459 (6th Cir.1995). A causal connection between the alleged breach and the alleged harm is thus a necessary element of an ERISA-participant's breach-of-fiduciary-duty claim. Where, as here, the alleged breach purportedly results in the wrongful denial or termination of a participant's benefits, the existence of a causal link between the breach and the harm is particularly dependant upon the equities of the participant's claim. Absent a showing that benefits were *wrongfully* denied, there can be no causal link between an alleged breach and a denial of benefits; and whether a claim for benefits is *wrongfully* denied depends on a number of factors peculiar to the claimant's case. See *Hein v. FDIC*, 88 F.3d 210, 224 (3d Cir.1996) (dismissing the plaintiff's breach-of-fiduciary-duty claim, explaining that “[b]ecause [the plaintiff] was not entitled to the benefits in the first place, there is no causal link between the alleged breach of fiduciary duty by [the defendants] and the denial of benefits to [the plaintiff]”).

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\*430 [1] Here, the plaintiffs have alleged that Unum breached its fiduciary duties by wrongfully denying or terminating disability insurance benefits on the basis of a uniform, profit-driven scheme. Indeed, central to the district court's class certification decision was its conclusion that "the theory of liability asserted by Plaintiffs in this case does not *focus* on individual factors ... because Plaintiffs have characterized their lawsuit as a challenge to UnumProvident's uniform policies and practices with respect to reviewing claims." Dist. Ct. Order of Certification (emphasis in original). That a uniform scheme is alleged, however, does not mean that a class is easily identified or that a class action is necessarily appropriate.

As requested by the plaintiffs, the district court in this case defined the class to include only those plan participants and beneficiaries whose long-term disability benefits were denied or terminated "after being subjected to any of the practices alleged in the Complaint." The district court rejected Unum's argument that, to determine who belongs in a class so defined, thousands of claim files would have to be examined to see if any of the alleged wrongful practices were employed in any particular case. While recognizing that "[i]t may be necessary for the Court to make some factual inquiry," the district court concluded that the class definition was "sufficiently definite so that it is feasible to determine who is or is not a class member." The district court relied on *Forbush v. J.C. Penney Co., Inc.*, 994 F.2d 1101 (5th Cir.1993) in reaching its conclusion.

In *Forbush*, a retired employee (Forbush) sought class certification in her lawsuit challenging the mathematical formulae used by J.C. Penney to calculate a retiree's estimated social security payments. The method used to estimate such payments was important because, under the company's retirement plans, the pension benefits due to retirees were offset by the amounts they were expected to receive from the Social Security Administration. Forbush sought to represent all

former and current Penney employees "whose pension benefits have been or will be reduced or eliminated as a result of the overestimation of their Social Security benefits." *Id.* at 1103. The various employees included in the class were covered by four different pensions plans; and, during the relevant time period, three different formulae were used to estimate a retiree's social security benefits. The district court denied Forbush's motion for class certification, concluding that "each class member's claim will have to be decided on an individual basis." *Id.* at 1104. In a two to one decision, the Fifth Circuit reversed, stating: "The concerns expressed by [the dissent], as well as the district court, regarding the necessity of individualized determinations are important but not, we believe, dispositive, at least at this stage of the litigation." *Id.* at 1106. The court noted that the class could be divided into sub-classes to resolve any issues arising from the use of three formulae.

\*\*7 Here, the district court's reliance on *Forbush* is unmerited. In *Forbush*, the plaintiff challenged a very specific practice uniformly applied to a discrete, easily-defined group of individuals. Indeed, every retiree in the class had his or her pension benefits calculated by using one of three mathematical formulae for estimating retirees' social security payments. If the mathematical formula was improper as used for one retiree, it was improper for every other retiree whose benefits were determined by application of that formula.

Unlike the plaintiff in *Forbush*, the plaintiffs in this case challenge a group of loosely-defined practices that were *not* applied uniformly to a discrete, easily-defined \*431 class of individuals. Indeed, the record reveals that Unum pays billions in disability benefits annually, which means that, despite Unum's alleged profit-driven claim review practices, many claimants successfully pass through the process and receive disability benefits as a result. Nor can it be said that all class members whose claims for long-term disability benefits were

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denied or terminated would have been entitled to benefits but for Unum's use of the alleged improper practices. Some of the denials and/or terminations were no doubt merited for medical reasons. As even a cursory search on Westlaw or Lexis Nexis will illustrate, many individuals who request disability benefits-whether under ERISA or social security-are unable to establish entitlement to those benefits. It follows that a class limited to those persons whose benefits were denied or terminated would necessarily include many individuals whose claims were *properly* denied for medical reasons. FN7

FN7. Counsel for the plaintiffs conceded at oral argument that a class of persons whose benefits were denied or terminated would necessarily include some individuals whose claims were properly denied for medical reasons.

To be sure, the district court did not define the class as including those participants whose disability claims were denied or terminated. The court was more specific, defining the class to include those participants whose claims were denied or terminated “after being subjected to any of the practices alleged in the Complaint.” Such definition, however, does little to distinguish between the set of individuals whose claims were properly denied for valid medical reasons and the set of individuals whose claims were improperly denied for profit-driven reasons. Indeed, as Unum has correctly argued, the only way to distinguish between the two sets of individuals is to engage in individualized fact-finding, and the need for such individualized fact-finding makes the district court's class definition unsatisfactory. See *John v. Nat'l Sec. Fire and Cas. Co.*, 501 F.3d 443, 445 (5th Cir.2007) (noting that “[t]he existence of an ascertainable class of persons to be represented by the proposed class representative is an implied prerequisite of Federal Rule of Civil Procedure 23”); *Crosby v. Social Sec. Admin.*, 796 F.2d 576, 580 (1st Cir.1986) (explaining that a class definition should be based on objective criteria so that class

members may be identified without individualized fact finding); 5 James Wm. Moore et al., Moore's Federal Practice ¶ 23.21[3][c] (3d ed.2007) (explaining that “[a] class definition is inadequate if a court must make a determination of the merits of the individual claims to determine whether a particular person is a member of the class”).

\*\*8 [2] The problem with the class definition, moreover, carries over into problems with typicality. As the court explained in *Sprague*, 133 F.3d at 399: “The premise of the typicality requirement is simply stated: as goes the claim of the named plaintiff, so go the claims of the class.” There must be some connection, in other words, between the merits of each individual claim and the conduct affecting the class. Absent such a connection, there is no basis upon which to fashion class-wide relief. Where a class definition encompasses many individuals who have no claim at all to the relief requested, or where there are defenses unique to the individual claims of the class members, *Beck v. Maximus, Inc.*, 457 F.3d 291, 296 (3d Cir.2006), the typicality premise is lacking, for under those circumstances-it cannot be said that a class member who proves his own claim would necessarily prove the claims of other class members.

Relying on a statement taken from Judge Martin's dissenting opinion in \*432 *Sprague*, the district court began its discussion of typicality by stating: “The test for typicality ... is not demanding.” *Sprague*, 133 F.3d at 415 (internal quotation marks and citation omitted). The district court went on to state that, while typicality is generally lacking when liability turns on individualized factors, typicality is not lacking in this case because the plaintiffs “characterized their lawsuit as a challenge to UnumProvident's uniform policies and practices with respect to reviewing claims.” We find the district court's analysis unpersuasive.

Here, the class members-who worked in different jobs, had different vocational skills, had

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different impairments, and experienced different disability review procedures managed by different claim representatives—are entitled to relief if, and only if, Unum wrongfully denied or terminated their benefits. That all of the plaintiffs may have been subjected to some or all of Unum's alleged wrongful practices does not eliminate the need for an individualized assessment as to the ultimate propriety of the benefits decisions affecting each and every class member. Because individualized assessments are necessary, it cannot be said that if a named plaintiff succeeds in establishing Unum's liability for breach of fiduciary duty, “so go the claims of the class.” *Sprague*, 133 F.3d at 399. Typicality is thus lacking.

In *Parke v. First Reliance Standard Life Ins. Co.*, 368 F.3d 999 (8th Cir.2004), the plaintiff alleged that an ERISA-plan fiduciary engaged in a practice of first awarding longterm disability benefits to a claimant, then terminating or suspending those benefits without asking for or receiving evidence that the claimant's conditions had changed. Among other things, the plaintiff sought injunctive relief for other claimants affected by the same practice. The district court denied the plaintiff's motion for class certification, finding that the plaintiff could not meet the threshold typicality requirement, given that the propriety of terminating any other claimant's benefits was dependent on the facts of each individual case. The Eighth Circuit affirmed, noting that, even if the plaintiff established a breach causing harm to her, the question of whether a breach caused harm to others remained “a case-by-case determination.” *Id.* at 1005; see also *Holmes v. Pension Plan of Bethlehem Steel Corp.*, 213 F.3d 124, 137-38 (3d Cir.2000) (affirming district court's denial of class certification for class of beneficiaries whose benefits were wrongfully delayed because “the issue of liability itself requires an individualized inquiry into the equities of each claim”). Like the plaintiffs in *Parke* and *Holmes*, the plaintiffs in this case have failed to demonstrate typicality.

\*\*9 [3] Even if the plaintiffs were able to demonstrate typicality, they have not shown that certification under Rule 23(b)(2) is appropriate. That rule provides that a class action may be maintained if Rule 23(a) is satisfied and “the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole.” Fed.R.Civ.P. 23(b)(2). A class action under Rule 23(b)(2) is referred to as a “mandatory” class action because class members do not have an automatic right to notice or a right to opt out of the class. The defining characteristic of a mandatory class is “the homogeneity of the interests of the members of the class.” *Reeb*, 435 F.3d at 649. Because homogeneity is required, unitary adjudication of the claims is feasible without the devices of notice and opt-out. On the other hand, where individualized determinations are necessary, the homogeneity \*433 needed to protect the interests of absent class members is lacking. *Id.*

In response to Unum's argument that a Rule 23(b)(2) class is inappropriate in this case because of the lack of homogeneity, the plaintiffs suggest that the presence of individual issues is immaterial because Rule 23(b)(2), unlike Rule 23(b)(3), contains no *predominance* requirement.<sup>FN8</sup> They do not address the well-recognized rule that Rule 23(b)(2) classes must be *cohesive*. See *Lemon v. Int'l Union of Operating Eng'rs*, 216 F.3d 577, 580 (7th Cir.2000) (explaining that “Rule 23(b)(2) operates under the presumption that the interests of the class members are cohesive and homogeneous such that the case will not depend on adjudication of facts particular to any subset of the class nor require a remedy that differentiates materially among class members”); *Barnes v. Am. Tobacco Co.*, 161 F.3d 127, 143 (3d Cir.1998) (noting that “[w]hile 23(b)(2) class actions have no predominance or superiority requirements, it is well established that the class claims must be cohesive”). The *Barnes* court recognized two reasons why cohesiveness, or homogeneity, is vital

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to Rule 23(b)(2) actions:

FN8. Rule 23(b)(3) requires that “questions of law or fact common to class members predominate over any questions affecting only individual members.”

First, unnamed members with valid individual claims are bound by the action without the opportunity to withdraw and may be prejudiced by a negative judgment in the class action. Thus, the court must ensure that significant individual issues do not pervade the entire action because it would be unjust to bind absent class members to a negative decision where the class representatives's claims present different individual issues than the claims of the absent members present. Second, the suit could become unmanageable and little value would be gained in proceeding as a class action if significant individual issues were to arise consistently.

*Id.* (internal quotation marks, ellipses, and citation omitted).

The plaintiffs in this case request, among other things, both imposition of a constructive trust as well as entry of an order requiring Unum “to provide a full and fair review ... of all claims for benefits under the plan that have been denied.” The plaintiffs do not explain how a constructive trust could be imposed without individualized review of every claim that was denied. Nor do they explain how the court could, if it ordered “a full and fair review ... of all claims for benefits under the plan that have been denied,” avoid exposing Unum to what Unum describes as “a one-way ratchet where [Unum] can lose but never win.” As Unum correctly asserts, Unum would have to provide the very relief requested (i.e., re-review) in order to determine whether any individual was, in the first instance, a class member, and, in the second instance, entitled to relief for an *improper* denial or termination of benefits. Class certification under the circumstances was an abuse of discretion.

### CONCLUSION

**\*\*10** For the foregoing reasons, we will **REVERSE** the district court's order of certification.

CLAY, Circuit Judge, dissenting.

This case is well-suited for class certification because it alleges a common course of wrongful conduct that warrants injunctive relief for the class as a whole. Today's result, which will require that Plaintiffs raise their claims in a series of individual but related lawsuits, will result \*434 in a waste of economic and judicial resources that will do very little to address the alleged system-wide directives and policies of Unum. The majority, with little focus on the deferential standard of review that is required in these matters, has grossly misapplied this Court's holdings in cases such as *Reeb* and *Sprague*, and has failed to apply a number of pertinent cases that support the district court's grant of class certification. For these reasons and others, I would affirm the district court's grant of class certification, and I respectfully dissent.

### I.

Before addressing the majority opinion, it would be helpful to briefly review the background of this case and Unum's responsibilities under ERISA. This case originated as a series of cases which were referred to the district court by a Judicial Panel on Multidistrict Litigation. On the basis of papers filed and a hearing held, the panel found that consolidated proceedings were appropriate because (1) the underlying actions involved common allegations that Unum engaged in improper claims handling practices in furtherance of a company-wide effort to reduce costs and inflate revenues; (2) the actions involved common questions of fact; and (3) litigation could be expected to focus on a significant number of common events, defendants, and/or witnesses.

The named plaintiffs in the consolidated case are long-term disability insurance claimants, each of whom alleges that he or she was improperly denied claim benefits by Unum. Collectively, Plaintiffs allege that Unum and its subsidiaries

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devised and implemented an elaborate scheme to illegally deny or terminate the long-term disability claims of thousands of disabled Americans, and brought this action to “stop [Unum's] illegal and alarming practices and to ensure that past, current, and future victims obtain a full and fair review of their claims.” More specifically, Plaintiffs claim that Unum fiduciaries systematically: (1) provide financial incentives to physicians who will ‘rubber stamp’ previously made business decisions in derogation of medical evidence and their ethical obligations; (2) authorize senior in-house physicians to alter the written reports of “uncooperative” physicians in order to justify a claim denial or termination; (3) deny or terminate claims without proper review by a fiduciary based on financial targets rather than the medical and vocational evidence concerning claimants' disabilities; (4) create ‘Duration Management’ documents that set target dates for cutting off claims and are withheld from claimants, attorneys, and reviewing courts; and (5) pressure physicians to change their medical opinions as to a claimant's disability in order to justify a business-driven claim denial. Plaintiffs argue that these practices constitute a breach of fiduciary duty under ERISA and the regulations promulgated thereunder.

**\*\*11** ERISA provides that “a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and-(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan....” 29 U.S.C. § 1104. The “minimum requirements for employee benefit plan procedures” under ERISA prohibit administration of claims procedures in a way that “unduly inhibits or hampers” the processing of claims for benefits. 29 C.F.R. § 2560.503-1(a)-(b)(3).

Interpreting these provisions, this Court has held that ERISA imposes high standards of fiduciary duty upon plan administrators which encompass three components:

The first is a “duty of loyalty” pursuant to which “all decisions regarding an \*435 ERISA plan ‘must be made with an eye single to the interests of the participants and beneficiaries.’ ” The second ... imposes “an unwavering duty” to act both “as a prudent person would act in a similar situation” and “with single-minded devotion” to those same plan participants and beneficiaries. Finally, an ERISA fiduciary must “ ‘act for the exclusive purpose’ ” of providing benefits to plan beneficiaries.

*Kuper v. Iovenko*, 66 F.3d 1447, 1458 (6th Cir.1995) (internal citations omitted). If a fiduciary fails to meet these standards, he or she may be held personally liable for any losses to the plan that result from his breach of duty. *Id.* (citing 29 U.S.C. § 1109(a)). In addition, plan members are statutorily authorized to seek injunctive relief to enjoin prohibited practices. *See* 29 U.S.C. § 1132(a) (“A civil action may be brought ... by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan....”).

If proven, Plaintiffs' allegations of Unum's systemic claims practices would certainly establish a violation of the terms of ERISA.<sup>FN9</sup> The salient question, therefore, is whether these claims must be brought as individual lawsuits by a series of claimants, or whether the claims can properly be raised under the auspices of a class action.

**FN9.** A fiduciary who issued corporate-wide directives to override or modify medical decisions based on predetermined target dates and financial incentives would plainly not be acting “with an eye single to the interests of” plan participants and “for the exclusive purpose” of providing benefits to plan participants. *See Kuper*, 66 F.3d at 1458.

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## II.

Inexplicably, given the nature of this case, the majority offers little analysis of this Court's holdings regarding the propriety of raising "course of conduct" cases as class actions. I will begin with this.

We recently advised that "cases alleging a single course of wrongful conduct are particularly well-suited to class certification...." *Powers v. Hamilton County Pub. Defender Comm'n*, 501 F.3d 592, 619 (6th Cir.2007). This proposition has been repeated consistently by this Court. See *Olden v. LaFarge Corp.*, 383 F.3d 495, 508 (6th Cir.2004) (case suited to class certification because plaintiffs raised common allegations which would allow the court to determine liability for the class as a whole); *Sterling v. Velsicol Chem. Corp.*, 855 F.2d 1188, 1197 (6th Cir.1988) (acknowledging an "increasingly insistent need" to certify class actions for lawsuits arising out of a "single course of conduct"); *Senter v. GMC*, 532 F.2d 511, 525 (6th Cir.1976) (finding that "[l]awsuits alleging class-wide discrimination are particularly well suited for 23(b)(2) treatment since the common claim is susceptible to a single proof and subject to a single injunctive remedy.").

**\*\*12** The rationale supporting these holdings is well-justified. In cases alleging a common course of prohibited conduct, "the class-action device saves the resources of both the courts and the parties by permitting an issue potentially affecting every [class member] to be litigated in an economical fashion...." *Gen. Tel. Co. of the Southwest v. Falcon*, 457 U.S. 147, 155, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982) (quoting *Califano v. Yamasaki*, 442 U.S. 682, 700-701, 99 S.Ct. 2545, 61 L.Ed.2d 176 (1979)). In this context, class actions serve to achieve economies of time, effort, and expense. See *In re American Medical Sys.*, 75 F.3d 1069, 1084 (6th Cir.1996).

**\*436** Moreover, in cases where the optimum result for any one plaintiff would be more than consumed by the costs, class actions may provide

the *only* method of vindicating the rights of individuals who otherwise could not afford the litigation. *Deposit Guar. Nat'l Bank v. Roper*, 445 U.S. 326, 338, 100 S.Ct. 1166, 63 L.Ed.2d 427 (1980). It is in this light that the Supreme Court observed that a district court's ruling on the class certification issue is often "the most significant decision rendered in [ ] class-action proceedings" because when it is not economically feasible to obtain relief by filing a multiplicity of individual suits for damages, "aggrieved persons may be without any effective redress unless they may employ the class-action device." *Id.* at 339, 100 S.Ct. 1166.

The purposes and benefits of class actions are particularly on point in the instant case. It is not practical or feasible for any one disability claimant to bear the cost of litigating the systematic and corporate-wide claims procedures and directives of a large, national disability provider such as Unum. The costs of conducting discovery regarding these procedures would undoubtedly exceed the damages any one plaintiff could hope to recover, and it would be a waste of economic and judicial resources to engage in duplicitous litigation of these common issues. Moreover, a relatively small award in favor of a given plaintiff would do nothing to address or deter the systemic processes of Unum. In such a case, class certification is the proper and practical way to proceed.

The majority takes issue with the fact that in any given plaintiff's case, individualized issues are present and a detailed review of a plaintiff's disability claim may determine that "the claim [was not] *wrongfully* denied." Op. at 429 (emphasis in original). However, if it is proven that Unum engages in systematic and prohibited claims practices, a plaintiff is statutorily entitled to injunctive relief. See 29 U.S.C. 1104(a)(1)(A) (fiduciary must discharge his duties for the exclusive purpose of providing benefits to participants and their beneficiaries); 29 U.S.C. § 1132(a) (a civil action may be brought by a plan

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participant to enjoy any act or practice which violates any provision of the plan).

Moreover, under the majority's reasoning, class actions would be prohibited in a wide variety of course of conduct cases that litigate issues of general liability before addressing individualized issues and damages. There are many such cases. In a toxic tort action, for example, the first order of business might be to determine that a corporation wrongfully disposed of an environmental toxin and created an environmental hazard. After this issue is resolved, individual plaintiffs would have to prove that the toxin caused injury their individual cases. In such cases, it may ultimately be determined that a given plaintiff's injuries were feigned, negligible or attributable to other sources, but so long as the named plaintiffs and the certified class proffered a cognizable claim of wrongdoing, the absence of damages in connection with one plaintiff's claim does not mean the case was not appropriately tried as a class action. *See, e.g., Sterling*, 855 F.2d at 1197 (affirming class certification and holding that the presence of questions peculiar to each individual member of the class was no bar when liability arose from a single course of conduct).

<sup>FN10</sup> Class certification is equally appropriate here, \*437 where Unum's system-wide claims practices and policies are alleged to be common and can be litigated before individualized questions are addressed.

<sup>FN10</sup>. Securities fraud and consumer protection cases also frequently address general liability issues before they move to individualized findings. *See, e.g., Mayer v. Mylod*, 988 F.2d 635, 640 (6th Cir.1993) (in a securities fraud action, class action certification was appropriate even though some investors made money and some lost money, because questions of liability were common to all class members regardless of their level of damages).

\*\*13 Similarly, in Title VII “pattern or practice” cases, courts routinely proceed by

examining allegations that a company engaged in a common pattern or practice of discrimination, and approach individualized relief in a separate process. *See Franks v. Bowman Transportation*, 424 U.S. 747, 772, 96 S.Ct. 1251, 47 L.Ed.2d 444 (1976) (establishing the “*Franks* model” where plaintiffs must demonstrate the existence of a discriminatory hiring pattern or practice, and the burden then shifts to the defendants to prove that individuals were not in fact victims of discrimination).<sup>FN11</sup> In *Cooper v. Federal Reserve Bank*, the Supreme Court observed that “[w]hile a finding of a pattern or practice of discrimination itself justifies an award of prospective relief to the class, additional proceedings are ordinarily required to determine the scope of individual relief for the members of the class.” 467 U.S. 867, 875-76, 104 S.Ct. 2794, 81 L.Ed.2d 718 (1984). In such cases, as here, it is not known at the onset of litigation whether an individual plaintiff has suffered discrimination that would warrant individualized relief: the primary and first issue to be addressed is the system-wide misconduct by the defendant.

<sup>FN11</sup>. The *Franks* model of litigating pattern or practice cases continues to apply. *See Int'l Bhd. of Teamsters v. United States*, 431 U.S. 324, 328, 97 S.Ct. 1843, 52 L.Ed.2d 396 (1977) (applying the *Franks* model); *McKennon v. Nashville Banner Publ. Co.*, 513 U.S. 352, 358, 115 S.Ct. 879, 130 L.Ed.2d 852 (1995) (citing *Franks* and *Teamsters* with approval); *Reeb v. Ohio Dep't of Rehab. and Corr.*, 435 F.3d 639, 658 (6th Cir.2006) (citing *Teamsters* and *Franks* as authority).

Affirmative action cases also bear similarities to the instant case. In such cases, courts commonly begin by addressing common questions of liability and then move to questions peculiar to each individual class member. In *Grutter v. Bollinger*, for example, the district court granted class certification to individuals of specified races who were denied admission to the law school, and

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bifurcated the trial into separate liability and damages phases. 539 U.S. 306, 317, 123 S.Ct. 2325, 156 L.Ed.2d 304 (2003). It goes without saying that any individual class member might not have been admitted to the law school, even in the absence of allegedly prohibited practices of the university. In that case, as here, to establish whether any individual plaintiff was entitled to individual damages, a detailed review of the individual's file would be required. But there, as here, the defendant's wrongful practices, if proven, might justify injunctive relief for the class as a whole and “the mere fact that questions peculiar to each individual member of the class remain after the common questions of the defendant's liability have been resolved does not dictate the conclusion that a class action is impermissible.” *Powers*, 501 F.3d at 619.

To be sure, there are “course of conduct” cases that are *not* suited for class certification. The most common of these are cases where: (1) injuries arise from individualized or isolated incidents of wrongdoing that do not apply to the class as a whole; or (2) issues of individual compensatory damages predominate. In *Falcon*, for example, the Supreme Court rejected the plaintiffs' claim that there was a policy of system-wide discrimination because the court found that the plaintiffs improperly generalized the experiences of discrete individuals who were subjected to discriminatory actions. 457 U.S. at 159, 102 S.Ct. 2364. The Court explained that “[i]f one allegation of specific discriminatory treatment were sufficient to support an across-the-board attack, every Title VII **\*438** case would be a potential companywide class action.” *Id.* The instant case does not raise the same concerns. Here, Plaintiffs are not using the experiences of the few to establish a system-wide policy; instead, the heart of their claim is that Unum has employed corporate-wide directives that claims must be denied based on financial targets. Any individualized grievances flow from that overarching policy.

**\*\*14** Class action designation is also inappropriate in course of conduct cases where issues of individual compensatory damages predominate. In *Reeb*, for example, this Court held that the district court abused its discretion by certifying a class under Rule 23(b)(2) because claims for individual compensatory damages predominated over declaratory or injunctive relief. 435 F.3d at 650-51 (expressing concern that highly individualized damages “counseled strongly” against certifying the class, but acknowledging that it would be appropriate for the plaintiffs to bring the case “in an action under Rule 23(b)(2) for declaratory or injunctive relief...”) That is exactly what is presented here: Plaintiffs seek injunctive relief as the primary form of relief, and individualized damages can be addressed at a later stage of the proceedings.

In sum, because this course of conduct case centers upon Unum's common and systematic claims practices, and because a finding of general liability would justify class-wide injunctive relief, class certification is appropriate.

### III.

In discussing the majority's conclusions to the contrary, first and foremost, we must recognize that this Court is obligated to provide “substantial deference” to a court's decision to grant class action certification inasmuch as a district court possesses the “inherent power to manage and control its own pending litigation.” *Reeb*, 435 F.3d at 643. The district court's decision is subject to a “very limited review” and should be reversed only upon a “strong showing that the ... decision was a clear abuse of discretion.” *Olden*, 383 F.3d at 507 (internal citation omitted).

As the majority states, a plaintiff seeking class certification is required to satisfy the prerequisites of Rule 23(a)-numerosity, commonality, typicality, and fair representation-along with the relevant subsection of Rule 23(b), which, in this case, requires that “the party opposing the class has acted or refused to act on grounds that apply generally to

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the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole[.]” FED R. CIV. P. 23(b)(2).

Defendants concede that the requirements of numerosity and commonality are met, but argue that typicality and cohesiveness are lacking. The majority agrees, and also asserts that Plaintiffs have failed to show “a causal connection between the alleged breach and the alleged harm.” Op. at 429. I disagree, and will address these issues in turn.

A.

The first contested issue is typicality. To establish this prerequisite, Plaintiffs must demonstrate that “the claims or defenses of the representative parties are typical of the claims or defenses of the class.” FED.R.CIV.P. 23(a)(3). A claim is typical if “it arises from the same event or practice or course of conduct that gives rise to the claims of other class members, and if his or her claims are based on the same legal theory.” *Beattie v. CenturyTel, Inc.*, 511 F.3d 554, 561 (6th Cir.2007) (quoting *American Med. Sys.*, 75 F.3d at 1082). This Court has explained that “[t]ypicality determines whether a sufficient\*439 relationship exists between the injury to the named plaintiff and the conduct affecting the class, so that the court may properly attribute a collective nature to the challenged conduct.” *Sprague v. GMC*, 133 F.3d 388, 399 (1998). For the district court to conclude that the typicality requirement is satisfied, “a representative’s claim need not always involve the same facts or law, provided there is a common element of fact or law.” *Beattie*, 511 F.3d at 561 (quoting *Senter*, 532 F.2d at 525 n. 31).

\*\*15 Here, as discussed above, Plaintiffs’ claims are typical because they arise from corporate-wide claims directives and procedures, which constitute a prohibited “course of conduct” and a “common element of fact or law,” as required in *Beattie*, 511 F.3d at 561. If Plaintiffs are able to prove that Unum has established corporate practices directing personnel to disregard medical

diagnoses to meet predetermined financial targets, those findings advance the claims of all class members and would warrant an injunction prohibiting the illegal practices. Individualized damages may remain, but this does not counsel against class certification.

The majority disagrees, relying upon misguided interpretations of *Reeb* and *Sprague* to support a conclusion that typicality is lacking. The majority cites *Reeb*, 435 F.3d at 644-45, for the proposition that allegations of a “general policy” of discrimination are inadequate to establish entitlement to class certification because courts are required to conduct a rigorous analysis of the “incidents, people involved, motivations and consequences regarding each of the named plaintiffs’ claims.” Op. at 429. However, the *Reeb* Court’s admonition was based upon a finding that there was an abundance of individualized issues of proof and damages present in that case.

The *Reeb* Court relied upon *Falcon*, 457 U.S. 147, 102 S.Ct. 2364, for the proposition that resolution of employment discrimination claims would “require proof that particular managers took particular employment actions and that either the managers were motivated by a discriminatory animus or the actions resulted in a disparate impact upon the class.” *Reeb*, 435 F.3d at 644. The Court expressed concern that the plaintiffs were using the experiences of the few to allege an “abstract policy” of discrimination, and expressed concern that the discrimination alleged could affect many different aspects of employment, such as hiring, firing, promoting, giving benefits, providing vacation time, or delegating work assignments. *Id.* at 644-45.

In contrast, here, Plaintiffs allege that Unum fiduciaries employ systemic policies and practices that instruct medical and claims personnel to deny claims based on preestablished financial targets. Unlike discriminatory hiring, firing, and promotion practices that turn upon the statements and actions of specific managers to specific employees,

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Plaintiffs here are challenging specific practices and directives that apply to claims procedures across the board.

Moreover, *Reeb* is distinguishable because the *Reeb* Court was particularly concerned with the nature of the damages that were sought. The *Reeb* plaintiffs asserted a wide variety of claims, and requested \$2 million in compensatory damages and \$3 million in punitive damages. *Id.* at 642. The Court expressed concern that these damages included “future pecuniary losses, emotional pain, suffering, inconvenience, mental anguish, loss of enjoyment of life, and other non-pecuniary losses.” *Id.* at 646. The Court noted that the plaintiffs sought an injunction but that “they did not specify the conduct they \*440 sought to have enjoined.” *Id.* at 640. This scenario offers a stark contrast to the present case, where Plaintiffs seek injunctive relief as the primary form of relief and are specific about the policies they seek to enjoin.

\*\*16 Most importantly, perhaps, the *Reeb* Court expressly advised that it would have been appropriate for the *Reeb* plaintiffs to bring the case as a class action under Rule 23(b)(2) for declaratory or injunctive relief. *Id.* at 651 (“We emphasize, however, that this holding does not foreclose all Title VII class actions. Plaintiffs now have the choice of proceeding ... in an action under Rule 23(b)(2) for declaratory or injunctive relief....”). This is precisely the type of claim that is filed here. In this regard, *Reeb* is not just inapposite; it actually supports Plaintiffs' argument for class certification.

The majority also relies on *Sprague*, 133 F.3d at 397-98, for the proposition that class certification is not proper if the plaintiff can prove his own claim but not prove the claims of other class members. *Op.* at 431-32. This case, if possible, is even more inapposite. The *Sprague* plaintiffs requested relief for the defendants' violations of ERISA based on a bilateral contract theory and on an estoppel theory, and the Court found that the claims lacked typicality because success on either

theory would require individualized proofs. 133 F.3d at 398. Under the bilateral contract theory, the district court would have to consider the a wide variety of documents signed by the plaintiffs; under the estoppel theory, the court would need to determine “what statements were made to a particular person, how the person interpreted those statements, and whether the person justifiably relied on the statements to his detriment.” *Id.* This Court noted that “because of their focus on individualized proof, estoppel claims are typically inappropriate for class treatment” and concluded that “because each plaintiff's claim depended upon facts and circumstances peculiar to that plaintiff, class-wide relief was not appropriate.” *Id.* Here, in contrast, Plaintiffs' claims focus on system-wide policies and directives. This is not a case like *Sprague* that had no common thread of liability. Although individualized *damages* may exist for the class members, this issue can be resolved after issues of general liability and injunctive relief are resolved.

The majority's faulty logic, and its misreading of *Sprague*, is perhaps clearest in the following statement: “That all of the plaintiffs may have been subjected to some or all of Unum's alleged wrongful practices does not eliminate the need for an individualized assessment as to the ultimate propriety of the benefits decisions affecting each and every class member. Because individualized assessments are necessary, it cannot be said that if a named plaintiff succeeds in establishing Unum's liability for breach of fiduciary duty, ‘so go the claims of the class.’ ” *Op.* at 432 (quoting *Sprague*, 133 F.3d at 399). This is perplexing. If a plaintiff proved that Unum engaged in systemic and illegal claims processing practices that harmed him as well as those similarly situated, he would certainly have proven that injunctive relief was warranted for the class. Moreover, if the majority's reading were applied across the board and a plaintiff had to *prove* all plaintiffs' claims by proving his own claim, class certification would be precluded in a wide variety of cases, including the toxic tort, Title VII, and

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affirmative action scenarios discussed above.

**\*\*17** The majority reads *Sprague* too broadly. The statement that “as goes the claim of the named plaintiff, so go the claims of the class,” 133 F.3d at 399, stands for the proposition that any one plaintiff, in pursuing his own claims, must *advance the interests* of other class members. The **\*441** *Sprague* Court, in the quoted passage, was actually paraphrasing its earlier statement that “[a] necessary consequence of the typicality requirement is that the representative’s interests will be aligned with those of the represented group, and in pursuing his own claims, the named plaintiff will also *advance the interests* of the class members.” *Id.* (quoting *American Med. Systems*, 75 F.3d at 1082) (emphasis added). The *Sprague* Court went on to say that “in pursuing their own claims, the named plaintiffs could not *advance the interests* of the entire early retiree class. Each claim, after all, depended on each individual’s particular interactions with GM...” *Id.* (emphasis added).

Consequently, *Sprague* does not support the majority’s conclusion that typicality is lacking. Instead, it supports the opposite conclusion: because Plaintiffs have established that the litigation of their cases would advance the interests of the class, they satisfy the requirement of typicality.

Perhaps because of the majority’s undue focus on generalized admonitions in cases such *Sprague* and *Reeb*, the majority fails to acknowledge that courts have granted class certification in a number of cases involving claims that a corporation engaged in a wrongful practice impacting all class members. In *Bittinger v. Tecumseh Prods. Co.*, 123 F.3d 877, 885 (6th Cir.1997), for example, this court affirmed the district court’s class certification decision in case governed by ERISA, over arguments that claims would be subject to varied defenses and arguments that the class members suffered varying levels of injury. This Court explained:

Though the level of claimed injury may vary throughout the class—a common feature of class actions routinely dealt with at a remedial phase—the basic injury asserted is the same: Tecumseh violated the terms of the collective bargaining agreements by unilaterally terminating fully-funded lifetime benefits. As noted above, those differences that exist—including the individual estoppel claims—can be dealt with through methods other than denial of class certification, at a later stage in the proceeding.

*Id.* In that case, we aptly noted that “the plaintiffs’ evidence appears to follow a pattern, and the people they claim made the representations are largely the same people.” *Id.* at 884. Here too, the evidence of alleged wrongdoing follows pattern; in this case, the alleged pattern is one of uniform and prohibited claims procedures. Plaintiffs’ claims, like the claims in *Bittinger* and *Beattie*, satisfy the typicality requirement because they arise “from the same event or practice or course of conduct that give[ ] rise to the claims of other class members, and ... are based on the same legal theory.” *Beattie*, 511 F.3d at 561.

**\*\*18** Although we are at an early stage of the proceedings, it is noteworthy that Plaintiffs provide reason to believe that they could succeed in establishing that Unum’s alleged practices exist. Other plaintiffs have succeeded in similar cases involving the same defendants. Recently, in the matter of *Merrick v. Paul Revere*, a district court in Nevada issued an order upholding a jury’s award of punitive damages to plaintiffs in a trial involving Defendants in the instant case.<sup>FN12</sup> See *Merrick v. Paul Revere*, 594 F.Supp.2d 1168 (D.Nev.2008). **\*442** In the district court’s findings of fact, the court stated that the plaintiff had presented “overwhelming” testimonial and documentary evidence of “the existence of targets and goals to terminate [disability] claims” that were “... communicated to claim handling employees by such means as e-mails, and weekly Staff Meetings.” *Id.* at 1171-72. The court found that “[b]ased on the

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credible testimony about targets and goals, documents, and the duration of Defendants' misconduct, there is every reason to conclude that Defendants gained well in excess of a billion dollars as a result of their claims handling misconduct." *Id.* at 1176.

FN12. The defendants in *Merrick* were The Paul Revere Life Insurance Company and UnumProvident Corporation. *Merrick v. Paul Revere*, 594 F.Supp.2d at 1168-69. The court's order explains that in 1996-1997, Provident and Paul Revere merged with Unum to form UnumProvident. UnumProvident then entered into an agreement in which it took over all responsibility for handling Revere claims. *Id.* at 1173-74.

In another case affirming a jury's award of punitive damages, the Ninth Circuit concluded that evidence existed that the same defendants "employed policies to achieve net termination ratios" and "had a conscious course of conduct firmly grounded in established company policies that disregarded the rights of insureds." *Hangarter v. Provident Life and Accident Ins. Co.*, 373 F.3d 998, 1014 (9th Cir.2004).<sup>FN13</sup> These findings support an argument that Plaintiffs' claims are more than unfounded allegations and that the alleged practices they describe are systemic.<sup>FN14</sup>

FN13. The defendants in *Hangarter* were Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company, and UnumProvident Corporation. 373 F.3d 998.

FN14. The claims in *Merrick* and *Hangarter* were raised by individual plaintiffs, but the courts' findings of fact, combined with large punitive damage awards that ranged from \$5 to \$8 million, indicate that the verdicts sought to target the deliberate and systemic practices of the defendants. See *Merrick*, 594 F.Supp.2d

1168; *Hangarter*, 373 F.3d 998. The availability of individual suits does not guarantee that the concerns of all potential class members will be protected, particularly when individual plaintiffs may not have the resources to bring a claim. In these circumstances, injunctive relief in a class action context is a particularly appropriate tool.

In sum, here, where the practices alleged are corporate-wide and purportedly affect all class members, the claims satisfy the requirements of typicality. In such a case, there is no sound reason to proceed by requiring individual plaintiffs to advance the claims and try common issues of fact separately and repetitively.

#### B.

The majority next asserts that the claims do not satisfy the requirements of Rule 23(b)(2), which requires that "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole[.]" FED.R.CIV.P. 23(b)(2).

Citing authority from the Third and Seventh Circuits, the majority asserts that there is a "well-recognized rule" that classes certified under Rule 23(b)(2) must be cohesive and homogeneous. Pointing to *Reeb*, 435 F.3d at 649, my colleagues declare that "where individualized determinations are necessary, the homogeneity needed to protect the interests of absent class members is lacking." Op. at 432-33. As discussed above, *Reeb* is not fatal to Plaintiff's case, and there is a long line of cases that establish that individualized issues maybe determined after general issues of liability are resolved.<sup>FN15</sup>

FN15. This Court has affirmed that "the mere fact that questions peculiar to each individual member of the class remain after the common questions of the

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defendant's liability have been resolved does not dictate the conclusion that a class action is impermissible." *Powers*, 501 F.3d at 619. This Court also advised that it is not uncommon for the level of claimed injury to vary throughout the class; this is "a common feature of class actions" that can be dealt with through "methods other than denial of class certification, at a later stage in the proceeding." *Bittinger*, 123 F.3d at 885.

**\*443 \*\*19** The majority opinion discusses reasons why "cohesiveness, or homogeneity is vital to Rule 23(b)(2) actions[.]" stating that there is the potential that unnamed class members will be prejudiced by a negative judgment in the class action, and that individual issues may pervade the action, making the suit unmanageable. Op. at 433. But the majority's analysis stalls and does not state why the requirement of cohesiveness is lacking here. This lapse is telling; cohesiveness is plainly present in this case, where Plaintiffs state a common theory of wrongdoing and seek injunctive relief that would benefit class members across the board. See *Beattie*, 511 F.3d at 564 (finding that the proposed class was sufficiently cohesive in a consumer protection claim because the issues in that case were "subject to generalized proof, and thus applicable to the class as a whole" and because such issues "predominate[d] over those issues that [we]re subject only to individualized proof.") (citations omitted).

Moreover, the majority appears to take issue with the relief that is sought. Glossing over the fact that the primary form of relief requested is injunctive, the majority states that Plaintiffs request a constructive trust and an order requiring Unum to provide a full and fair review of claims for benefits that have been denied. My colleagues then conclude that this relief would expose Unum to a "one-way ratchet" where Unum would have to provide re-review of claims to determine if a class member was entitled to relief for an *improper* denial or

termination of benefits.

Plaintiffs seek the following forms of relief:

[1.] Awarding plaintiffs and the Class declaratory relief determining the illegality of the conduct alleged and injunctive relief whereby UnumProvident and its subsidiaries are ordered to immediately cease ... engaging in the offending practices delineated herein;

[2.] Awarding plaintiffs and the Class equitable relief whereby Unum Provident and the subsidiaries are ordered to institute, under the supervision of the Court, new, national procedures that are in full compliance with ERISA;

[3.] Awarding plaintiffs and the Class equitable relief appointing a receiver and/or special master to serve as a neutral claims adjustor and assume the role of responsibility for responding to, acting upon, and making determinations pertaining to claims by plaintiffs and the Class and to provide a full and fair review, as required by 29 U.S.C. § 1133(2) of all claims for benefits under the plan that have been denied;

[4.] In the alternative, awarding plaintiffs and the Class a permanent injunction enjoining [the named defendants] from serving as claim fiduciaries and an the [sic] imposition of a constructive trust over the any [sic] trust assets controlled by [said defendants] [pursuant to] 29 U.S.C. § 1109; [and]

[5.] Awarding plaintiffs and the Class other appropriate relief[.]

(J.A. 38.)

As the request for relief indicates, the imposition of a constructive trust is only one alternative form of relief. Plaintiffs also request injunctive and declaratory relief enjoining Unum from engaging in the specified prohibited practices, which are more general forms of relief that apply to

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the class as a whole.

**\*\*20** Moreover, it would be perfectly acceptable for the district court to address individualized damages in a separate proceeding. There are a “number of management tools available to a district court to address any individualized damages issues,” such as “bifurcating liability and damage trials, or appointing a magistrate judge or special master to preside over individual damages proceedings.” *Beattie*, 511 F.3d at 562. **\*444** This is not an uncommon practice. “By bifurcating issues like general liability or general causation and damages, a court can await the outcome of a prior liability trial before deciding how to provide relief to the individual class members.” *Olden*, 383 F.3d at 509 (citations omitted); see also *Fed.R.Civ.P. 23(c)(4)* (“When appropriate, an action may be maintained as a class action with respect to particular issues.”); *Reeb*, 435 F.3d at 658 (suggesting that bifurcated phases of the class action could help separate issues of class-wide claims of discrimination from individual employment decisions).<sup>FN16</sup> Consequently, the majority’s concerns regarding the form of relief sought are unwarranted.

**FN16.** Insofar as the Defendants claim that an individual may not have a medical condition warranting disability benefits, Unum’s records are the most relevant items of proof. If the refusal of benefits was based on permissible factors, such as the lack of a qualifying medical condition, Unum and its agents know best what those factors are and the extent to which they influenced Unum’s decision-making process. See *Teamsters*, 431 U.S. at 359, 97 S.Ct. 1843; *Franks*, 424 U.S. at 772, 96 S.Ct. 1251.

### C.

Finally, the majority asserts that class certification is inappropriate because, under *Kuper*, 66 F.3d at 1459, “a causal connection between the alleged breach and the alleged harm is ... a

necessary element of an ERISA-participant’s breach-of-fiduciary-duty claim.” Op. at 429. The majority reasons that “whether a claim for benefits is *wrongfully* denied depends on a number of facts peculiar to the claimant’s case” and that “absent a showing that benefits were *wrongfully* denied, there can be no causal link between an alleged breach and a denial of benefits.” Op. at 429 (emphasis in original). This analysis is misguided for several reasons.

First, and importantly, the *Kuper* Court did not find that plaintiffs must provide a “causal connection” that their claims were “wrongfully denied” at the *class certification* stage of proceedings. The district court in *Kuper* had *already granted* class certification to the plaintiffs at an earlier stage of litigation, and was reviewing, *de novo*, the grant of summary judgment in favor of the defendants, after considerable discovery had been conducted, and after other dispositive motions had been decided. 66 F.3d at 1451-52. The Court did not discuss class certification requirements anywhere in its opinion, nor was the Court reviewing the district court’s decision with the substantial deference that is required when reviewing class certification.

Second, the *Kuper* Court’s discussion of a “causal connection” is taken out of context. In the passage cited by the majority, op. at 429, the *Kuper* Court concluded that summary judgment was appropriate because the plaintiffs had not demonstrated a “causal link” between the failure to investigate an investment and the harm suffered by the plan because the plaintiff had not demonstrated that “an adequate investigation would have revealed to a reasonable fiduciary that the investment at issue was improvident.” 66 F.3d at 1459-60. In other words, the *Kuper* plaintiffs had not proven that the defendants’ actions were improper, even on a general level. Here, as discussed above, proof that Unum had issued directives that valid medical decisions be disregarded in a quest to meet financial targets

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would certainly constitute a breach of duty warranting injunctive relief. Consequently, the *Kuper* Court's statements cannot be plausibly offered for the proposition that each plaintiff must demonstrate that his claim was *wrongfully denied* at the class certification stage of proceedings.<sup>FN17</sup>

FN17. The majority also cites to *Hein v. Fed. Deposit Ins. Corp.*, 88 F.3d 210, 224 (3d Cir.1996), for the proposition that when a plaintiff is not *wrongfully* denied benefits, no "causal link" is established between the alleged breach of fiduciary duty and the denial of benefits. Op. at 429. Similarly, the *Hein* court was addressing a grant of summary judgment and not class certification, and the majority's arguments fail for the same reasons discussed above.

**\*445 \*\*21** This Court must take care not to confuse issues of general liability with issues of individualized causation and damages. As we have advised:

Although such generic and individual causation may appear to be inextricably intertwined, the procedural device of the class action permitted the court initially to assess the defendant's potential liability for its conduct without regard to the individual components of each plaintiff's injuries. [...] The main problem on review stems from a failure to differentiate between the general and the particular. This is an understandably easy trap to fall into.... Although many common issues of fact and law will be capable of resolution on a group basis, individual particularized damages still must be proved on an individual basis.

*Sterling*, 855 F.2d at 1200 (affirming grant of class certification in a mass tort class action). Here, by holding that Plaintiffs must establish that their claims were "wrongfully denied" at the class certification stage of proceedings and by denying class certification based on the presence of individualized issues, my colleagues fall into the "trap" of which the *Sterling* Court warned. Because

general issues of liability could be resolved for the class as a whole, individualized issues of causation and damages were no bar to class certification in that case, and they should be no bar here.

#### IV.

In conclusion, the district court's class certification decision should stand even under *de novo* review. But given the deferential standard of review that applies in this case, it is particularly improper for this Court to reverse the district court's judgment. In so doing, my colleagues have misapplied the law of this Court, and have disregarded the valid purposes that a class action serves. For these reasons, I respectfully dissent.

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(Cite as: 2006 WL 1008002 (E.D.Mich.))

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Only the Westlaw citation is currently available.

United States District Court,  
E.D. Michigan, Southern Division.  
Jacqueline SNOW, et al, Plaintiffs,

v.

ATOFINA CHEMICALS, INC., Defendants.

No. 01-72648.

March 31, 2006.

Jason J. Thompson, Charfoos & Christensen, Wade  
A. Myers, Wade A. Myers Assoc., Plymouth, MI,  
for Plaintiffs.

Steven D. Liddle, Macuga & Liddle, Detroit, MI.

John E.S. Scott, Rebecca L. Takacs, Dickinson  
Wright, Detroit, MI, for Defendants.

ORDER DENYING PLAINTIFFS' MOTION FOR  
CERTIFICATION OF CASE AS CLASS ACTION  
ROBERTS, J.

#### I. INTRODUCTION

\*1 This matter is before the Court on Plaintiffs' Motion for Certification of Case as a Class Action. For the reasons stated below, the Court DENIES Plaintiffs' Motion.

#### II. BACKGROUND

Plaintiffs Jacqueline Snow, Joe Orta, Dave Flaishans, Elizabeth Adkins and Dave Thomas filed this action on behalf of themselves and others similarly situated.<sup>FN1</sup> Plaintiffs seek both monetary and injunctive relief against Defendant Atofina Chemicals, Inc. ("Atofina"), for chemicals emitted on July 14, 2001 during a chemical explosion at Defendant's facility.

**FN1.** Plaintiff Snow filed the initial complaint in this matter. She subsequently amended her complaint to add seven Plaintiffs. Thereafter, three of Plaintiffs

voluntarily dismissed their claims, leaving the five Plaintiffs named herein.

Defendant's facility is located on West Jefferson in the City of Riverview. Plaintiffs seek to certify a class defined as:

[A]ll persons or entities having claims for damages or injuries caused by the chemical explosion at Defendant's facility on July 14, 2001, and who or which own property in the communities of Grosse lie, Riverview, Wyandotte [,] Gibraltar and Trenton, or were present at the time of the explosion.<sup>FN2</sup>

**FN2.** Excluded from the class are governmental entities, Defendant and its officers and directors (and their families), affiliates, heirs, successors, assigns, parents and subsidiaries.

Pl Mot. at 1. Plaintiffs' prayer for damages includes: 1) loss of use and enjoyment of home and property; 2) mental and emotional anguish; 3) diminution of market value; 4) personal property damage; 5) real property damage; 6) exemplary damage; 7) medical monitoring; and 8) injunctive relief.

The underlying facts are not materially in dispute. At its production plant in Riverview, Atofina produces chemicals used in the production of a range of products, including pharmaceutical products, agricultural products, water treatment products, photographic chemicals and electronic components. At Defendant's facility at approximately 3:45 a.m. on July 14, 2001, a pipe connected to the discharge valve at the top of a rail car containing approximately 147,750 pounds of methyl mercaptan failed, causing a leak of liquid mercaptan. Shortly thereafter, vapors from the leaking rail car ignited and ultimately resulted in a violent eruption, creating a 200 foot fire column. Firefighters responded and determined that it was

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safest to allow the fire to bum itself out. The fire burned for several hours until approximately 8:30 a.m. FN3

FN3. Plaintiffs assert that the fire was not extinguished until 11:30 a.m.

At approximately 6:30-7:30 a.m., another rail car containing chlorine began leaking as a result of the fire and released approximately 26,000-27,000 pounds of chlorine. For Defendants, the chlorine leak was contained by 2:50 p.m. Defendants further contend that the large amounts of water poured over the accident site substantially diluted the chlorine before it got off-site.

Because Defendant's facility is located in proximity to several residential communities, local governmental agencies decided to evacuate certain neighborhoods. Included in the evacuation were Grosse lie, Wyandotte, Riverview and Trenton. Per Defendant, the largest evacuation area was in Grosse lie, where the evacuation zone stretched from the northern part of the island to Ferry Road in the south. The other areas evacuated were bordered on the north by Eureka Road in Wyandotte, on the south by West Road in Trenton, and on the west by the railroad tracks that run through Wyandotte, Riverview and Trenton. Defendant contends that the evacuation boundaries expanded over the course of the morning to include certain areas, solely as a precautionary measure, based on concerns about weather or accident condition changes. FN4

FN4. Specifically, Defendant contends that Trenton was evacuated based on a weather forecast predicting a change in wind direction; some areas upwind of the accident site were evacuated out of concern that one or more of the chemical rail cars in the vicinity might overheat and explode; and, Grosse lie's evacuation zone was expanded three times the local officials' emergency guidelines because of strong odors in the initial evacuation zone.

\*2 The evacuation orders were in effect from approximately 6:30 a.m. until 3:00 p.m. Based upon newspaper reports, the parties estimate that approximately 2,000 people were evacuated, including 400 households in Grosse lie and 40 households in Riverview and Wyandotte.

Per Plaintiffs, the methyl mercaptan had a distinct rotten cabbage odor and caused imitation of the skin, eyes, mucous membranes, headaches, nausea, chemical burns in the esophagus and stomach and other health related issues. Plaintiffs assert that numerous individuals found it necessary to seek medical attention.

Plaintiffs Snow, Orta, Adkins and Thomas were all in one of the evacuation zones. Plaintiff Flaishans was not in one of the zones, but claims that he was physically affected by the methyl mercaptan and other airborne chemicals. Plaintiffs indicate that over 200 individuals who have allegedly suffered similar injuries have expressed an interest in joining this lawsuit. See list at Pl Exh 16. Defendant contends, however, that only 31 of the people identified by Plaintiffs live in one of the evacuated areas.

Plaintiffs assert claims of negligence, nuisance, medical monitoring and strict liability. Defendant argues that Plaintiffs have not precisely specified either their alleged injuries or damages. Pointedly, Defendant contends that contrary to their claims that they seek three categories of damages- evacuation, diminution in property value and emotional distress-Plaintiffs identified 6 categories and 29 kinds of injuries and damages in their Preliminary Damage Statement. Def Exh 13.

Defendant further says that Plaintiffs' definition of the class is overbroad. Although only approximately 2,100 people and portions of the identified communities were evacuated, Defendant argues that Plaintiffs' definition of the class seeks to include all 80,000 members of the five communities. FN5

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FN5. See illustration of the proposed class area at Def's Mot., p. 13.

### III. APPLICABLE LAW

The question of whether to grant a motion for class certification must be answered by reference to [Fed.R.Civ.P. 23](#). In relevant part, that Rule states:

(a) Prerequisites to a Class Action. One or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

(b) Class Actions Maintainable. An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition:

...

(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or

(3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The matters pertinent to the findings include: (A) the interest of members of the class in individually controlling the prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; (D) the difficulties likely to be encountered in the

management of a class action.

\*3 [Rule 23](#) includes two additional provisions that are relevant. First, under [Rule 23\(c\)\(1\)](#), an order granting class action status “may be conditional, and may be altered or amended before the decision on the merits.” Secondly, [Rule 23\(c\)\(4\)](#) allows a court to grant class action status only to particular issues, and to divide a class into subclasses:

(4) When appropriate (A) an action may be brought or maintained as a class action with respect to particular issues, or (B) a class may be divided into subclasses and each subclass treated as a class, and the provisions of this rule shall then be construed and applied accordingly.

The party seeking class certification has the burden of demonstrating that all of the prerequisites of [Rule 23\(a\)](#) are met, and that the case falls within one of the subcategories listed in [Rule 23\(b\)](#). *In re American Medical Systems, Inc.*, 75 F.3d 1069, 1079 (6<sup>th</sup> Cir.1996). And, although a district court has broad discretion to grant class certification after conducting a “rigorous analysis” of the prerequisites of [Rule 23](#), the decision must be made within the framework established in the Rule. *Id.*, quoting *General Tel. Co. v. Falcon*, 457 U.S. 147, 161, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982), and *Gulf Oil Co. v. Bernard*, 452 U.S. 89, 100, 101 S.Ct. 2193, 68 L.Ed.2d 693(1981).

Importantly, an analysis of the [Rule 23](#) prerequisites should be the extent of the Court's inquiry. “[W]hen determining the maintainability of a class action, the district court must confine itself to the requirements of [Rule 23](#) and not assess the likelihood of success on the merits.” *Weathers v. Peters Realty Corp.*, 499 F.2d 1197, (6<sup>th</sup> Cir.1974). The *Weathers* court relied upon *Elsen v. Carlisle and Jacquelin*, 417 U.S. 156, 177-178, 94 S.Ct. 2140, 40 L.Ed.2d 732 (1974), which held:

We find nothing in either the language or history of [Rule 23](#) that gives a court any authority

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to conduct a preliminary inquiry into the merits of a suit in order to determine whether it may be maintained as a class action.... In short, we agree with Judge Wisdom's conclusion in *Miller v. Mackey International*, 452 F.2d 424 (C.A.5 1971), where the court rejected a preliminary inquiry into the merits of a proposed class action: 'In determining the propriety of a class action, the question is not whether the plaintiff or plaintiffs have stated a cause of action or will prevail on the merits, but rather whether the requirements of Rule 23 are met.'

*Id.*, at 427.

#### A. Rule 23(a)

A Court is required to analyze each of the Rule 23(a) factors. Those factors are commonly referred as (1) numerosity; (2) commonality; (3) typicality; and (4) adequacy of representation. The relevant rules for each of these factors is set forth below.

##### 1. Numerosity

Rule 23(a)(1) sets forth the numerosity requirement, requiring the class to be "so numerous that joinder of all members is impracticable." Although there is no magic number that determines when joinder of all members would be impracticable, "[w]hen class size reaches substantial proportions ... the impracticability requirement is usually satisfied by the numbers alone." *American Medical Systems* at 1079. Nonetheless, class sizes that are relatively small have been held to suffice.

\*4 In fact, circuit precedent has recognized class certification in classes with as few as eighteen members, [*Brady v. Thurston Motor Lines*, 726 F.2d 138, 145 (4<sup>th</sup> Cir.1984) ], (citing *Cypress [v. Newport News General and Nonsectarian Hospital Ass'n*, 375 F.2d 648, 653 (4<sup>th</sup> Cir.1967) ](eighteen members)), and that a class of as few as twenty-five to thirty members raises a presumption that joinder would be impracticable. *In Re Kirschner Medical Corporation Securities Litigation*, 139 F.R.D. 74, 78 (D.Md.1991) (citing *Dameron v. Sinal Hospital*

*of Baltimore, Inc.*, 595 F.Supp. 1404, 1408 (D.Md.1984)).

*Rodger v. Electronic Date Systems Corp.*, 160 F.R.D. 532, 535-536 (E.D.N.C.1995). In *Brady, supra.*, the court held that "74 persons is well within the range appropriate for class certification." *Brady* at 145.

At the stage of the proceedings in which class certification is being considered, it is not necessary for the Court to know the precise number of class members. Instead, the Court may rely upon reasonable inferences drawn from the known facts. *American Medical Systems* at 1079.

##### 2. Commonality

Rule 23(a)(2) mandates that, in order for a class to be certified, there must be "questions of law or fact common to the class." This factor recognizes the judicial efficiency that class action litigation is designed to foster:

The class-action device was designed as 'an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.' *Califano v. Yamasald*, 442 U.S. 682, 700-701, 99 S.Ct. 2545, 2557-2558, 61 L.Ed.2d 176 . Class relief is 'peculiarly appropriate' when the 'issues involved are common to the class as a whole' and when they "turn on questions of law applicable in the same manner to each member of the class." *Id.*, at 701, 99 S.Ct., at 2557. For in such cases, 'the class-action device saves the resources of both the courts and the parties by permitting an issue potentially affecting every [class member] to be litigated in an economical fashion under Rule 23 .' *Ibid.*

*General Telephone Co. of Southwest v. Falcon*, 457 U.S. 147, 155, 102 S.Ct. 2364, 72 L.Ed.2d 740 (1982).

Of significance is the fact that, to meet the commonality test, "there need be only a single issue common to all members of the class." ' *American*

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*Medical Systems* at 1080, quoting 1 Herbert B. Newberg & Alba Conte, *Newberg on Class Actions*, § 3.10, at 3-47 (3d ed.1992). “Consequently, the mere fact that questions peculiar to each individual member of the class remain after the common questions of the defendant’s liability have been resolved does not dictate the conclusion that a class action is impermissible.” *Sterling v. Valsicol Chemical Corp.*, 855 F.2d 1168, 1197 (6<sup>th</sup> Cir.1988). Further, when the legality of the defendant’s standardized conduct is at issue, the commonality factor is normally met:

Where a question of law refers to a standardized conduct of the defendants toward members of the proposed class, a common nucleus of operative facts is typically presented, and the commonality requirement of Rule 23(a)(2) is usually met.... [A] lack of identical factual situations will not necessarily preclude certification where the class representative has shown sufficient common questions of law among the claims of the class members.

\*5 *Franklin v. City of Chicago*, 102 F.R.D. 944, 949 (N.D.Ill.1984). In accord, the court in *Keele v. Wexfer*, 149 F.3d 589, 594 (7<sup>th</sup> Cir.1998) stated: “Common nucleus of fact are typically manifest where, like in the case *sub judice*, the defendants have engaged in standardized conduct towards members of the proposed class....”

### 3. Typicality

The typicality factor is met if “the claims or defenses of the representative parties are typical of the claims or defenses of the class.” Rule 23(a)(3). “The test for typicality, like commonality, is not demanding....” *Forbush v. J.C. Penney Co., Inc.*, 994 F.2d 1101, 1106 (5<sup>th</sup> Cir.1993).

The typicality requirement is meant to assure that the class representative is, indeed, representative of the class. “A necessary consequence of the typicality requirement is that the representative’s interests will be aligned with those of the represented group, and in pursuing his

own claims, the named plaintiff will also advance the interests of the class members.” *American Medical Systems* at 1082. Typicality may be presumed when the plaintiff’s claim “arises from the same event or practice or course of conduct that gives rise to the claims of other class members.” *Id.*, quoting 1 Herbert B. Newberg & Alba Conte, *Newberg on Class Actions*, § 3.13, at 3-76 (3d ed.1992).

### 4. Adequacy of Representation

Pursuant to Rule 23(a)(4), a class may be certified only if “the representative parties will fairly and adequately protect the interests of the class.” “This prerequisite is essential to due process, because a final judgment in a class action is binding on all class members.” *American Medical Systems* at 1083.

The adequacy of representation factor requires the Court to consider two criteria: “1) The representative must have common Interests with unnamed members of the class, and 2) It must appear that the representatives will vigorously prosecute the interests of the class through qualified counsel.” *Senter v. General Motors Corp.*, 532 F.2d 511, 525 (6<sup>th</sup> Cir.1976), *cert den*, 429 U.S. 870, 97 S.Ct. 182, 50 L.Ed.2d 150 (1976). *Accord*, *American Medical Systems* at 1083.

As can be gleaned, the adequacy of representation factor relates in part to the same concern as the requirement that the representative’s claims be typical of those of the class. “The adequate representation requirement overlaps with the typicality requirement because in the absence of typical claims, the class representative has no incentives to pursue the claims of the other class members.” *American Medical Systems* at 1083. What distinguishes the adequacy of representation factor is that it also requires the Court to consider the competency of the class counsel and to consider whether the representative and class have any conflicts of interest. *Id.*

Notwithstanding the importance of assuring

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that class counsel is competent, the Court must also be satisfied with the class representative's ability to "vigorously prosecute the interest of the class." *Senter* at 525. In *American Medical Systems*, the district court overlooked the evidence of the class representative's psychological problems, reasoning that the representative was a mere symbol who would not control anything in the litigation. The Sixth Circuit, however, found that reasoning to be "clearly contrary to our holding in *Senter*." *American Medical Systems* at 1083. Also see *In re K Mart Corp. Securities Litigation*, 1996 WL 924811, \*5 (E.D.Mich.1996)(Cook, J.)(finding it significant that a proposed class representative had demonstrated only a cursory knowledge of the litigation at issue).

#### B. Rule 23(b)(2)

\*6 An action is only maintainable under Rule 23(b)(2) if the relief sought is primarily injunctive or declaratory. *Alexander v. Ford Motor Co.* 204 F.R.D. 314, 320 (E.D.Mich.2001); *Fuller v. Fruehauf Traller Corp.*, 168 F.R.D. 588, 602-603 (E.D.Mich.1996). Under (b)(2), "defendants' allegedly wrongful conduct need not be directed at or damaging to every member of the class." *Little Caesar Enterprises, Inc v. Smith*, 172 F.R.D. 238, 267 (E.D.Mich.1997). Also, "[u]nlike Rule 23(b)(3), [ (b)(2) ] does not require the Court to determine the predominance of common questions of law and fact or the superiority of class action treatment of adjudication." *Id.*

#### C. Rule 23(b)(3)

In *American Medical Systems*, the court noted the parallel between Rule 23(a)(2)(commonality) and (b)(3), In that both require examination of the common questions involved. "[B]ut subdivision (b)(3) contains the more stringent requirement that common issues 'predominate' over individual issues." *American Medical Systems* at 1084.

#### IV. ANALYSIS

The Supreme Court has recognized that class actions are sometimes appropriate for mass tort actions. *Amchem Products, Inc. v. Windsor*, 521

U.S. 591, 625, 117 S.Ct. 2231, 138 L.Ed.2d 689 (1997). However, the Court finds that this case is not suitable, at this time, for class certification. Even assuming without deciding that Plaintiffs meet the requirements of Rule 23(a), Plaintiffs' claims do not satisfy the requirements for class certification under either Rule 23(b)(2) or (3).

Plaintiffs over the course of briefing this motion, reformulated their definition of the proposed class into four sub-classes: evacuation, economic harm, medical monitoring and personal injury. The Court will address each in turn.

##### i. Evacuation Class

Plaintiffs propose the following definition for the evacuation class:

A Rule 23(b)(3) class of all persons or entities having claims for damages or injuries caused by the chemical explosion/fire at the Atofina Chemicals, Inc. facility located in the City of Riverview, Michigan on July 14, 2001, and who or which own property, or where [sic] physically present in the official evacuation zones.

"As a preliminary matter, a class must meet a minimum standard of definiteness which will allow the trial court to determine membership in the proposed class." *Earnest v. General Motors Corp.*, 923 F.Supp. 1469, 1473 (N.D.Ala.1996). "[F]or the proposed class to be sufficiently defined, the identify of the class members must be ascertainable by reference to objective criteria." *Ball v. Union Carbide Corp.*, 212 F.R.D. 380, 391-392 (E.D.Tenn.2002), quoting 5 Moore's Federal Practice § 23.21[1] (3<sup>rd</sup> ed.1997).

Limiting those who qualify for this class only to those "having claims for damages or injuries" is extremely vague and susceptible to subjective interpretation. This broad definition invites limitless types of claims for injuries and damages. To the extent that Plaintiffs intended to narrow the scope to property or personal injury damages, it is not clear how this class differs from the economic

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harm or personal injury classes that will be discussed below.

\*7 Consequently, because the nature of the damages that are to be covered under this class are unclear, the Court is precluded from making a meaningful assessment of the viability of this class under Rule 23(b)(3). It is impossible for the Court to determine whether common questions of law or fact predominate or whether certification is a superior method of adjudicating these claims, without knowing what issues will be presented by this class. Plaintiffs' request for certification of this sub-class, therefore, is denied.

*ii. Economic Harm Class*

Plaintiffs propose the following definition for the economic harm class:

A Rule 23(b)(3) class of all persons or entities having claims for economic damages or injuries caused by the chemical explosion/fire at the Atofina Chemicals, Inc. facility located in the City of Riverview, Michigan on July 14, 2001.

This class definition, too, is extremely vague. As with the evacuation class, the limitation of "economic damages or injuries" does not adequately narrow the potential class of claimants or sufficiently put potential claimants on notice regarding whether they have a viable claim. For instance, economic damages can include property damages, lost wages, incidental expenses, the cost of temporary relocation necessitated by the fumes, medical costs, etc.

To the extent that Plaintiffs intended to limit this class to those who have suffered a diminution in the market value of their real property, the Court finds that the individual proofs required to establish such a claim predominate over any common issues of law or fact. Courts consistently decline to certify a class when individual issues of causation, injury and damage outnumber the common issues.

In *Thomes v. FAG Bearings Corp, Inc*, 848

F.Supp. 1400 (WD Mo 1994), Plaintiffs were allegedly exposed to groundwater contamination and brought claims of mental anguish, fear of cancer, increased risk of cancer and medical monitoring. The Court declined to certify the class under Rule (b)(3), finding that the individual issues of damages and causation rendered a class action unhelpful. 848 F.Supp. at 1404. The Court noted that the measure of damages was almost exclusively dependent on individual factors and that other damages, such as medical damages, diminution in property value, loss of use and enjoyment and annoyance, all would require Individualized proofs. *Id.* Consequently, the Court stated with regard to the manageability of such an action:

This would start hundreds or thousands of individual mini-trials on complex causation and damages issues, while the only benefit of a class would be that the ruling of several common, but not particularly daunting issues, would be made applicable to the entire class.

*Id.*

Also, in *Newton v. Southern Wood Pledmont Co.*, 163 F.R.D. 625, 632 (S.D.Ga.1995), *aff'd*, 95 F.3d 59 (11<sup>th</sup> Cir1996), where residents sued for alleged chemical exposure from a local wood treatment plant, the court found that the definition of the class was too broad to allow certification stating:

\*8 Because there exists no uniform exposure by all putative class members, all of these elements are incapable of common proof. Designating the members of the class would require an Individualized inquiry into the existence of an [injury] for each putative class member.

In this case, of the common issues that Plaintiffs delineated in their Reply Brief, the only common issue listed pertaining to property values was—"Did the explosion reduce real estate values?" Pl Reply, p 3. In order to prevail on the claim,

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however, each claimant would have to produce Individual proofs as to causation, actual injury and the amount of damages. For instance, each claimant would have to establish that there was a reduction in their property value; the extent of the reduction; and, that the reduction was caused by the accident, as opposed to a myriad of other potential causes. There is no apparent means of presenting this type of evidence on a mass basis. This class, therefore, falls to meet the requirements for [Rule 23\(b\)\(3\)](#) certification.

### *iii. Medical Monitoring Class*

Plaintiffs propose the following definition for the medical monitoring class:

A [Rule 23\(b\)\(2\)](#) or [23\(b\)\(3\)](#) class of all those individuals who will require medical detection services, including independent inspections and surveys, for a reasonable number of years in the future to monitor the possibility of latent defects of exposure to the chemicals emitted from the Atofina Chemicals, Inc. facility located in the City of Riverview, Michigan as a result of the chemical explosion/fire that occurred on July 14, 2001.

As with the previously discussed classes, the primary problem with this proposed class under either [Rule 23\(b\)\(2\)](#) or [\(b\)\(3\)](#) is its vague definition. As formulated, there is no objective means for the Court, or indeed even potential claimants, to discern who qualifies. Plaintiffs have failed to explain what criteria would be used to identify those “who will require medical defection services” without an individual assessment of every person who *thinks* that he or she qualifies.

If potential claimants had all been exposed to the same level of the chemicals, potential claimants may be readily identifiable. However, in this instance, the evacuation zone encompassed into five communities with varying degrees of exposure in each area. Before even deciding whether a person qualifies as a potential claimant, it will be necessary, at a minimum, to determine: whether there was actual exposure; the length of exposure;

and, the level of the exposure, considering various factors such as whether the individual was inside or outside, whether the windows were open, etc.,. Additionally, prior medical histories may mean that certain individuals are more susceptible than others to future medical injuries.

Class certification was denied in *Bledsoe v. Combs*, 2000 WL 661094, \*4 (SD Ind 2000) where extensive factual inquires were required in order to identify potential claimants:

\*9 The problem with this proposed class definition is that the court could not determine whether any individual was a member of the class without hearing evidence on what would amount to the merits of each person's claim. Where that type of inquiry is needed to determine whether a person is a member of a class, the proposed class action is unmanageable virtually by definition.

Certification of this class will, likewise, be denied.<sup>FN6</sup>

<sup>FN6</sup> Since certification is denied on this basis, it is not necessary for the Court to reach the issue of whether Michigan even recognizes a claim of medical monitoring or, if so, whether the proposed remedy is primarily injunctive or monetary under [Rule 23\(b\)\(2\)](#).

### *iv. Personal Injury Class*

Plaintiffs propose the following definition for the personal injury class:

A [Rule 23\(b\)\(3\)](#) class of all persons who claim physical injury as a result of exposure to the chemicals emitted from the Atofina Chemicals, Inc. facility located in the City of Riverview, Michigan as a result of the chemical explosion/fire that occurred on July 14, 2001.

Plaintiffs request that this class only be certified as to the common issues of liability under [Rule 23\(b\)\(3\)](#) and [23\(c\)\(4\)](#), with individual issues of causation and damages to be litigated in

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“follow-on” trials.

Before Rule 23(c)(4) can be implemented to bifurcate this class as Plaintiffs propose, Plaintiffs must satisfy the predominance requirement of Rule 23(b)(3). *Castano v. American Tobacco Co.*, 84 F.3d 734, 745 n. 21 (5<sup>th</sup> Cir1996). The Court in Casiano stated:

The proper Interpretation of the interaction between subdivisions (b)(3) and (c)(4) is that a cause of action, as a whole, must satisfy the predominance requirement of (b)(3) and that (c)(4) is a housekeeping rule that allows courts to sever the common issues for a class trial.... Reading rule 23(c)(4) as allowing a court to sever issues until the remaining common issue predominates over the remaining individual issues would eviscerate the predominance requirement of rule 23(b)(3); the result would be automatic certification in every case where there is a common issue, a result that could not have been Intended.

*Id.* Rule 23(c)(4) may not be used to circumvent the predominance requirement of Rule 23(b)(3).

In this proposed class, Plaintiffs essentially concede that the Individual issues of causation, injury and damages predominate over the common issues of law and fact. Plaintiffs, nevertheless, cite *Sterling v. Velsicol Chemical Corp.*, 855 F.2d 1188 (6<sup>th</sup> Cir1988) in support of their contention that individual issues regarding damages are not fatal to class certification. *Sterling*, however, is distinguishable. In *Starling*, residents living near a corporation's chemical waste burial site brought a class action against the company for personal injuries and property damage. The Appeals Court held that the district court did not err in certifying the class because the claimants had virtually identical claims:

Almost identical evidence would be required to establish the level and duration of chemical contamination, the causal connection, if any,

between the plaintiffs' consumption of the contaminated water and the type of injuries allegedly suffered, and the defendant's liability. The single major issue distinguishing the class members is the nature and amount of damages, if any, that each sustained. To this extent, a class action in the instant case avoided duplication of judicial effort and prevented separate actions from reaching inconsistent results with similar, if not identical, facts.

\*10 855 F.2d at 1197. The Court noted, however, that in complex, mass torts that do not have “one set of operative facts [that] establishes liability, no single proximate cause equally applies to each potential class member and each defendant, and individual issues outnumber common issues, the district court should properly question the appropriateness of a class action resolving the controversy.” *Id.*

Unlike *Sterling*, in this case each claim of personal injury will require individual proofs regarding: duration and level of exposure; the nature and extent of alleged injuries; causation, which will include an assessment of prior and current medical histories; and, damages. Therefore, this proposed class is unsuitable under either Rule 23(b)(3) or 23(c)(4).<sup>FN7</sup>

FN7. Note that Plaintiffs did not address how claims in this class could be bifurcated without running afoul of the Seventh Amendment. “A judge must not divide issues between separate trials in such a way that the same issue is reexamined by different juries.... The right to a jury trial in federal civil cases, conferred by the Seventh Amendment, is a right to have jurable issues determined by the first jury impaneled to hear them ... and not reexamined by another finder of fact.” *In re Rhone-Poulenc Roter, Inc.* 51 F.3d 1293, 1303 (7<sup>th</sup> Cir1995).

## V. CONCLUSION

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Plaintiffs' Motion for Certification of Case as a  
Class Action is DENIED.

IT IS SO ORDERED.

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