UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

In re Evanston Northwestern Healthcare Corporation Antitrust Litigation	)	**Master File No. 07-CV-4446**
	)	**Judge Lefkow**
	)	**Magistrate Judge Denlow**
This Document Relates To:	)	
All Actions.	)	

EXPERT REPORT OF DR. MONICA G. NOETHER SUPPORTING OPPOSITION TO PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

REDACTED VERSION
FOR PUBLIC FILE

June 9, 2009

CRA International Inc.
200 Clarendon Street
Boston, MA 02116-5092

TABLE OF CONTENTS

TABLE OF CONTENTS (cont'd)

I. INTRODUCTION

1. I am an executive vice president of CRA International ("CRA"), an economic consulting firm headquartered in Boston, Massachusetts. For more than twenty years of my professional career, I have specialized in health care economics, focusing on antitrust, competitive issues, reimbursement, and other policy issues relevant to dynamic health care markets. I have published various articles on competition and reimbursement in health care markets and presented health care policy research to the United States Congress and both state and federal government agencies, including numerous state departments of insurance, the Federal Trade Commission, and the Department of Justice. I also served as a vice chair of the Antitrust Practice Group of the American Health Lawyers Association for seven years.

2. I have provided expert testimony on health care antitrust and reimbursement matters in a variety of health care cases. I worked with the Federal Trade Commission and Department of Justice in their investigations of various hospital mergers and testified on their behalf in three merger challenges. I also testified on behalf of Evanston Northwestern Healthcare ("ENH), now NorthShore University HealthSystem ("Northshore"), in its response to the Federal Trade Commission's post-merger challenge ("FTC challenge") to the combination of Evanston and Glenbrook Hospitals with Highland Park Hospital (the "merger").

3. Before joining CRA, I was managing vice president of Abt Associates Inc., a policy research and consulting firm in Cambridge, Massachusetts. At Abt Associates, I performed federally-funded research on a variety of topics related to hospital reimbursement. Prior to my employment at Abt Associates, I worked at the Federal Trade Commission, where I served as a Commissioner Advisor and as Deputy Assistant Director of the Competition Division with the Bureau of Economics.

4. I have a Ph.D. in economics and an M.B.A. in finance and economics from the University of Chicago. A copy of my resume, which describes my background, including education and publications, is attached as Exhibit 1.

5. I have been retained by ENH to assess whether the merger could have had an anti-competitive impact on all members of the proposed class and whether the methods proposed by plaintiffs to establish class-wide impact and measure damages to class members are reliable. In this context, I also evaluate the report of plaintiffs' expert, Dr. David Dranove.

6. To assess the impact and damages issues related to class certification, I have performed a variety of analyses using the data that were produced in discovery in the FTC challenge, as well as more recent data provided by ENH. I have also reviewed a substantial number of the contracts between ENH and various managed care organizations and have examined data and documents produced by the named plaintiffs in this matter. I summarize my findings and resulting opinions in the next section and provide detail in the remainder of this report. A list of the materials that I reviewed is included as Exhibit 2. To date, I have spent over 160 hours on this matter, and staff working under my direction have spent over 2,500 hours on the research and data analysis contained in this report. My work is ongoing. As new information becomes available, I reserve the right to supplement my opinions.

II. SUMMARY OF OPINIONS

7. Plaintiffs allege that the merger provided the combined entity with market power sufficient for it to raise prices anti-competitively to a class of "persons or entities…who purchased or paid for inpatient hospital services or hospital-based outpatient services…." They assert that the impact of the merger was common to all members of the proposed class and that this impact can be demonstrated with common evidence. Plaintiffs also argue that the damages suffered by class members from the alleged anti-competitive price increases can be measured using a common methodology. Furthermore, they claim that named plaintiffs are typical and adequate representatives of all members of the proposed class.

8. I disagree with these allegations. It is my opinion that:

   - Even if it were true that ENH successfully raised prices anti-competitively following its merger, which I do not believe to be the case, it is not possible to define a class whose members all were impacted by these actions without substantial analysis of each individual proposed member of such a class. Rather, any general class definition, such as that proposed by Plaintiffs, contains numerous members who were not impacted.
   - Any impact of price increases on those affected individuals or entities must be measured on an individual basis, given the complexity of the payment arrangements that determine who pays how much for each service provided by ENH.
   - The various named plaintiffs are not typical and adequate members of the alleged class.

9. I believe that a variety of members of the proposed class suffered no impact from the alleged anti-competitive behavior. These individuals and groups must be eliminated from the proposed class, but, as I explain in great detail in Section V below, identifying them will require a detailed, individualized analysis of the payment terms and cost-sharing arrangements that apply to each proposed class member. In particular, the following categories of proposed class members did not experience any impact from the alleged anti-competitive behavior and must be eliminated.

   - Blue Cross Blue Shield of Illinois ("BCBSI") was not injured by the conduct at issue in this case. It has indicated in a declaration from its director of managed care contracting that the conduct challenged by the FTC and at issue in the current matter "did not cause BCBSI any injury or damage,"[1] and, as the FTC found, "Nearly every empirical test found little or no unexplained merger-coincident average net price increase for BCBS."[2] Redacted and provides managed care services to a variety of employers and other groups in the area, including one of the named plaintiffs, the Painters' District Council No. 30 Health & Welfare Fund ("Painters' Fund"), this assertion demonstrates that a substantial segment of the proposed class experienced no impact.[3]
   - Many managed care organizations ("MCOs"), particularly those that provide Third Party Administrator ("TPA") services to self-insured employers, pass on the medical costs they incur completely to their customers. As a result, they did not suffer from any alleged anti-competitive price increase.
   - For a variety of the individuals who are included in the proposed class, the combination of the general pattern of their utilization of health care services with the cost-sharing provisions in their health benefits plan imply that they did not pay directly for any anti-competitive price increase.

[1] Declaration of Joseph Arango, attached to Non-Party Blue Cross Blue Shield of Illinois' ("BCBSI") Reply in Further Support of Its Motion for Protective Order and Objection to the Production by Northshore University Healthsystem (Formerly Evanston Northwestern Healthcare Corporation) ("Northshore") of BCBSI's Highly Confidential and Business-Sensitive Documents, filed October 22, 2008, ("Arango Declaration"), ¶¶ 3-4.

[2] Opinion of the Commission, In the matter of Evanston Northwestern Healthcare Corp., Docket No. 9315, by Majoras, Chairman, filed August 6, 2007, ("FTC Opinion"), p. 39.

[3] Redacted

- The prices paid for many ENH services did not increase anti-competitively after the merger, and, therefore, the consumers of those services were not impacted.

10. I also disagree with the conclusions of plaintiffs' expert, Dr. David Dranove, that

- "Economists have reached consensus on the appropriate damages methodology for this case"[4], and
- "The ways that hospitals charge for their services imply common impact of anticompetitive overcharges"[5].

I demonstrate below that the methodology that he proposes (but has not yet attempted) to assess class-wide damages is unreliable as it requires data that are not available, relies on false assumptions regarding the common features of contracts between health plans and hospitals, and ignores key features of the payment arrangements between health plans and employers as well as between employers and their employees. As a result, Dr. Dranove's methodology cannot demonstrate the alleged impact of the merger across all, or even most, members of the proposed class, let alone estimate reliably the damages suffered by different members of the proposed class.

11. Indeed, as Dr. Dranove acknowledges, the methodology that he proposes to estimate the extent of any anti-competitive price increase by ENH during the proposed class period at best provides an estimate of any average price increase. It is not capable of distinguishing the effect of all of the unique circumstances that affect the prices paid by each particular member of the proposed class. Moreover, as my analyses demonstrate, the average is an inaccurate indicator of the potential damages accruing to specific class members.

12. Dr. Dranove has presented no analysis to justify his assumptions regarding the uniformity and simplicity of managed care contracting arrangements. As I summarize below and discuss further in later sections of my report, the analyses that I have performed demonstrate that many of his assumptions are false. Since these assumptions are essential underpinnings to his proposed common approach to identify members of the class and assess their damages,

[4] Heading to section 1.2 of Expert Report of Dr. David Dranove Supporting Motion for Class Certification, dated February 13, 2009 ("Dranove Report"), p. 3.

[5] Heading to section 1.3 of Dranove Report, p. 6.

his methodology would be unreliable. The analyses that I have conducted include the following, which lead me to various conclusions, summarized below:

- A review of the available ENH contracts with MCOs during the proposed class period reveals that the payment terms are substantially more heterogeneous than Dr. Dranove assumes. Many contracts contain specific terms including multiple payment provisions that apply to different services and these terms change over time and are modified by special provisions unique to each contract.
- Even if it were true that average prices at ENH rose anti-competitively following the merger, it is not the case that all prices increased. Rather, for a substantial number and variety of services, the payment data demonstrate declines in prices at various points in time during the proposed class period.
- The ENH chargemaster, which describes the list prices for approximately 11,000 items, is not uniformly increased at periodic intervals, as Dr. Dranove claims. Rather, a minority of items is changed (both increases and decreases) at any point in time, and the changes across items whose prices are modified are far from uniform.
- Within the unit of analysis that Dr. Dranove proposes to use to assess damages to inpatients at ENH, the Diagnosis Related Group ("DRG") there is substantial heterogeneity across patients in the charges associated with the services consumed. As a result, even if the underlying charges increased uniformly (which they do not), Dr. Dranove's aggregated analysis would not accurately assess the damages associated with class members whose bill was based on a discount off charges approach.
- Analysis of ENH payment data reveals that because of the cost-sharing features of group health benefit plans, the payment amounts to ENH by many individual patients would be unaffected by increases in ENH prices, and that for those individuals whose payments would be affected, these amounts can only be determined by a specific individual analysis of the patients' billing records.
- The approach that Dr. Dranove proposes to use to assess the amount of "overcharge," which relies upon publicly available data on the charges associated with hospital discharges at ENH and other comparison hospitals, produces results that are at odds with

the "real data" available for ENH – indeed in some cases it suggests price increases when prices declined and vice versa. Thus, it is evident that Dr. Dranove's proposed method for assessing the extent of the average anti-competitive price increase would be unreliable.

13. In the next section I present some background on the complex nature of contracting between hospitals and MCOs and between MCOs and their customers, employers, other groups and individuals. This background is critical for assessing whether members of the proposed class are likely all to have been impacted by the alleged anti-competitive behavior and whether those that were impacted likely experienced damages that can be estimated using a common framework. Indeed, as I explain, some of the features of the contracting process imply that not all members of the proposed class are likely to have been impacted at all. In the following sections, I discuss the methodology proposed by plaintiffs' expert, Dr. Dranove, and demonstrate why it cannot provide a reliable common framework for assessing damages that might have accrued even to impacted members of the proposed class. Finally, I describe why the named plaintiffs are not typical members of the proposed class and are therefore not valid class representatives.

III. MANAGED CARE CONTRACTING IS COMPLEX

A. CONTRACTING ARRANGEMENTS BETWEEN A HOSPITAL AND A MANAGED CARE ORGANIZATION

14. Dr. Dranove ignores much of the complexity of managed care contracting and asserts that three simple, uniformly applied payment rules fully explain the prices that members of the proposed class have paid ENH.[6] He ignores the variation in how these payment mechanisms – case rates, per diem rates, and discounts off of charges – are applied. Moreover, he totally ignores the various other critical features of managed care contracting that explain the variety of cost sharing arrangements between employers or other groups and their members. Dr. Dranove has not reviewed any ENH contracts and done no empirical analysis to test whether

[6] In his report he states, "Hospital-insurer contracts typically specify that the hospital is paid using one of three primary systems: case rates, per diem rates, or discounted list charges." (Dranove Report, ¶ 16.) He also states "Payment rules are most commonly adopted across-the-board; that is, the contracted payment rules apply to all or nearly [all] inpatient services (or outpatient services for outpatient contracting). For example, a DRG-based payment system is applied to all DRGs, and any increase in the price for a base case DRG is therefore applied across-the-board." (Dranove Report, ¶ 87.)

his assumptions regarding the payment rules are correct.[7] In underestimating the complexity and variation in payment arrangements, Dr. Dranove substantially oversimplifies the process necessary to identify who belongs in the class (who was injured) and to allocate damages appropriately to those different members in the class.

15. As one of the experts for the Federal Trade Commission in its challenge of the ENH merger explained in his report, Redacted [8] In this section, I discuss some of the important complexities of managed care contracting and explain why they imply that any assessment of the injury suffered by members of the purported class must be done on an individual basis. Only such an analysis can distinguish those purported class members who actually experienced an impact from those who did not, and for those who did, correctly measure their harm. Appendix 1 provides further detail on the intricacies of managed care contracting.

16. Per case reimbursement relies on a set of relative values, usually known as Diagnosis Related Groups or "DRGs," that measure the average relative cost to provide a particular set of services consumed in a hospital stay. For example, one DRG includes all of the hospital costs associated with a hospital stay for "chest pain," while another pertains to "major joint replacement or reattachment of lower extremity" based on the diagnoses assigned to the patient and the procedures that are performed during the hospital stay. Relative values in the commonly used Medicare weights range from 0.1577 to 23.6701, representing a 150-fold difference in the average relative cost to treat patients across the DRGs.[9] These are combined with a base rate that converts the relative values into a dollar payment value. For example, if a hospital stay is assigned to a DRG with a relative weight of 3, and the base rate for that type of DRG negotiated between the hospital and the patient's MCO is $6,000, then the hospital will receive payment of $18,000 (3 times $6,000.) The relative weights are generally assigned by commercially available software known as a "grouper", while the base rates are negotiated between a hospital and a MCO. Different payors use different groupers,

[7] Videotaped Deposition of David Dranove taken on May 8, 2009 ("Dranove Deposition"), p. 81.

[8] Redacted

[9] Actual variability in the costs to treat individual patients at a given hospital may be substantially larger, since each DRG itself reflects an average across a group of patients.

which implies different relative values (and associated prices) for a particular service. Moreover, the groupers change over time.

17. Dr. Dranove suggests that a uniform price increase applies to all patients whose stays are reimbursed under a case weight system because any price increase is accomplished through a simple increase in the base rate.[10] This oversimplifies the mechanism for price changes. First, even when a payor reimburses for some services on a case rate system, it may not use the case rate system for all its patients. Second, even among those patients whose stays are reimbursed under the case rate system, there may be multiple base rates – for example, one base rate may apply to obstetric cases, while another applies to medical admissions and a third to surgical stays. These base rates may not increase by uniform percentages or simultaneously. An analysis of ENH contracts, described in the next section, reveals that multiple base rates are common. Therefore, it is incorrect to assume that all the patients who belong to a particular health plan have experienced the same increases in prices at each point in time.

18. Some hospital stays are reimbursed using per diem amounts. Under this payment mechanism, the hospital receives a fixed amount per day for each day a patient is in the hospital.[11] However, there may be multiple per diem rates that apply within a single contract between a payor and a hospital; for example, medical, surgical, obstetric, newborn, and intensive care days may have different per diems. Moreover, as with per case rates, they may not all increase uniformly over time. As described in the next section, it is common for ENH contracts to contain multiple per diems that change by varying amounts over time. Therefore, it is again incorrect to assume that all the patients who belong to a particular health plan have experienced the same increases in prices at each point in time.

19. Third, many hospital contracts with MCOs reflect negotiated discounts off the hospital's charges. Hospitals maintain lists of the gross charges associated with every single item or service that they provide – for example there is a charge associated with each type of suture used in the operating room, as well as a charge for daily room and board on the med-surg floor, and a charge for each brand of hip implant used in hip replacement surgery. These

[10] See Dranove Report, ¶ 71.

[11] Dranove Report, ¶ 76.

thousands of items (ENH's chargemaster contains approximately 11,000 items) are compiled into a "chargemaster", which is periodically updated.

20. Dr. Dranove asserts that uniform price increases occur under discount off charges arrangements because he believes that 1) a single discount rate is negotiated for all services, and 2) hospitals increase the prices of all items on their charge masters uniformly (by the same percentage and simultaneously).[12] As a result, Dr. Dranove concludes that a common impact can be presumed for all members of the class who used ENH under a discount off charges arrangement. In fact, however, neither of his assumptions is true. Payors may negotiate a variety of discounts that pertain to different sets of services. Over time, they may maintain the same discount percentages or change them when they recontract. My analysis of ENH contracts, described in the next section, reveals that the use of multiple discounts in a single contract is common.

21. Moreover, even if the percentage discount negotiated by an MCO with a hospital remains constant over time and applies to all services, changes in the relative chargemaster prices (against which the discount is applied) may vary across different services. Additional complexities exist in the typical payment approaches used by MCOs to reimburse hospitals. Many contracts include "stop loss" or "outlier" provisions, which provide a hospital with additional payment for unusually costly cases. Such outlier provisions can take many forms. They may be defined to take effect at different thresholds; they may cover all the charges associated with a given stay (first-dollar coverage) or they may include only those charges exceeding the threshold; they can cover varying percentages of total charges, once they take effect.[13] Furthermore, the stop losses may apply only to specific services or treatments.

[12] Dranove Report, ¶ 79.

[13] Redacted

Certain procedures, such as prosthetics and implants, are particularly likely to be subject to stop loss provisions.

22. In addition, certain services may be "carved out" of a particular contracting arrangement. For example, a hospital may be reimbursed on a per diem basis (with one or multiple per diem rates) for the majority of the services it provides, except that transplants and behavioral health and burn care are provided on a discount off charges basis.

23. Outpatient reimbursement can be equally complex. There are a variety of grouping mechanisms that are used to design outpatient per case reimbursement systems, with different relative values to reflect variation in case complexity. These relative value systems tend to be more varied than those used for inpatient services. Some consist only of categorizations of more elaborate coding systems into fewer groups, while others bundle related services together into a single payment. Alternatively, outpatient services may be paid as a discount off of charges, or by using a fixed fee schedule. In some cases, multiple methodologies may be employed in a single contract: for example, surgical procedures may be reimbursed using a grouping system that bundles a variety of ancillary services with a primary procedure, such as Ambulatory Patient Groups, while laboratory services are reimbursed based on a fee schedule that separately identifies each individual test, while visits to outpatient clinics may be paid on a percentage of charges. [14]

Redacted

[14] Redacted

B. FEATURES OF THE CONTRACTUAL RELATIONSHIP BETWEEN EMPLOYER AND EMPLOYEE OR MCO AND INDIVIDUAL

24. In addition to the variety of contracting arrangements between MCOs and hospitals, the terms that describe the contracts between MCOs and their customers – either employer and other groups or individuals – as well as between groups and their individual members, are also complex and varied. Dr. Dranove appears to overlook these contract features and their impact on class definition and damage allocation entirely.

25. Terms between MCOs and their customers, who are primarily employer-sponsored groups, depend first on whether the group self-insures or purchases a fully insured contract from the MCO. When a group self-insures, it bears the risk itself for all medical costs rather than contracting with an insurer to handle that risk. It does typically contract with an MCO to function as a Third Party Administrator ("TPA") that negotiates fees with a network of providers and processes claims on behalf of the self-insured group. The TPA generally passes on the cost of the medical claims directly to the group, along with an administrative fee. As a result, an MCO functioning as a TPA would not generally have been harmed by any anti-competitive price increase by ENH.

26. Moreover, there is substantial variation in how the administrative fees are determined. In some cases, they are a fixed amount per member of the self-insured group. In other cases the administrative fee can be a function of the discount that the TPA achieves.[15]

Redacted

[redacted]

[15] Redacted

[redacted]

27. Fully-insured employers pay the MCO a premium, which covers medical and administrative costs as well as the cost for the insurer to bear the risk associated with uncertainty over medical claims experience of a particular group. While it is difficult to disentangle precisely the separate components determining the level of the premium, it is likely that at least the majority of the medical cost increases that affect all MCOs are passed on to the MCOs customers.[16]

28. The benefit packages that the groups that purchase insurance or administrative services from MCOs provide to their enrollees (e.g., individual employees or members of a Union Trust Fund) also vary along a number of dimensions that affect the impact any anti-competitive activity could have had on different individual members of the proposed class. These features include various cost sharing provisions, such as copayment and coinsurance terms. As plaintiffs appear to have acknowledged, those individuals who have only paid a fixed copayment (e.g. $20 per visit) for their services at ENH were not harmed, as the copayment is, by definition, invariant to the amount of the bill. Coinsurance generally implies a percentage (e.g. 10%) of the bill and therefore generally can be expected to rise proportionately with the bill. However, coinsurance rates can vary across different services within a given plan – for example there may be no coinsurance on well-care visits or

[16] See, for instance, FTC Opinion, p. 11.

laboratory services, but 10% on other outpatient services and 5% on inpatient services.[17] If the individual receives care from a provider that is not part of the MCO network, other cost sharing provisions may apply.[18]

29. Moreover, both copayment and coinsurance amounts are affected by deductible and out-of-pocket maximum policies. A deductible is the amount that a patient is required to pay out-of-pocket each calendar year before his/her benefits begin. However, there is variation in the way the deductible is applied. Some services may be exempt from the deductible, while others (such as behavioral health) may be subject to a separate deductible. Individuals enrolled in an MCO as part of a family likely share a deductible amount with the other members of their family who are covered by the same policy. Out-of-pocket maximums cap the amount that the individual must pay out of pocket in any given year. Again, different services may be subject to separate out of pocket maximums, and members of a family who share coverage will likely be subject to a common out of pocket maximum. Regardless, once an individual or family has reached his/her out of pocket maximum for the year, (s)he is no longer harmed by any anti-competitive price increase.[19]

30. While it is certainly true that not all insured individuals hit their out of pocket maximums in each year, it is common for some insured members to hit the maximum each year. As

[17] Redacted

[18] Redacted If the provider is not in the MCO network, the total charges may not be discounted, or discounts may be applied if the provider is party to an agreement that stipulates discounts for care provided to members of other MCOs. Redacted

[19] Redacted

described in Appendix 2, analysis of ENH claims data shows that hitting a yearly out-of-pocket maximum appears common for ENH patients, and that this phenomenon affects both the probability that a patient will pay out-of-pocket, as well as the amount the patient pays.

31. These features add complexity to identification of members of the class and allocation of their damages. Indeed, the variety of factors that must be considered implies that any assessment must be done on an individual basis as no single model can accommodate all of the relevant determinants of impact and harm to allocate damages accurately to class members.

32. In addition, currently available data are insufficient to permit accurate determination of whether certain individuals have been injured and, if so, by how much. For all MCOs, the ENH data can only reveal the direct payor to ENH and cannot discern which of their payments were made on behalf of self-funded groups, such as the Painters' Fund. As a result, to allocate the payments for an ENH service – and the changes in payments – among the MCOs and the self-employed employer groups who ultimately pay some of these amounts requires investigating the contracts between the many MCOs and their many self-funded employer-sponsored plans (contracts that ENH is not a party to), and reviewing the individual EOB forms for each visit by a covered individual (which would require discovery on every self-funded employer group whose covered individuals may had received services at ENH). However, because both the MCO/TPA and the self-funded employer groups are part of the proposed class, this allocation would be necessary. Thus, the economic analysis would necessarily require highly detailed and lengthy investigation of the individual circumstances of each self-funded employer group who is potentially a member of the proposed class.

33. Moreover, the interests of TPA and employer group members of the proposed class are in conflict. Each type of proposed class member will want to claim that it bore a larger share of any anti-competitive price increase in order to claim a larger portion of the damages that are assessed. Sorting out the relative merits of their respective claims, if any, is an individual, case-specific analysis.

IV. ENH CONTRACTS AND PRICES ARE NOT AS SIMPLE AS DR. DRANOVE ASSUMES

A. CONTRACTS BETWEEN ENH AND MCOS ARE MORE COMPLEX THAN DR. DRANOVE ASSUMES

34. Despite this complexity in the types of contract terms commonly employed in contracting between hospitals and MCOs, Dr. Dranove assumes that a specific MCO contract tends to have a single payment rule (case rates, per diem rates, or discounts off of charges) and that the same payment rule tends to be employed in successive contracts between ENH and that MCO. Dr. Dranove is mistaken on both counts. It is undisputable that the ENH contracts over the proposed class period do not conform to the simple model that Dr. Dranove assumes (but does not test). All of the ENH contracts employ more than one of the three payment methods (per diem, one DRG base rate, or one discount off charges), and most employ all three. All ENH contracts have multiple "price terms" for each payment method; that is, there are multiple discount percentages for the discount off charges parts of the contract, and multiple per diems for the per diem part of the contract. Most contacts also have multiple carve-outs and stop-loss provisions. It is simply not correct, as Dr. Dranove assumes, that "payment terms are most commonly adopted across the board."

35. I have examined each available contract between ENH and the largest MCOs with which it contracts over the class period. This includes R contracts or amendments with R payors.[20] For each contract, I determined whether the contract had price terms based on a per diem payment rule, a DRG basis (or case rate) rule, a discount off charges rule, or some combination. I also determined how many different services were uniquely specified as being paid by each rule, and how many unique price terms there were for that rule. For example, a contract may include a per diem payment rule, and specify three different types of service that are paid by that type of rule, e.g., a per diem for medical days, for surgical days, and for neo-natal nursery days.) The specified price for the medical and surgical beds may be the same, while there may be a different per diem price for the nursery beds. In this case, I would count this as three unique items priced by a per diem rule, with two unique per diem prices.

[20] Redacted

36. I perform the same analysis for other payment rules that appear in the contracts. For all payment rules, I also count the number of carve-outs, the number of maximum payment provisions, and the number of stop-loss provisions. I perform this analysis separately for the inpatient services and outpatient services covered by the contract.

37. Table 1 summarizes the payment rules in ENH contracts with MCOs over the class period. Most, indeed, virtually all of these contracts use multiple payment rules with multiple "price terms" (per diem, DRG base rate, or discount off charges).

38. As one example, Redacted

39. Redacted It is simply not correct, as Dr. Dranove assumes, that "payment terms are most commonly adopted across the board."

B. CHANGES TO THE ENH CHARGEMASTER PRICES ARE NOT COMMON

40. I have analyzed changes to the ENH chargemaster prices across all versions of the chargemaster that are available.[21] Redacted [redacted] Again, for those items that do increase, the pattern of increase is highly varied. That analysis shows that changes to the ENH chargemaster are not anything close to "across the board." Therefore, it is evident that Dr. Dranove's assumption that all patients subject to a discount off of charges payment methodology suffered a common impact is flawed.

41. Redacted [redacted]

42. Redacted [redacted]

[21] The ENH chargemaster contains approximately 11,000 items, although the number of items is subject to constant change as new items are added and old items are dropped. Redacted [redacted]

43. Redacted The rate at which prices increased is important for questions of impact, not only for questions of damages, as it may be the case that the observed price increases are consistent with market trends rather than the result of an exercise of market power.

44. Redacted [22] These analyses indicate that regardless of whether or not chargemaster items are weighted by the number of services or dollars associated with them and regardless of the time period considered, the price changes evident across chargemasters are not "across the board." As a result, Dr. Dranove's assumption that all patients subject to a discount off of charges payment methodology suffered a common impact is seriously flawed.

V. A NUMBER OF MEMBERS OF THE PROPOSED CLASS SUFFERED NO IMPACT FROM THE ANTI-COMPETITIVE BEHAVIOR

45. The class defined by the plaintiffs includes "[a]ll persons or entities in the United States of America and Puerto Rico, except those who solely paid fixed amount co-pays, uninsureds who did not pay their bill, Medicaid and Traditional Medicare patients, governmental entities, defendant, other providers of health care services, and the present and former parents, predecessors, subsidiaries and affiliates of defendant and other providers of healthcare services who purchased or paid for inpatient hospital services or hospital-based outpatient services directly from NorthShore University Healthcare (formerly known as Evanston Northwestern Healthcare), its wholly-owned hospitals, predecessors, subsidiaries, or affiliates other than those acquired as a result of the merger with Rush North Shore

[22] Redacted

Medical Center (the 'Class') from at least as early as January 1, 2000 to the present (the 'Class Period')."[23] Plaintiffs' expert further indicates in his report that Plaintiffs' Counsel has acknowledged that the class excludes "those who solely paid fixed amount co-pays, uninsureds who did not pay their bill, Medicaid and Traditional Medicare patients…".[24]

46. Based on these definitions, I understand that the proposed class is intended to include

- all commercially insured individuals or individuals enrolled in a Medicare managed care product (known now as "Medicare Advantage") who were admitted to an ENH facility as an inpatient or treated as an outpatient over a more than nine year period, regardless of the form of insurance they possessed, unless the insurance required them to pay only a fixed copayment amount regardless of the size of their bill,
- the MCOs who covered these individuals and paid the balance of their bills, Redacted [25]
- the employers or self-insured funds who contracted with these MCOs (whose identity and number are not ascertainable from public or ENH data),
- any uninsured individuals who paid a portion of their bill.

47. Each of these categories raises a variety of questions and likely includes members who did not suffer any impact from ENH's alleged anti-competitive behavior. For example, BCBSI, which is by far the largest payor in the Chicago area Redacted , has acknowledged it suffered no impact. Indeed, Joseph Arango, the Divisional Vice President of Provider Contracting and Strategy for BCBSI, who has been a contracting manager since 1990, declared that "BCBSI did not pay artificially inflated prices to Evanston Northwestern Healthcare for those health care services. The conduct which Evanston Northwestern Healthcare allegedly engaged in, as stated in this case, did not cause BCBSI any injury or

[23] Plaintiffs' Motion for Class Certification, Case No. 1:07-CV-04446, filed February 13, 2009, p. 1.

[24] Dranove Report, ¶ 27.

[25] Redacted For patients for whom ENH was an out-of-network facility, the MCO does not have a contract with ENH. However, all of these MCOs, as well as the individual patients, fall into the class definition.

damage."[26] BCBSI's statement that it was not harmed is also consistent with the analysis done by both FTC and ENH experts in the FTC litigation regarding the merger.[27] This evidence implies that a large segment of the proposed class, namely any individual or group covered by a plan operated by BCBSI, should be excluded from the class. In addition to providing self and fully insured plans to a variety of employers, various employee welfare funds, including the Painters' Fund, contract with BCBSI to access the BCBSI rates with providers.

48. As I explained earlier, TPAs are not harmed by any anti-competitive price increase because they generally pass on 100 percent of the medical costs that they incur on behalf of their customers to those customers. These TPAs are often major MCOs such as BCBSI or UnitedHealthcare, and, as noted above, without extensive discovery of the TPAs' data, it is not likely possible to distinguish the claims that they pay to ENH for their fully insured customers from those paid on an administrative service only basis. As a result, even with detailed TPA data, a specific individual analysis of each TPA would be required to calculate the portion of a MCO's business on which it might possibly have suffered some harm from ENH's alleged actions (except in the case of BCBSI, where we know the affected portion is zero.) Dr. Dranove has not proposed a useful common framework for assessing MCO harm.

49. Conversely, for any particular MCO, it is not straight-forward to distinguish those individuals and groups that are covered under its self-insured (TPA) arrangements and its fully-insured contracts. ENH has no way of knowing whether the patient who carries a (say) Aetna insurance card is a member of a self-funded employer plan or a fully funded plan. Indeed, often, even the patient does not know. Thus, without the complete claims history of each self-funded plan and a highly detailed, individual analysis, it is not possible to identify patients at ENH who were members of each self-funded plan or to assess how much of any anti-competitive price increase has been borne by the individual or group and how much remains with the MCO.

[26] Arango Declaration, ¶¶ 3-4.

[27] The FTC found that "Nearly every empirical test found little or no unexplained merger-coincident average net price increase for BCBSI," ("FTC Opinion", p. 39). A recent FTC working paper by Haas-Wilson and Christopher Garmon, "Two Hospital Mergers on Chicago's North Shore: A Retrospective Study," dated January 2009, p. 3, also reveals that one of the (unnamed) payors experienced no unusual price increase. Since this analysis relies on the same data used in the FTC challenge, this unaffected payor is likely BCBSI.

50. Rental networks, such as Preferred Healthcare Systems ("PHCS"), were also not likely impacted. These organizations assemble provider networks by negotiating rates with a set of providers in an area. They then "rent" their networks to a self-insured employer, a TPA, or another MCO. Since they fully pass on the medical costs of these providers, as well as an administrative fee, rental networks also have not been injured or impacted.

51. MCOs that provide fully insured products would only have suffered injury from an anti-competitive price increase to the extent that they cannot pass on the full amount of such an increase in their costs. While, during the life of existing contracts with its fully-insured customers, such an MCO probably cannot pass on provider cost increases, when those contracts come up for renewal (typically annually), it is likely to pass on most or all of any cost increase. As a result, if an anti-competitive price increase had occurred, which I do not believe to be the case, the MCOs are unlikely to have suffered much impact, even on their fully-insured business.[28] Moreover, without extensive analysis of each MCO's contracts with its fully insured customers, as well as of the premiums it earns and the medical costs it incurs on behalf of each of these customers, it will be impossible to determine how harm attributable to any anti-competitive price increase is distributed.

52. Self-funded groups who have stop-loss coverage that covers any amount beyond a threshold and who would have reached their stop-loss threshold regardless of whether ENH's prices were at competitive levels or higher have also not suffered any injury.[29] Again, however, the data necessary to distinguish such groups, which include an assessment of what each group actually paid each year as well as what it would have paid absent the alleged ENH action, will require a complete review of all the claims for each group. Such an analysis is inherently individualistic. Because of variation in stop-loss provisions, even if it were determined that multiple plans all were charged prices that were, say, 10% higher than they would have been if ENH had priced competitively, the stop loss provisions of each group

[28] See, for instance, Expert Report of Deborah Haas-Wilson, FTC Docket No. 9315, dated September 21, 2004, pp. 14-16, and FtC Opinion, p. 11

[29] Self-funded employer plans often have a "stop-loss" insurance policy that limits the plans total healthcare expenditures. Thus, while these plans are commonly called "self insured," they only self insure up to the stop-loss policy limit. Above this limit, they are a fully insured plan. Most plans have both an aggregate stop-loss policy (that limits total expenditures by the plan on all enrollees) and a "per individual" stop-loss plan (which limits the plans expenditures on a single enrolled member). Based on conversations with insurance plan brokers, I understand it is common for self-funded plans to hit some stop-loss limit.

will need to be separately assessed to determine whether they paid any, and if so, how much, of the anti-competitive price increase.

53. There are also several types of individual proposed class members who likely suffered no injury. These include:

- Any individuals whose policies limit the amount that the beneficiary (or his or her family) must pay themselves each year and who have reached this out-of-pocket maximum for the year when they receive a service from ENH. Redacted [redacted][30] As discussed above, it is common for some group members in each year to hit their out-of-pocket maximums.
- Individuals who have supplemental or secondary insurance that covers amounts that are not covered by the primary insurance may have no out-of-pocket expenditures. However, the arrangements between primary and secondary insurance coverage can be complex and it is not obvious how a specific proposed class member's circumstances can be understood without a specific analysis of that individual's coverage.
- Individuals who receive a service from ENH whose price had not increased anti-competitively at the time the individual received the service. As I discuss later,

[30] Redacted [redacted]

contrary to Dr. Dranove's assertions, price increases (anti-competitive or otherwise) did not occur uniformly at ENH following its merger.

- Uninsured individuals who do pay ENH are offered special payment terms under ENH's charity care policy. The policy outlines the eligibility guidelines that govern financial assistance to patients, based on federal poverty levels. Patients ineligible for assistance from a public aid program are evaluated based on income and asset levels, family size, and patient account history. Asset spend-down, out-of-pocket caps on expenses, free or discounted care (based on a sliding scale discount), or installment payment plans may be determined appropriate. Emergency care is provided by ENH, regardless of a patient's financial situation.[31]
- Individuals who receive services whose quality increased post-merger by more than the increase in price (relative to a benchmark.) This may be particularly likely for individuals who received services at the Highland Park facility, where substantial improvements were made and new services initiated. The FTC found that several improvements and new services were introduced by ENH at the Highland Park Hospital after the merger. While the FTC did not find all of these improvements to be merger-specific, these are nonetheless improvements in quality that increase the value of the services (and hence, all else constant, their competitive price).[32]
- Individuals who received a service from ENH under an out-of-network arrangement, where the terms are based on an external benchmark of "usual and customary" such as Ingenix, which is commonly used in such situations. These individuals were charged based on this external benchmark rather than ENH's charge.
- Any individual or plan who paid for a service at ENH received after the FTC's remedy, which was designed to restore competitive pricing.

[31] Evanston Northwestern Healthcare Charity Care and Financial Assistance Evaluation and Eligibility, Administrative Directives Manual AD05-1032, effective October 1, 2007. Patients with income levels below 200% of the federal poverty level (FPL) are eligible for free care. Patients with income levels up to 600% of the FPL are eligible for sliding scale discount on care. Attachment A of the guidelines gives the Sliding Scale Discount Table as well as the 2008 HHS Poverty Guidelines.

[32] FTC Opinion, pp. 48-49, 89-90.

54. The services covered under the proposed class definition include some that were unlikely to have been impacted by a merger between ENH and HPH, because they are provided in product and geographic markets that contain a substantial number of competitors. Redacted These types of outpatient imaging services are performed at a number of free-standing facilities. Currently there are over 20 imaging centers within 25 miles of one of the three ENH hospitals.[33] Indeed, Dr. Dranove agreed in his deposition that for a variety of outpatient services, free-standing facilities provide "the same service."[34]

55. Another example is Lasik eye surgery. This service is performed at the Glenbrook hospital, and therefore these patients are within the proposed class definition. However, this service is not covered under most MCO contracts. Therefore, these patients (who pay out-of-pocket) would not be impacted by a change in ENH contract prices with MCOs. While they might be impacted if the billed charges to self-pay patients increased anti-competitively, such an increase seems unlikely since it is unlikely that ENH possesses market power in Lasik surgery. Because of the lack of insurance coverage, patients are much more likely to shop around for Lasik services and cause providers to compete directly on price. Moreover, the market for Lasik surgery services cannot have been impacted by the ENH/Highland Park merger, as Highland Park did not provide this service, and there are many other competing providers in the area of ENH and Highland Park.[35] Once again, an individual analysis of many outpatient services, such as Lasik surgery, is required to determine who has suffered impact and to what extent.

[33] Imaging centers may provide one or many types of imaging services, including CT scans, PET scans, MRI, mammography, ultrasound, fluoroscopy, among other services. These outpatient imaging services are typically contracted as a carve-out. Redacted

[34] Dranove Deposition, pp. 54, 56.

[35] Many providers of Lasik surgery offer this service at geographic locations near ENH, Highland Park, and Glenbrook. For instance, Myers Wyse Center for the Eye (Lasik performed at Advocate Illinois Masonic Medical Center), Lieberman Eye Associates (Lasik performed at Northwest Surgery Center in Arlington Heights), Kraff Eye Institute, Sullivan Laser Vision Correction (Lasik performed at Northwest Surgicare), Northwest Ophthalmology, Koziol- Thoms Eye Associates (Lasik performed at Doctors for Visual Freedom), Lasik Plus Vision Center, Chicago Cornea Consultants, Ritacca Laser & Cosmetic Surgery Center, Eye Care Center of Lake County, Northwest Memorial Hospital, The Laser Network at Elmhurst, and TLC Arlington Heights all offer on-site Lasik surgery within 20 miles of ENH, Highland Park Hospital, or Glenbrook Hospital.

VI. DR. DRANOVE'S PROPOSED USE OF A DIFFERENCE IN DIFFERENCE METHODOLOGY CANNOT ADEQUATELY ASSESS INDIVIDUAL DAMAGES

A. PREVIOUS ANALYSIS USING THE DIFFERENCE IN DIFFERENCE METHODOLOGY

56. As Dr. Dranove has noted in his report, in the FTC challenge, the FTC's expert, Dr. Deborah Haas-Wilson, used a Difference in Difference ("DID") analysis to show that the price increases that occurred at ENH post merger were significantly higher than those that occurred at a group of "control group" hospitals. One of ENH's experts, Dr. Jonathan Baker, also used a DID analysis but drew different conclusions from its results.[36]

57. DID is used to distinguish the effects of any change in market power resulting from a merger on prices at the merged facilities from other factors that might also affect those prices, such as changes in demand, cost and quality. It attempts to isolate the merger effect by comparing the changes in prices from before to after the merger at the merged facilities with price changes over the same time period at other facilities that did not merge but otherwise experienced all the same changes as the merged facilities. If, in fact, the chosen comparable hospitals are identical to the merging facilities in all dimensions that affect prices both before and after the merger, then the difference between the price change at the merging facilities and the price changes at the other comparable hospitals can be attributed to the merger. In the case in question, DID was used to compare the price changes observed at ENH following the merger of Evanston/Glenbrook and Highland Park Hospitals with the price changes that occurred at other hospitals in the Chicago area that did not merge.

58. The methodology relies critically on the ability to define an appropriate comparison or control group that is matched in every way with the studied firm except for the merger. In other words, the studied firm and members of the control group must be identical in all relevant attributes before the merger, and the only difference in the change they experience over time must be attributable to the merger of the studied facilities. In this case, hospitals

[36] Redacted

are all unique in terms of the clinical quality and range of services they provide, the medical staff available, their location, the amenities that they offer to patients and the markets in which they compete, both before and after the merger. Moreover, over time they each change in somewhat different ways, by offering new services, attracting new physicians, augmenting their physical plant, initiating various quality initiatives, or gaining information about the market place in which they operate. As a result, it is not possible to identify an ideal control group, and therefore it is not possible to be certain that the results of a DID analysis can in fact be attributed to the merger .[37]

59. Dr. Dranove has not indicated how he plans to select his control group. His report is silent on the issue, and in his deposition he indicated only that comparable labor costs would be an important determinant, since they represent a substantial portion of hospital costs in general.[38]

B. DRANOVE'S PROPOSED USAGE OF DID

60. There are a variety of reasons why Dr. Dranove's proposed use of DID analysis cannot validly identify impact and assess damages that may have accrued to individual members of the class. These include:

- the inability of the methodology to distinguish all the unique circumstances that affect individual plaintiffs' payments to ENH other than by literally assessing each individual plaintiff separately (i.e. there is no common framework that can be used);
- inadequacies in the data that are available, particularly in the time period post-2003;
- the lack of a framework and commensurate data that can be applied to those patients who received "hospital-based outpatient services";

[37] ENH provided two explanations that were not accounted for by the DID analysis. First, there was substantial evidence that prior to the merger, ENH had underestimated the demand for its services. Various analyses that compared pricing between ENH and Highland Park revealed more favorable terms for Highland Park, even though it was a community hospital providing a simpler range of services than the academic ENH and consultants to ENH also indicated that it was under-pricing its services. Second, substantial quality enhancements were initiated, particularly at the Highland Park campus following the merger. One would expect that customers would be willing to pay more for higher quality services. Indeed, the Federal Trade Commission, in devising its final remedy to the transaction, eschewed a divestiture mandate, citing the substantial community benefits that would be lost with such a drastic undoing of the merger.

[38] See the Dranove Deposition, p. 261.

- the inability, without substantial additional discovery and an individual analysis, to distinguish ENH patients who are not members of the proposed class; and
- the inability to deal with particular class types, such as the uninsured.

I discuss each of these methodological flaws below.

1. Inability to Account for the Specific Circumstances of a Particular Plaintiff using a Common Methodology

61. Even if all of the other criticisms attributable to DID analysis could be overcome so that it could reliably assess differences in the changes in prices that are attributable to the merger, the analysis is insufficient for identifying injury and allocating the resulting damages to individual members of a class of heterogeneous plaintiffs. The most that even the ideal DID analysis can measure is the ***average*** change in prices over time. As Dr. Dranove states in his expert report, "The DID estimates of ENH overcharges represent the excessive increase in prices for the *average* (emphasis in original) ENH patient."[39] To assess injury and allocate damages to members of a class, it is also necessary to have a framework that can account for all the factors that lead to differences in the impact of the alleged action on each member. Any damage allocation methodology must be capable of handling the substantial complexity of contracting arrangements between MCOs and hospitals, between MCOs and employers or other group customers, and between groups and their individual members, described earlier. DID analysis falls far short of the necessary tool. At the very least, the impact of the alleged anti-competitive price increases should be expected to vary across payors, type of plan (HMO/PPO), patient cost-sharing arrangements, and type of service. It is not possible to design a DID analysis that comprehensively reflects all these sources of variation.

62. Indeed, Dr. Dranove acknowledges that he will have to estimate a number of different models for different members of the class. In his report, he proposes to estimate a DID model for each payor, and perhaps for each plan (HMO, PPO, etc.) that each payor offers. He also suggests that estimation of DID models at the DRG level (in addition to the payor and plan level) may be necessary.[40] There are over Redacted with which ENH contracts, many have two or three plans, and there are over Redacted. Thus, Dr. Dranove proposes

[39] Dranove Report, ¶15.

[40] Dranove Report, ¶¶ 88-89.

potentially to conduct over 18,000 different DID analyses.[41] However, even at this level of individualized analysis, the results would not be reliable, as they would still ignore several other sources of variation across individual class members. Moreover, as I discuss in the next section, data limitations will not permit this sort of refined analysis; there simply are insufficient data to conduct the analysis at the necessary granular level.

63. Plaintiffs and Dr. Dranove might argue that such granularity is unnecessary because many of the differentiating characteristics do not in fact create meaningful differences in the damages that different plaintiffs have suffered.[42] However, as I discuss below, analyses of ENH claims data demonstrate that meaningful differences do in fact exist and therefore, it would be inappropriate to combine the claims of different plaintiffs.

64. Dr. Dranove's conclusions regarding common impact rest on the assumption that when average prices to an MCO increase, the price of each service to each patient covered by that MCO also increases by the same amount.[43] However, Dr. Dranove performed no analysis to test this conclusion. I have performed an analysis that demonstrates that his assumption is incorrect. Using the same data and econometric models that Dr. Baker and Dr. Haas-Wilson employed in the FTC challenge, I have estimated these models separately for each DRG (rather than, as was done in the FTC case, aggregating all DRGs together). This analysis shows that while *average* ENH prices – across all DRGs – may have increased for some payors at a rate greater than the increase in prices at the control hospitals, the prices of very many individual DRGs did not increase at a higher rate at ENH than at the control hospitals for these payors. Thus, even if the FTC and current Plaintiffs were correct that the average ENH price represented an "overcharge," prices for many specific services did not reflect the average. Indeed, for all 4 payors there are DRGs for which ENH prices increase less than at

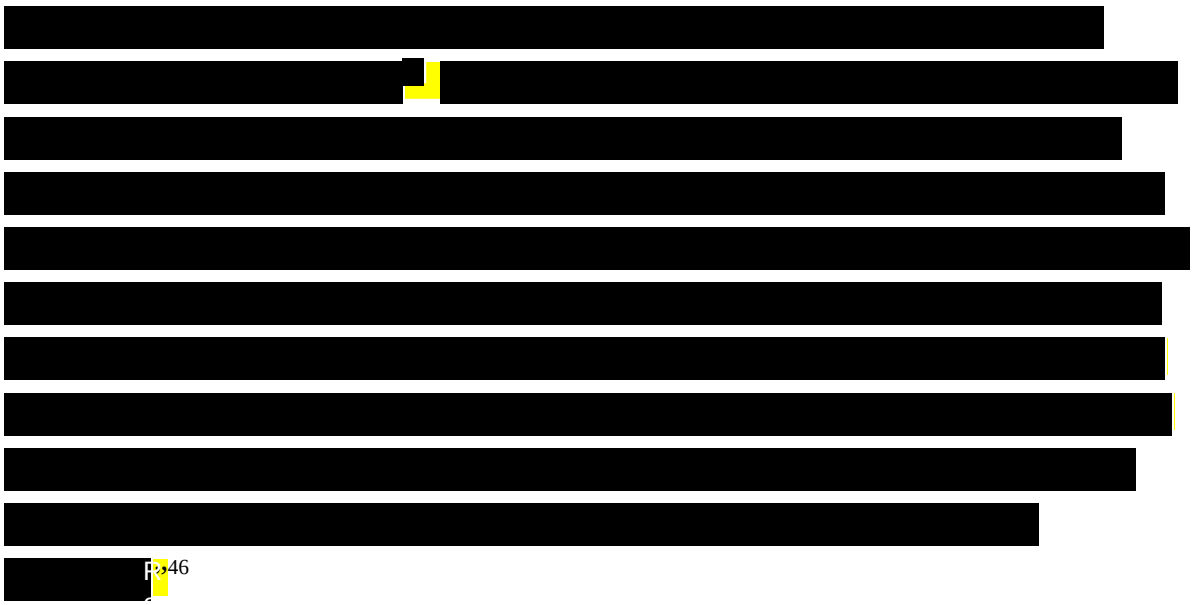
[41] Redacted

[42] In his deposition, he indicated that he thought he could take care of most or all of the variation by focusing on groupings of DRGs known as Major Diagnostic Categories ("MDCs"), because he believed that the services within each MDC were common. However, as I discuss below, even the more narrowly defined DRGs are not homogenous, so Dr. Dranove's assumption of commonality is unfounded.

[43] See, for instance, ¶15 of the Dranove Report: "The DID estimates of ENH overcharges represent the excessive increase in prices for the *average* (emphasis in original) ENH patient. In theory, an increase in average price does not imply that all patients pay higher prices. For example, it could be that prices escalated substantially more than average for some ENH patients but not at all for others. This is unlikely to be the case here. The nature of contracting between hospitals and insurers is such that when average prices increase, all or substantially all class members are affected. In other words, when I use DID to estimate the average overcharges for each insurer, I am also providing reliable estimates of the overcharges to all class members covered by that insurer."

control hospitals (to a statistically significant degree). That is, the DID model shows some post-merger ENH prices represented an "undercharge" rather than the uniform "overcharge" that Dr. Dranove assumes.

65. These results are presented in [redacted][44] Redacted



[46]

66. Moreover, DRGs themselves are not homogeneous categorizations of chargemaster items. In paragraph 103 of his report, Dr. Dranove is implicitly assuming that all patients within a DRG experience the same price increase because he assumes that under a discount off charges payment formula, the discount percentage is uniform and price increases in the chargemaster are "across the board." I have already discussed why these assumptions are unfounded. In fact, the charge line items comprising the bills of patients all categorized into the same DRG vary substantially. Therefore, two claims categorized into the same DRG but

[44] At his deposition, Dr. Dranove stated that he may perform his analysis at the MDC (Major Disease category) level. Since MDCs are larger aggregations of DRGs, and since there is substantial variation in price changes at the DRG level, analysis at the more aggregated MDC level will not be sufficient to show impact for all class members. However, I have also performed the above analysis at the MDC level. Even at this level of aggregation, there are MDCs (i.e., very large categories of class members) for whom the Difference in Difference is negative – that is, for whom the ENH price increased post-merger by smaller amount than the price for that category of service increased at the control hospitals. Redacted

[45] As discussed in the reports in the FTC matter, there was some question about the validity of the data on OB cases. Therefore, Dr. Baker and I analyzed the data both including and excluding the OB cases. The general results are largely unaffected by whether these cases are included or excluded. The data cover the following time periods by payor: Aetna, 1/1/98 to 8/24/02; BCBSI, 1/1/98 to 7/28/03; Humana, 1/1/98 to 5/31/04; United, 1/1/98 to 12/31/03.

[46] Dranove Report, ¶ 2.

priced using a discount off charges payment methodology will exhibit substantial variation in impact unless all chargemaster items have increased by the same amount.

67. Redacted [redacted] Therefore, we cannot directly examine the variation in the chargemaster items that are included in a specific DRG. However, indirect analysis of ENH charges by DRG shows that the underlying composition of chargemaster items within a DRG varies widely. I have analyzed the variance in billed charges, for a single DRG for a single year. Since billed charges are simply the sum of the underlying chargemaster line items, if most occurrences of a specific DRG have the same or similar chargemaster line items, then the amount of the billed charges should be similar or identical. On the other hand, if different patients' services categorized into the same DRG in a single year have widely varying billed charges amounts, it must be the case that the individual occurrences of this DRG are comprised of widely varying chargemaster line items.

68. My analysis indicates that there is enormous variation in the amount of billed charges, within a single DRG. I present my analysis looking separately at all DRGs and at the top 10 DRGs.[47] For each DRG, and for each ENH fiscal year, I calculated the range in billed charges for that DRG and the standard deviation of the billed charges for that DRG/fiscal year.[48] Standard deviation is a measure of the "spread" in a sample of data; in this case it is a measure of the variability of the total billed charges for the specific DRG and fiscal year. Standard deviation is often expressed as a percentage of the mean (or average) value. For any distribution, approximately 75% of the data lie within plus or minus two standard deviations from the mean.[49]

69. As an example, assume that for a specific DRG in a specific fiscal year the mean (or average) of the billed charges is $1000. Assume the standard deviation is 25% of the mean. In this case, the range of values for billed charges that will include 75% of the observations will be

[47] The Top 10 DRGs are defined based on total payments made to ENH for that DRG, between FY 2002 and FY 2007.

[48] I perform the analysis on a fiscal year basis because billed charges are a function of the chargemaster prices. Re da [redacted]

[49] By Chebyshev's Theorem. See, e.g., Robert Hogg & Allen Craig, Introduction to Mathematical Statistics, Fourth Edition, Macmillan Publishing co., Inc., 1978, pp 58-60.

from $500 to $1500.[50] Thus, if the charges for DRG have standard deviation equal to 25% of the mean, some of the cases have charges 3 times as high as others (and this still excludes the 25% of cases with the most extreme high and low values).

70. Redacted

71. The wide variance in the amount of billed charges for a single DRG in a single year illustrates the variability in the underlying chargemaster items that are "triggered" by a specific patient service; even for patients who appear otherwise to be very similar. Since changes to the ENH chargemaster prices are not uniform or common, whether a specific patient is impacted by an increase to some ENH chargemaster prices will depend on which chargemaster items were included in the patient's bill. However, even observationally equivalent patients (same DRG, same year) are billed for very different combinations of chargemaster line items. Thus, impact from changes in ENH chargemaster prices is not common across all class members who paid based on these prices. Furthermore, Dr. Dranove's proposed solutions to this issue (using various "dummy variables" to perform his analysis at the payor, plan or DRG level) will not address the heterogeneity within DRGs. Even with this detailed analysis, substantial variability remains in the potential impact across class members.

[50] The standard deviation is 25% of $1,000, or $250. The range that includes 75% of the observations is plus or minus two standard deviations, or plus or minus $500.

2. DATA DO NOT EXIST TO IMPLEMENT DR. DRANOVE'S PROPOSED METHODOLOGY

a. Sufficient Data Are Not Available for Many Payors for Any Time Period and Sufficient Data are Not Available After 2003 for Any Payor

72. Dr. Dranove begins by assuming that he will rely on data from the FTC challenge initiated in February 2004. In fact, usable data to implement the DID methodology, which requires data not only for ENH but also for the "control group" hospitals, existed for only four payors from that proceeding – Aetna, BCBSI, Humana, and United – while, in fact ENH receives payments from at least Re[illegible] commercial payors on a regular basis. Moreover, the data for the majority of these four payors are not available after 2003[51] As a result, at best, Dr. Dranove has data for a minority of payors during a minority of the proposed class period.

73. Dr. Dranove proposes an alternative strategy to handle the payors and years for which he has no information.[52] However, this strategy relies on a single calculation for each hospital and year, since that is all the data permit. Specifically, Dr. Dranove proposes to use a state of Illinois Hospital Association data base, known as COMPdata, which contains observations for every, or nearly every, hospital discharge from an Illinois hospital. However, the discharge records do not contain any information on the actual prices paid for the hospital services. Rather they present only a measure of the "gross charges" for the particular services associated with a discharge. As Dr. Dranove acknowledges,[53] these gross charges often bear little resemblance to the prices actually paid. As a result, Dr. Dranove proposes to adjust the gross charges by a discount factor that reflects an average ratio of net revenues (payments) to gross charges for the hospital and year in question, calculated from a Medicare Cost Report that every Medicare-accredited hospital must file annually with the Centers for Medicare and Medicaid Services ("CMS"). However, the Medicare Cost Report data do not permit calculation of such a ratio that is specific to any of the factors that Dr. Dranove has

[51] The Aetna data go through August 2002, and the BCBSI and United data end in July and December 2003, respectively. The Humana data currently available end in May 2004.

[52] In his deposition, Dr. Dranove appeared to describe a method for estimating prices at the control hospitals that is different than the method he proposes in his report. The method described at his deposition was even more overly simplistic than that proposed in his report. Therefore, I focus here on the shortcomings of the relatively more sophisticated method from Dr. Dranove's report. The criticisms I describe here of that method apply with even more force to the more simplified analysis Dr. Dranove appeared to advocate at his deposition.

[53] Dranove Report, footnote 7.

acknowledged are relevant, such as payor, plan, or type of service. In fact, the data do not even allow isolating private pay patients from government (e.g. Medicare or Medicaid) patients who are excluded from the Class definition.[54] Moreover, the data cannot calculate separate average ratios for inpatient and outpatient services, even though the markets in which these services are offered may vary significantly.

74. I have tested the accuracy and reliability of Dr. Dranove's proposed method, by comparing actual data on price increases from ENH with estimated price increases using the Medicare Cost Reports and the COMPdata set as proposed by Dr. Dranove. This analysis shows that the method Dr. Dranove proposes is not an accurate or reliable method to estimate the changes in the prices for specific services or groups of services at a specific hospital. Sometimes Dr. Dranove's method overstates the change in price, sometimes it understates the changes. Dr. Dranove's method does not even accurately predict the direction of changes in relative prices. Often his method will predict that prices have increased when in fact they decreased.

75. Redacted

[54] In Dr. Dranove's deposition, he indicated that he believed he could isolate the average price increase attributable only to private payors by, for each control group hospital, using other information on standard rates of increase for Medicare and Medicaid patients and on the proportion of the hospital's patients that are enrolled in Medicare and Medicaid. While this is theoretically possible when all the information pertaining to the individual nuances of each hospital in question is accurately available, there are a variety of factors that make the calculation difficult. For example, as noted earlier, some Medicare patients are enrolled in managed care products, and for these patients, the "standard" Medicare increase rates do not apply, however, it would be difficult, without extensive discovery of multiple hospitals, to determine which of their Medicare patients belong to Medicare MCOs. Moreover, hospital-specific adjustments must be made to Medicare's annual rates of increase to account for its teaching role and the proportion of indigent patients that it treats. Again, such information could be difficult to obtain for every relevant hospital. Similar variation exists in the Medicaid adjustments made to Illinois hospital payments for factors such as rural location, tertiary care and psychiatric service provisions. In addition, different Medicaid payment methodologies apply to different hospitals in Illinois (Illinois Department of Healthcare and Family Services, Fiscal Year 2007 Annual Report for the Department of Healthcare and Family Services' Medical Assistance Program, Reimbursing Hospitals, http://www hfs.illinois.gov/annualreport/reimbursing_hospital.html, accessed June 2, 2009). As a result, Dr. Dranove's proposed adjustment to the aggregate Medicare Cost Report data to isolate the price increase for private payors would likely be unreliable. Moreover, it does not address the issue of combined inpatient and outpatient discount rates.

76. Since, as discussed above, changes in average prices are not sufficient to draw accurate conclusions about changes in specific prices (such as the prices for specific DRGs or even more narrowly defined services to a specific payor), I have also performed this analysis at a variety of different levels. Redacted

77. I also performed the same analysis for the largest DRG in each Major Disease Category (MDC). The results are the same. Sometimes Dr. Dranove's method overstates the change in price, sometimes it understates the changes, and his method often will predict that prices have increased when in fact they decreased.

78. I have also performed this analysis by DRG and by payor. Even when the analysis is performed at this level of detail, Dr. Dranove's proposed method does not produce accurate results. Redacted [55] These disaggregated analyses confirm my conclusion that Dr. Dranove's proposed methodology for calculating price changes does not remotely match the actual changes in ENH prices, and even often concludes that prices have increased when they have in fact decreased. I conclude that Dr. Dranove does not have a method for estimating the changes in prices at his control hospitals. Therefore, he cannot reliably perform the DID analysis that he proposes.

79. The approach Dr. Dranove outlined in his deposition is even more simplistic and cannot possibly distinguish all the relevant characteristics affecting determination of injury. In his deposition, Dr. Dranove implied that he would rely exclusively on Medicare Cost Report data to calculate the average price increase that occurred at a set of (as of yet, unspecified) control group hospitals. Because of the limitations in the cost report data described above,

[55] The top DRGs, as defined by total payments made. I have also reviewed the top five DRGs for each payor, and there is no qualitative difference to my opinion.

such an average would not account for case mix differences, payor mix differences, or contractual differences at any of the levels of contracting (MCO-group, MCO-hospital, group-individual.) Instead, all this methodology will produce is a single price increase for each control group hospital each year.[56]

b. The ENH Claims Data Cannot Identify Class Members and Impact on These Members

80. Dr. Dranove also proposes to rely on ENH's own claims data to identify members of the proposed class and to calculate their damages. While he does not discuss any of the issues associated with the allocation of payments for a particular service across different members of the proposed class including the individual patient, her employer and the MCO or TPA, he likely believes that ENH data will be able to address this issue as well.

81. I have examined ENH data available to me to investigate whether it is possible to use these data to determine how any increase in ENH prices affected payments by the various entities who shared responsibility for the cost of healthcare services provided to members of the proposed class. These data include ENH clinical and financial data as well as the EOB forms produced by Plaintiffs. Analysis of these data reveals a number of issues that would make it impossible to determine on a class-wide or formulaic basis whether ENH price changes had a common impact (or even any impact at all) on the prices paid by the numerous parties who share in the cost of healthcare services for members of the proposed class. While these data do appear to provide a relatively complete and accurate history for patients treated at ENH for the limited time period covered by the data as well as a relatively complete and accurate record of overall payments by insurers and patients to ENH, the payment data are provided at a level of aggregation that renders it impossible to determine who paid what amount for a specific covered service. Consequently, these data cannot be used to determine how an increase in ENH charges for a healthcare service would change the amount paid by each party for that healthcare service. That is, these data cannot be used to determine whether and to what extent any increase in ENH prices would impact a member of the proposed class.

[56] By using the COMPdata, one is able at least to determine changes in hospital *list* prices at the procedure level, and for each payor. Using the Medicare Cost Report data alone, one can only calculate a single metric – such as average net revenue per patient encounter – across all payors, and all types of patient encounters. This includes all inpatient and outpatient encounters, of all severities.

82. For instance, the class definition excludes individuals who paid a "fixed co-pay." However, Dr. Dranove does not have a workable method to identify patients who paid a fixed co-pay. Thus, he cannot identify who should be excluded from, or what claims and payments to ENH are the subject of this litigation. The ENH data do not report whether a patient payment is the result of a "fixed co-pay," a percentage based co-insurance, payment for a non-covered service, payment in (full or partial) fulfillment of a deductible or out-of-pocket maximum, or for some other reasons.[57]

83. In addition, I have reviewed the Explanation of Benefit (EOB) forms produced by Plaintiffs and compared the data in these EOBs to the ENH clinical and financial data. This comparison indicates a lack of correspondence between the two data sources. The patient payments (and in some cases, the provider payments) shown on the EOB forms do not clearly match the payments shown in the ENH data. In my experience, the EOB forms are the record of the actual, final incidence of healthcare payments, after distribution and adjustment of these payments according to the complex contract arrangements described above. Since the ENH data do not correspond to the data on the EOBs, the ENH data cannot be used to analyze the incidence of ENH payments, and the incidence of changes in ENH prices, on a formulaic or class-wide basis. Appendix 4 provides additional detail on the shortcomings of the ENH and EOB data and explains why the data cannot be used to allocate damages across members of the proposed class.

c. Dranove's Own Empirical Analysis is Flawed

84. Finally, the only empirical analysis included in Dr. Dranove's report is in Appendix C, where he reviews the ENH data used in the FTC challenge. This analysis contains numerous errors. These errors reveal Dr. Dranove's lack of understanding of the complexities that must be taken into account in analyzing healthcare claims data and of the danger of attempting to draw conclusions about charges for specific services from aggregate analysis of claims data. Redacted [redacted] This is, firstly, inconsistent. It

[57] In his deposition, Dr. Dranove states that he may need to look at the medical records of each patient to determine who is in the class (Dranove Deposition, pp. 27-29).

is also incorrect in either instance. The data Dr. Dranove relies on appear to contain multiple records for a single instance of care. As a result, it is likely necessary to sum a variety of adjustments across records to determine the net total payment for a service. This is likely the cause of the obviously erroneous results Dr. Dranove reports, Redacted [redacted] The data that Dr. Dranove relies on are clearly erroneous in other ways. For example, Redacted [redacted]

3. Dr. Dranove has no Method for Dealing with Variation in Outpatient Payments

85. Dr. Dranove presents no plan to estimate impact and damages for outpatient services. Even if the methodology Dr. Dranove proposes to handle inpatients by grouping them into their respective DRGs were valid (which it is not), and even if there were evidence that ENH gained market power in outpatient services (which there is not), Dr. Dranove cannot apply the DID methodology to outpatient cases. While a variety of classification or grouping systems exist for outpatient services, there is substantially less uniformity in their application than on the inpatient side, where almost all hospitals incorporate some form of DRG. ENH's own outpatient claims data, as well as the data of at least some of the managed care payors, include Current Procedural Terminology ("CPT") codes and International Classification of Diseases, version 9 ("ICD-9") codes to identify the services provided. Neither of these coding systems readily translates into a categorization system for facility payments.[58] As a result, it is not clear how Dr. Dranove proposes to categorize outpatient service for purposes of a DID comparison across hospitals.

86. The ENH data demonstrate the heterogeneity of outpatient services. Over the period October 1, 2001, to April 30, 2008, ENH provided services billed under at least Redacted unique diagnosis codes and Redacted unique procedure codes. For both codes, the average number of codes per visit was approximately two, with up to R ed final diagnosis codes and R ed procedure

[58] CPT codes are often used as the basis for reimbursement of physician services, but the determinants of payments to a physician for a service are very different from the determinants of payments for the corresponding facility (e.g., hospital or imaging center) are very different.

codes. The second most commonly utilized diagnosis code is Redacted a catch-all category that includes a variety of patients that do not fit into a particular defined grouping. As a result, no meaningful standard price exists for these patients.

4. Dr. Dranove's Methodology does not Account for Charity Care Policies that Apply to the Uninsured

87. Dr. Dranove states that the uninsured pay based on the hospital chargemaster. Since Dr. Dranove mistakenly believes that changes in the chargemaster are typically "across the board," he posits that if an overall analysis of the chargemaster shows a (say) 10% increase, he can presume that each chargemaster price increased by about 10% and payments by the uninsured increased by a comparable amount. He does not present any workable plan, however, to estimate changes in ENH chargemaster prices, relative to changes in chargemaster prices at control group hospitals. Data on ENH chargemasters do not exist over the entire time period and data on the chargemasters of control group hospitals would have to be obtained form each hospital (if they exist for the entire class period). Therefore, he will not be able to perform a DID analysis directly on the chargemasters

88. Dr. Dranove appears to believe that his standard DID analysis (presumably run using data from the Illinois COMPdata, limited to hospital encounters by the uninsured at ENH and control group hospitals) will accurately identify any differences in the payments made by the uninsured at ENH relative to payments to other hospitals. However, as Dr. Dranove acknowledges, some uninsured patients don't pay their entire bill. Thus, he cannot base his analysis on the billed charges data in the Illinois COMPdata (which would not reflect patient discounts). He may plan to use the Medicare cost reports to estimate the discount to uninsured patients. However, as I explained earlier, this approach relies on a single common discount factor, calculated from Medicare cost reports. Even if a common discount factor applied to different private payors, which it does not, such a discount factor could not reflect different hospitals' charity care policies. As a result, there is no way to make a reliable comparison of the prices that the uninsured pay at ENH relative to other hospitals without extensive discovery from a variety of comparison hospitals.

89. As described above, under the ENH charity care policy, patients that meet income and asset requirements are eligible for free or discounted care, typically applicable to patients who fall

under 600% of the federal poverty level. While Dr. Dranove would apparently exclude from the proposed class those patients who did not pay substantially all of their bill, he does not indicate how he will account for the effect of ENH's charity care policy on individual patients' bills without an individual analysis of those patients.[59]

5. Dr. Dranove Cannot Account for the Interrelationship Between Different Types of Proposed Class Members which Affects how Damages Must be Allocated

90. Dr. Dranove does not explain how he plans to assess the damages that have accrued to any type of class member other than MCOs and uninsured individuals. In fact, his proposed use of dummy variables to adjust for different plaintiffs' circumstances or received services is too imprecise to account for the myriad payment arrangements and interrelationships that exist. He does not, for example, explain how he plans to assess the damages that have accrued to a self-funded employer-sponsored plan from an increase in average MCO contract prices. One cannot assume that a self-funded plan will experience the same percentage change in prices as the average percentage change in prices experienced by the MCO/TPA of that self-funded plan. A self-funded plan may only consume a few services, while the MCO/TPA will typically consume many services. Since, as elaborated above, price changes differ markedly across services, the presence or absence of impact on a specific self-funded plan may depend critically on which services its members received at ENH. Redacted [redacted] Clearly, had it been the case that BCBSI had experienced an anti-competitive price increase (which it did not), one cannot assume that the change in the average price per case for BCBSI is the same as the change in the average price per case for the Painters' Fund, given the variation in price changes across services described above.

91. Also, while hospital charges are always passed through from the TPA to the self-funded group dollar for dollar, additional administrative fees distort the simple relationship between what the TPA pays and what the self-funded group pays. In this case, the self-funded group is not a direct purchaser and the impact, or pass-through, on the plan of an increase in hospital prices depends on the effect of the administrative fee, which may be unique to each

[59] Dranove Report at ¶¶ 85-86 and Dranove Deposition, pp. 31-35.

contract between the self-funded plan and plan's TPA. For example, in the contract between the Painters' Fund and BCBSI, Redacted [60]

92. Network access fees are also a common feature of TPA contracts with self-funded employer groups.[61] The formula by which this fee is calculated differs across contracts, however Redacted thereby affecting the total price that the group pays the TPA. Thus, the impact of changes in the ENH contract price with an MCO/TPA will not be common to the self-funded employer groups who contract with that MCO/TPA.

93. Dr. Dranove also does not explain how an increase in MCO contract prices would impact an individual in an insurance plan. As discussed, how individuals pay for healthcare is affected by numerous factors and is not a direct proportional function of the amount the MCO pays the hospital. Therefore, even if the price of a specific service increases in a contract between an MCO and a hospital, the patient portion of that claim may not increase, and, even if it does, may not increase uniformly for different patients.

VII. THE NAMED PLAINTIFFS ARE NOT TYPICAL MEMBERS OF THE PROPOSED CLASS

94. The claims of the named class members, and economic proof of these claims, is not typical of the claims of the broader proposed class.

95. The vast majority of the claims of the broader class are by MCOs who directly negotiated contracts with ENH. Pricing to these MCOs was the sole focus of the FTC challenge on which Plaintiffs heavily rely. However, none of the named plaintiffs is an MCO, and none has ever directly negotiated prices with ENH. Redacted

[60] Redacted

[61] Redacted See also http://www.pmcsonline.com/pmcs-wp05.aspx and http://www.pmcsonline.com/pmcs-wp08.aspx , accessed on June 8, 2009.

96. The named individual plaintiffs consumed a very narrow range of services from ENH. None received any inpatient services. Redacted [redacted][62] Over the time period of the available data, ENH provided over 6,200 different outpatient services. Redacted [redacted]

97. As discussed above, the Painters' Fund – who is the only non-individual entity among the named plaintiffs – is very different from MCOs such as BCBSI. While BCBSI directly negotiated prices with ENH, the Painters' Fund never did so. Redacted [redacted].[63]

VIII. CONCLUSIONS

98. I disagree that there is an identifiable class of individuals and other entities who were harmed by anti-competitive behavior by ENH and whose damages can be measured on a class-wide basis using a common methodology. The complexity and diversity of payment arrangements between health plans and hospitals, on the one hand, and between health plans or their customers, such as employers, and the individual patients of hospitals, on the other, implies that a highly specific and individual analysis of each ENH customer's unique circumstances is required in order to assess impact and damages reliably.

99. The common methodology proposed by plaintiffs' expert, Dr. David Dranove, to assess impact and allocate damages to specific members of the class is insufficient in its ability to

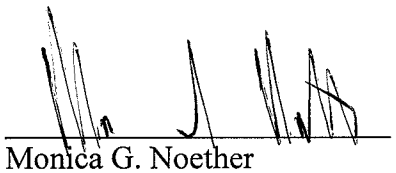
[62] Redacted [redacted]

[63] Redacted [redacted]

account for all of the factors that determine each class member's damages. As a result, Dr. Dranove's approach would produce unreliable estimates of damages and would be unable to distinguish those members of the proposed class who did and did not experience an impact.

100. Since Dr. Dranove has not analyzed any managed care contracts that were obtained in discovery in this matter, he has incorrectly concluded that the pricing terms are relatively uniform. Moreover, he has ignored all of the complexities associated with cost-sharing arrangements among different members of the proposed class that affect what each member has paid to ENH. Even with additional data, which could only be obtained through extensive and costly discovery of plaintiffs, and substantial increased complexity in his model, Dr. Dranove's approach would still be unreliable.

101. Named plaintiffs, Berkowitz, Lahmeyer, and Messner and the Painters' Fund, are not good representatives of the underlying class. The individuals consumed no inpatient services at ENH, even though such services comprise over 50% of ENH's revenues, and consumed a small variety of the thousands of outpatient services that ENH offers. The Painters' Fund, which contracted with BCBSI throughout the proposed class period, was unharmed because of its relationship with BCBSI.



Monica G. Noether
June 9, 2009

APPENDIX 1

DISCUSSION ON THE COMPLEXITIES OF PAYMENTS TO PROVIDERS

I. INTRODUCTION

1. The purchase of health care services in the U.S. is unlike the purchase of most other services by consumers.[64] In most transactions, a purchaser knows the price of a service prior to receiving that service and often pays the entire cost at the time of the service.[65] In contrast, the payment system for health care services in the U.S. is much more complex. A patient who visits a doctor or hospital for health care services rarely knows in advance the total cost of that visit, and has little incentive to determine it because it is likely the case that the patient will pay only a small portion of that total cost. Rather, a combination of one or more entities may contribute to the payment for a single patient visit to or service by a physician, hospital, or outpatient facility. In addition to payments by the patient receiving the service, parties responsible for payment may include government programs (e.g., Medicare, Medicaid, and/or other state, local or federal government health care programs, such as the State Children's Health Insurance Program or the Department of Veterans Affairs), private or "commercial" health plans (e.g., Blue Cross Blue Shield or UnitedHealthcare), employers, and/or other organizations that sponsor or organize health care financing and insurance (such as the Painters' Fund).

2. When a patient visits a hospital for an inpatient stay or outpatient procedure, the payment that the provider ultimately receives for that service, as well as the distribution across different

[64] Plaintiffs define "Healthcare Services" in the complaint as "general inpatient and outpatient hospital services provided by ENH that are ordinarily provided by hospitals, including primary, secondary, and tertiary services. These include, but are not limited to, obstetrical and pediatric services, psychiatric care, neurosurgery, radiation therapy, cardiology services, orthopedics, trauma centers, diagnostic centers, cancer treatments, internal medicine and general surgical services." (*United States District Court for the Northern District of Illinois Eastern Division, Painters District Council No. 30 Health & Welfare Fund, on its own behalf and on behalf of all others similarly situated, Plaintiff, vs. Evanston Northwestern Healthcare Corporation, Defendant,* Case No. 08 CV 2541, Class Action Complaint ["Complaint"], p. 3.) It is not clear what is included in this definition. While facility charges for inpatient and outpatient medical services appear to be included, it is not clear if Plaintiffs intend for "Healthcare Services" also to include charges for physician services (and if so, for only hospital based physicians or only ENH employed physicians), charges for other services such as rehabilitation and behavioral health, and charges for health care supplies (such as pharmaceuticals, implants, or consumable medical supplies). This payment tutorial focuses on facility charges for inpatient and outpatient services. To the extent that Plaintiffs intend "Healthcare Services" to include additional items, the payment system described herein is even more complex.

[65] For instance, when a person gets a hair cut, the customer knows exactly what the barber will charge and will expect to pay the full charge.

responsible entities, depends on numerous contractual relationships. First, the ultimate payment received by a hospital for the services it renders to a patient depends on the type of contract that the hospital has negotiated with that patient's health plan (if any). Contracts between hospitals and payors are complex and typically employ multiple payment methodologies, and multiple payment rates for each employed methodology.[66] Moreover, when contract rates (or prices) change, the payment methodologies and rates for different services may change in different ways. Thus, one cannot presume that an increase in the average price paid by one payor means that the prices of all services purchased by that payor have increased.

3. Second, how the ultimate payment to a health care provider for its services is distributed across responsible entities also depends on the contract that the patient's insurance plan has negotiated with that patient's employer or with the patient directly (in the case of a patient who purchases his insurance through the individual market). Because the payment for a single patient encounter can be divided among various entities, an increase in the total contract price paid to the provider does not imply that every involved payor (e.g., individuals, self-funded employer groups, or Managed Care Organizations ("MCOs")) experiences a payment increase.

4. Determining which entity pays what part of the total amount is usually the result of a series of complex and non-uniform contracts between multiple tiers or levels of these entities. A change in the terms of one of these contracts, such as a change in the contract prices between a provider and a specific health plan, will not have a common or predictable effect on the many entities who may share in the payment for a hospital or outpatient visit by a patient whose visit is priced according to a contract between the provider and that health plan. Similarly, a change in a provider's list of gross charges, or "chargemaster," will not have a common or predictable effect on the many entities who may share in the payment for a particular hospital service that is priced according to that chargemaster.[67] Moreover, due to

[66] In addition, as described in more detail below, other features that further complicate ultimate payments to providers and the distribution of those payments among responsible entities, including carve-outs, maximums and stop-loss provisions, are not uncommon.

[67] The chargemaster contains the "standard" prices charged by a hospital, when there is no applicable contract (such as with an MCO), government fee schedule (such as for Medicare), and when there is no discount (such as in the case of financial need discounts). The chargemaster can be thought of as the "list prices" for the hospital's services.

the way in which hospital charges for health care services are allocated among all the responsible parties, it is often the case that an increase in a hospital charge will have *no* impact on some of the entities that share in paying that charge.

5. This review is intended to describe these various contracts and relationships that contribute to both the determination of payments for health care services and the distribution of those payments among various entities. It also explains why one cannot assume that all entities that pay some part of those payments would be impacted by provider price increases or that the impact of those price increases on these entities can be determined by a common or formulaic approach. In Section II, I describe the most common types of payors of health care services. In Section III, I describe the contracts between health plan payors and health care providers and outline the various types of payment methodologies. In Section IV, I describe the features of contracts for health insurance financing, typically between payors and employers (or self-funded employer groups), that affect payments for health care services. In section V, I describe how these various contracts affect the distribution of payment sources to health care providers and explain how changes in hospital chargemaster prices do not necessarily impact all entities equally. Finally, I conclude that, because the cost of health care services is typically shared among many entities, and because many of these entities are in the proposed class, there is an inherent conflict of interest among the class members.

II. TYPES OF PAYORS OF HEALTH CARE SERVICES

6. There are numerous entities that typically pay for health care services in the U.S. The most common payors include: commercial insurance firms (providing both group and individual plans), self-funded employer groups (who typically contract through a managed care company acting as a third party administrator ("TPA"), but may contract directly), government programs (such as Medicare, Medicaid, and many other programs), and individuals. Below, I describe these types of payors and the general way in which they incur health care charges.

A common form of hospital pricing involves discounts off the chargemaster. (Kongstvedt, Peter R., Ed., *Essentials of Managed Health Care, Fifth Edition*, Sudbury: Jones and Bartlett Publishers, 2007, pp. 141-142, 145-148, 793.

A. Commercial Insurers

7. Commercial (or "private") health insurance typically includes group coverage through an employer or other entity, such as a union, that covers all individuals in the group, individual insurance coverage, and Federal Employee Health Benefit plans. Commercial health plans offer both plans that are insured by the health insurer and self-insured plans in which the customer group, typically an employer, union, or pool of small employers, is responsible for the payment of medical claims and for which the health plan provides administrative services only. Employer-based insurance covers more than 60% of the non-elderly population.[68]

8. Commercial health insurance also encompasses multiple benefit designs, including traditional indemnity (or "fee-for-service") plans as well as various managed care plan designs such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and Point-of-Service Plans (POS). The various managed care plans differ in plan benefits and network structure. In traditional indemnity plans, the insurer typically pays the full provider charges or a percentage of those charges while the patient pays the residual. In an attempt to contain health care costs, MCOs establish provider "networks" that typically include an array of provider types, such as primary care physicians, specialists, hospitals, diagnostic services, therapeutic services, pharmaceutical benefits, and non-physician health care providers.[69] They negotiate contracts with providers in which the discounts that providers are willing to give to the managed care plan generally vary with the size of the network as well as the number of lives that the plan covers. Smaller provider networks, historically characteristic of HMO plans, are designed to steer more patients to the in-network providers, who, consequently, are more willing to provide higher discounts in exchange for the higher volume of patients.[70] This, in turn, lowers the costs to the insurer and customers. Plans with broader networks, more typical of PPOs, usually receive smaller discounts from these providers, but their members benefit from their broader choice of health care providers. However, the terms of contracting and the functions of these MCOs have

[68] http://facts kff.org/chart.aspx?ch=889.

[69] Kongstvedt, Peter R., *Managed Care: What It Is and How It Works, Third Edition,* Sudbury: Jones and Bartlett Publishers, 2009, p. 56.

[70] Cleverley, William O., and Andrew E. Cameron, *Essentials of Health Care Finance, Sixth Edition,* Sudbury: Jones and Bartlett Publishers, 2007, pp.127-128.

evolved over time. There has been a blurring in the distinction of managed care plan designs, especially as plans adopt a combination of strategies or blend types of MCOs.[71]

9. Because MCOs negotiate individual contracts with providers, provider rates for the same service can vary widely depending on which MCO contract applies.[72] Further, MCOs commonly have multiple plan designs, and, thus, even for a single MCO, provider rates may vary by the specific plan in which a patient is enrolled. Thus, a single health care provider may receive different payments for the exact same service it provides, simply because of the different contracts that are negotiated, both across MCOs and across plans within the same MCO.

10. Additionally, as discussed in more detail below, an MCO and a provider contract may employ a wide variety of price structures, and often contracts employ more than one reimbursement system. The resulting contract – both the price structure and the specific prices – is the result of a bilateral negotiation between the MCO and the provider. In these negotiations, the MCO and the provider bargain over multiple dimensions and trade off price and non-price terms. For example, an MCO may agree to pay higher prices for some services in return for lower prices on other services. Because of such trade-offs, one cannot simply look at the price for an individual service when determining if the contract has changed in favor of the provider or the MCO. Conversely, the average change in contracted prices between a particular payor and provider does not indicate anything about the change in the price of a particular service, given variation across service price changes.

11. Another important aspect of commercial health insurance is the practice of using rental networks. Because negotiating individual contracts with a large number of health care providers can be costly and time-consuming, some MCOs choose to lease provider networks from other MCOs or commercial health insurers in lieu of creating their own networks.[73] In

[71] Hurley, Robert E., Bradley C. Strunk, and Justin S. White, "The Puzzling Popularity of the PPO," Health Affairs 23, March/April 2004, pp. 56-68.

[72] In this instance, BCBSI Redacted has stated that the prices it paid ENH have always been reasonable and have never been anticompetitive. Thus, whether prices are fair or anticompetitive is a determination that must be made for each MCO, and for each contract between the provider and the MCO. Over the class period, there have been at least R MCOs who have had contracts with ENH. These MCOs have had at least R contracts with ENH over the class period.

[73] Kongstvedt, Peter R., Ed., *Essentials of Managed Health Care, Fifth Edition*, Sudbury: Jones and Bartlett Publishers, 2007, p. 25.

some cases the lessee rents not only the network and associated contract terms but also the administrative services such as claims processing from the lessor. Indeed, some of the large commercial payors, such as Private Healthcare Systems ("PHCS"), are simply entities that contract networks, lease these networks to MCOs and self-funded employers, and process claims for these leasing entities. While the payment to the provider may come from an entity such as PHCS, this entity does not ultimately pay for the health care service; rather, the payment comes from the lessee MCO or the self-funded employer group.

12. Groups that contract with MCOs can contract on either a fully-insured or self-insured basis. In the former arrangement, the employer pays the MCO a monthly premium for each enrolled employee or dependent, which covers the medical expenses, administrative costs and the insurance risk associated with the uncertainty of the level of actual medical expenditures the group will incur in a particular time period.[74] This premium amount is fixed for the term of the contract (typically one year) and is therefore invariant to changes in provider rates. In establishing a fully-insured plan, an employer group also determines how it wants its employees to fund their health insurance, by structuring the plan to include such factors as deductibles, co-pays, and out-of-pocket maximums. The MCO pays the provider the entire contracted amount for the health care service, except for amounts paid by the patient through deductibles, co-payments, co-insurance, and payment for non-covered services.

13. Under a self-funded plan, the employer or other group is responsible for all health care expenses incurred by its covered employees, and thus bears the insurance risk for its medical costs.[75] Self- funded employer plans typically employ a Third Party Administrator ("TPA") to administer the plan. In this arrangement, while the employer group bears the risk of paying the medical expenses, it is not responsible for negotiating rates with providers; rather, that is done by the MCO or TPA that creates the network used by the employer group in its self-funded plan. The TPA will adjudicate the provider claims and directly pay the provider for valid claims. Thus, while direct payment to the provider comes from the TPA and not the

[74] Kongstvedt, Peter R., *Managed Care: What It Is and How It Works, Third Edition*, Sudbury: Jones and Bartlett Publishers, 2009, pp. 21-22.

[75] Kongstvedt, Peter R., Ed., *Essentials of Managed Health Care, Fifth Edition*, Sudbury: Jones and Bartlett Publishers, 2007, p. 819.

self-funded employer, the TPA then passes the bill on to the employer or other group who ultimately bears the cost of the health care service.

14. The TPA typically also charges the self-funded group an administrative fee for its services. These administrative fees may be based on the number of participants or a percentage of savings from the discounts that the TPA has negotiated. The fee structure may also comprise of a combination of fee options.

15. While self-funded plans are responsible for paying all the provider charges, many self-funded plans have supplemental "stop-loss" insurance that caps the possible total payments owed in a period, in order to insure against catastrophically high medical expenses. Self-funded plans typically have both aggregate and individual stop loss coverage.[76] Aggregate coverage limits the plan's total costs for the period. For instance, if a plan has a $10 million aggregate stop loss coverage, when total plan expenses exceed $10 million, all additional expenses are paid under the stop loss policy provisions. Individual stop loss coverage limits the plan's total cost for any enrolled individual. For instance, if a plan has a $1 million individual stop loss coverage, when total plan expenses exceed $1 million for any individual in the plan, all additional expenses for that individual are paid under the stop loss policy. It is more common for a self-funded plan to hit the individual stop loss threshold for at least one individual in any year than it is for a plan to hit the aggregate stop loss threshold in that year.[77]

16. The Painters' Fund is an example of a self-funded organization that contracts with an MCO acting as a TPA (BCBSI) Redacted [redacted].[78]

17. Though less common, employers can contract directly with health care providers to provide care for their employees. For example, Redacted [redacted]

[76] http://www.physicianscare.com/content/public/default.aspx?id=330, accessed on June 4, 2009.

[77] Interviews with health care plan broker/consultant Michael Curtin of Wayne Gallagher.

[78] Redacted [redacted]

[redacted]

B. Government Programs

18. There are many government sponsored health care payment programs. These include Medicare, Medicaid, Tricare, VA, and other programs sponsored by state or local municipalities, such as State Children's Health Insurance Program ("SCHIP"). While the rates for some of these programs are set by the government authority administering the particular program, some programs contract with private MCOs to offer managed care versions of their products, using their provider networks and associated negotiated payment rates. While Plaintiffs exclude traditional government entities from the class definition[80], the proposed class appears to include the managed Medicare products. Moreover, even some patients covered by traditional government programs may have secondary coverage with a private payor. In this situation, aggregate payments to providers may be covered by

[79] Redacted [redacted]

[80] Complaint, p. 5.

government payor program fee schedules, but other more complex arrangements among the payors may also prevail.

1. Medicare

19. The largest government-sponsored health care program is Medicare, which is also typically the single largest payor for hospital services.[81] Medicare is the national health insurance program for people age 65 or older, those with certain disabilities, or with End-Stage Renal Disease ("ESRD").[82] As described in more detail below, individuals eligible for Medicare may choose from a traditional Medicare Fee-for-Service ("FFS") program or a managed care Medicare program (Medicare Advantage or "MA") through a commercial MCO.[83] In the traditional FFS program, Medicare sets the rates paid to providers. In a managed care Medicare plan, Medicare pays a fixed amount per member to the commercial plan and the plan negotiates the rates it pays to providers. These rates may or may not be based on the Medicare FFS rates. To the extent that an MA plan's rates are based on Medicare FFS rates, changes in a provider's chargemaster prices would not affect the rates paid by that MA plan. However, if the rates that the MA plan negotiates with a provider are like its other commercial payment rates, then changes in those prices would affect the amount that the plan pays to that provider.

20. Since traditional Medicare does not cover all health care services, Medicare participants who want full health care coverage must also enroll in a supplement policy of some sort, such as an employer health plan (if they are still working or have medical benefits into retirement) or a Medicare supplement policy ("Medigap").[84] Medicare supplement policies, which are sold by private health insurers such as commercial MCOs, provide coverage for some of the "gaps" that basic Medicare excludes, including deductibles, coverage of skilled nursing co-insurance, coverage of skilled nursing care, foreign travel emergency coverage, preventive

---

[81] National Health Expenditures, Table 7, Hospital Care Expenditures Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2007, available at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf, accessed on June 4, 2009.

See also, http://www hhs.gov/asl/testify/t990422a.html, accessed on June 4, 2009.

[82] The Henry J. Kaiser Family Foundation, "Medicare: A Primer," 2009, ("Medicare Primer"), p. 1, available at http://www kff.org/medicare/upload/7615-02.pdf, accessed on June 4, 2009.

[83] *Ibid*.

[84] To be eligible for a Medicare supplement policy, a participant must be enrolled in both Medicare Parts A and B.

care, or a combination of these and other benefits.[85] Medicare also offers supplemental prescription drug plans ("PDPs") for which enrollees pay a monthly premium.

21. Alternatively, as noted above, in lieu of traditional Medicare FFS program, Medicare beneficiaries can choose to obtain their full health plan coverage through a Medicare MCO, known as an MA plan (formerly called Medicare + Choice).[86] MA Plans must be approved by the Medicare program, but they are managed by commercial insurance companies. These plans may charge co-payments, co-insurance, or deductibles, depending on the specific terms of each plan. They negotiate rates with providers for the health care services that MA enrollees consume.

22. Finally, there are other Medicare programs that do not fall under any previously discussed category, including the Program of All Inclusive Care for the Elderly ("PACE"), Medicare Cost Plans, and Demonstration or Pilot Programs. The extent and cost of coverage for these plans vary.

2. Medicaid

23. Medicaid is a federal entitlement program that provides health insurance to individuals and families that meet eligibility requirements. Medicaid covers low-income individuals and families as well as the disabled and low-income elderly persons, and is a major health insurer of children through SCHIP. Each state designs and runs its own programs according to federal guidelines, and these programs are financed jointly by states and the federal government. Medicaid typically covers a broader range of health services than many private insurers or Medicare, including long-term care, dental, vision and mental health care services.[87] Medicaid benefits vary widely by state, with each state offering different optional

[85] In Illinois, 12 Medicare supplement policies are available. The plans are categorized based on the benefits included (labeled Plans A through L). All plans that fall within a single letter category offer the same coverage and may be offered by more than one commercial MCO at varying rates. "2008 Medicare Supplement Premium Comparison Guide" for the State of Illinois (http://www.idfpr.com/DOI/medsup/MedSupFull2008.pdf, pp. 6-7, accessed on June 4, 2009).

[86] http://www medpac.gov/publications/congressional_reports/Jun04DataBookSec12.pdf, p.188, accessed on June 4, 2009.

[87] Medicaid Primer, p. 10.

services and placing its own limits on duration and scope of coverage. States may charge premiums and require cost-sharing by enrollees, subject to federal limitations.[88]

24. As with Medicare, many state Medicaid programs offer traditional Medicaid Fee-for-Service programs as well as managed care Medicaid plans. However, nearly two-thirds of all Medicaid beneficiaries are enrolled in a managed care Medicaid plan. If states offer a choice of at least two plans, they can mandate enrollment in a managed care plan.[89]

25. In Illinois, the majority of hospital payments for Medicaid beneficiaries are reimbursed under a Diagnosis Related Group ("DRG") Prospective Payment System methodology, comparable to Medicare.[90] However, some Illinois hospitals are reimbursed according to a facility specific per-diem payment. Additionally, hospitals can qualify for a number of other payment programs that provide additional payment adjustments, including, among others, quarterly payment adjustments for hospitals that serve high volumes of Medicaid patients (a program that was created in 2002 to restore some funding to Illinois hospitals that were negatively impacted by Medicaid funding reductions), payment adjustments for hospitals providing tertiary care, additional payments to rural hospitals that are considered critical to the provision of health care in Illinois, adjustments for psychiatric care, additional outpatient funding for high-volume Medicaid providers, and additional per diem payments for hospitals that have Medicaid inpatient utilization rates above a certain threshold.[91]

26. How Medicaid beneficiaries would be impacted by changes in provider rate depends on the program in which they are enrolled and their level of income. Healthcare and Family Services in Illinois offers numerous medical programs to children, adults and the disabled, including All Kids, FamilyCare, and Moms & Babies, among others.[92] The amount that beneficiaries pay varies by program and family income. For example, in the All Kids program, which offers comprehensive health care to all uninsured children in Illinois regardless of family income, premiums and out-of-pocket costs vary by family income. A family of four with income up to $2,444 per month pays no monthly premium per child and

[88] For example, while premiums are permissible for most children, cost-sharing is prohibited for preventive care for children, regardless of income. (Medicaid Primer, p.12.)

[89] Medicaid Primer, p.13.

[90] http://www hfs.illinois.gov/annualreport/reimbursing_hospital.html.

[91] http://www hfs.illinois.gov/annualreport/reimbursing_hospital.html.

[92] http://www hfs.illinois.gov/annualreport/, accessed on June 4, 2009.

no co-payments for medicals visits, whereas a family of four with monthly income between $3,676 and $5,513 pays a monthly premium of $40 per child (with a maximum of $80 for two or more children), pays co-pays for doctor visits, ER visits, hospital admissions, and prescription drugs (with maximum co-pays of $500 per child for hospital services) as well as co-insurance of 5 percent for outpatient services.[93] In the FamilyCare program, a family of four earning less than $2,350 per month pays no monthly premiums, no co-pays for generic drugs and emergency room visits, and minimal co-pays for medical visits, inpatient hospitalizations and brand drugs, while a family of four earning up to $7,067 per month pays monthly premiums of $140 per adult and the same cost-sharing fees as the family of four with lower income.[94]

C. Individual Coverage

27. Individuals who do not have employer-sponsored insurance, such as the self-employed, and who do not qualify for some type of government-sponsored insurance may contract directly with an MCO to obtain coverage in a specially designed and regulated individual product. Individuals purchasing health care insurance through an MCO must pay the entire premium as well as any other fees (co-payments, co-insurance, deductibles, and services not covered by the policy) specified by the plan when they seek health care services.

28. Individuals with no insurance coverage (either government-sponsored or commercial) must pay for care "out-of-pocket." These individuals may pay for care from their general funds (i.e., cash) or from a designated health care account such as a Health Savings Account (HSA) or Healthcare Spending Account, or they may not pay anything if they qualify for charity care. Depending on how these individuals pay for medical expenses, the increase in the cost of a particular medical service may or may not increase the individual's actual spending on health care services.

29. Created as part of the Medicare Modernization Act in 2003, HSAs are medical savings accounts available to taxpayers funded by pre-tax income. Qualified medical expenses may

[93] http://www.allkids.com/income html and http://www.allkidscovered.com/pocket.html, accessed on June 5, 2009.

[94] http://www familycareillinois.com/income.html and http://www.familycareillinois.com/cost html, accessed on June 5, 2009.

be paid for through an HSA, which account holders elect to fund each year. Funds in HSAs for people enrolled in a High Deductible Health Plan ("HDHP") roll over from year to year.[95]

30. Similar to Health Savings Accounts, Healthcare Spending Accounts are flexible spending accounts funded by pre-tax income. Funds may be used only on qualified expenses, which include co-payments for office visits and prescription drugs, deductibles, and other eligible health-related expenses. Unlike Health Savings Accounts, Healthcare Spending Accounts must be used by the end of the "Plan Year" or any remaining funds are forfeited.[96] Thus, if a patient "over-funds" his/her Healthcare Spending Account, an increase in the cost of a particular medical service has no impact on the patient's total health care costs for the year (since the funds would be lost at year-end regardless).

31. Other savings accounts designated for funding health care also exist. For instance, Health Reimbursement Accounts, which are accounts funded by employers, are somewhat similar to insurance companies. Employees are reimbursed from funds allocated to their Health Reimbursement Account by their employer. The funds are treated like employer-funded insurance and are therefore tax advantaged. Funds can roll over from year to year, but do not follow an employee that leaves the company.[97] In this case, as with a Healthcare Spending Account, an increase in the cost of medical care would affect a patient only if their Health Reimbursement Account would be exhausted, regardless.

32. Many hospitals have charity care policies for which uninsured patients may qualify. The amount an uninsured patient pays for medical care may vary based on her income and the policies of the hospital or physician providing the care. For example, the chargemaster charges may be discounted up front under the hospital's charity care or discount policy, where the terms of the discount vary based on individual income. Or, the hospital may also charge a reduced rate that matches the price negotiated in contracts with MCOs. Some charity care programs may also require co-payments.

[95] See U.S. Department of Treasury website at http://www.ustreas.gov/offices/public-affairs/hsa/, accessed on June 5, 2009.

[96] See Bureau of Labor Services website at http://www.bls.gov/opub/cwc/cm20031022ar01p1.htm, accessed on June 4, 2009.

[97] Ibid.

33. ENH has a formal Charity Policy. The policy outlines the eligibility guidelines that govern financial assistance to patients, based on federal poverty levels. Patients ineligible for assistance from a public aid program are evaluated based on income and asset level, family size, and patient account history. Asset spend down, out-of-pocket caps on expenses, free or discounted care (based on a sliding scale discount), or installment payment plans may be determined appropriate. Emergency care is provided by ENH, regardless of a patient's financial situation.[98]

34. Consequently, charges to an uninsured patient for health care services will vary depending on whether the patient qualifies for charity care and how the patient funds his health care. Depending on how patients fund their health care, as well as how a hospital sets fees for uninsured patients, a change in average prices for health care services does not impact uninsured patients uniformly. Further, physicians may or may not participate in hospital discounting plans, depending on the terms of their affiliation with the hospital (physician charges are typically billed separate from hospital charges).[99] Thus, the amount that patients pay will vary with the specific provider.

III. CONTRACTS FOR THE PROVISION OF HEALTH CARE SERVICES BETWEEN PAYORS AND HOSPITALS

35. Determining the payment to a hospital for an inpatient or outpatient service depends in large part on the contract negotiated between the provider and the payor. Such contracts establish the rates and payment methodologies that are used to determine the payment amount when a patient with that payor's coverage receives health care services from the provider. Because of variation across contracts, payments to a given provider for the same health care service may vary across patients.[100]

---

[98] See Evanston Northwestern Healthcare Charity Care and Financial Assistance Evaluation and Eligibility, Administrative Directives Manual AD05-1032, effective October 1, 2007. Patients with income levels below 200% of the federal poverty level (FPL) are eligible for free care. Patients with income levels up to 600% of the FPL are eligible for sliding scale discount on care. Attachment A of the guidelines gives the Sliding Scale Discount Table as well as the 2008 HHS Poverty Guidelines.

[99] See description of Intermountain Health Care charity care program at http://deseretnews.com/article/1,5143,595084065,00 html, accessed on June 4, 2009.

[100] As noted later, even for patients with the same insurance, it is possible that ultimate payments for the same service can differ depending on other factors, such as whether that patient has more than one type of insurance and whether they have met certain criteria, such as annual deductibles and out-of-pocket maximums.

36. Contracting between health care providers and payors is complex. Numerous payment methodologies are used to determine payment rates to providers, and a single payor contract typically employs multiple payment methodologies as well as multiple payment rates for each employed methodology. As a result, when some contract rates (or prices) change, the rates for other services may remain the same or change by a different amount. Thus, one cannot presume that an increase in average prices paid by a payor implies that the prices of all services purchased by that payor have increased. Similarly, because payors use different methodologies to determine their contracted provider rates, one cannot presume that an increase in the contract price paid by one MCO for a service results in an increase in the payments of other MCOs.

A. Inpatient Care

37. The pricing of inpatient hospital visits can be based on several different methodologies, including per diem rates, case rates, percent of charges, capitation, and performance outcomes. It is frequently the case that a single payor may employ some or all of these methodologies in a given contract.

1. Per Diem

38. Per diem rates are payments based on a fix dollar amount per day, and, thus, the total payment for a patient visit would depend on a patient's length of stay. A contract can specify one per diem rate for any patient visit or, more commonly, it specifies different per diem rates for different service types, such as medical, surgical, obstetric, nursery, and intensive care unit ("ICU").[101] Further, per diem rates can include all services, supplies and equipment related to the patient visit or they can exclude more costly supplies and equipment that are charged separately (on a cost basis for example).

2. Case Rates

39. Case rates are payments of a fixed dollar amount for an entire patient stay (case), the amount of which is determined by the reason for the patient stay, typically specified by DRGs. The DRG system was developed through support of the Centers for Medicare and Medicaid

[101] Kongstvedt, Peter R., Ed., *Essentials of Managed Health Care, Fifth Edition,* Sudbury: Jones and Bartlett Publishers, 2007, pp. 147-148.

Services ("CMS") as a way to classify hospital stays that are similar and, therefore, would be expected to use similar hospital resources. As part of its prospective payment system, Medicare imposed a DRG-based payment system for all hospitals in 1983.[102] In 2007, CMS restructured the DRG system to account for the severity of a patient's condition. CMS replaced the 538 DRGs with approximately 745 Medicare severity DRGs (MS-DRGs).[103] MS-DRG payment rates are comprised of two pieces: relative value scale that indicates the relative cost to provide different services, with weights that currently range from 0.16 to 23.7, and a base rate, divided into a labor-related and non-labor share, that translates the relative value into a dollar charge.[104] For example, if a particular stay is classified into a DRG with a relative weight of 3 and the base rate that pertains to a particular plan at Hospital X is $6,000, then Hospital X will be paid $18,000. DRG-based payments may be adjusted for different levels of complexity and for outlier cases that have especially long or complex stays.[105]

40. In addition to the original Medicare DRGs, there are several different DRG-based systems that have been developed over time to attempt to account for the increasing complexity and variety of available hospital services and are used by many payors, including Severity-Adjusted DRGs, Refined DRGs, and All Patient Refined DRGs, among others. Software, known as a grouper, uses patient demographic and clinical information to categorize each patient stay into the appropriate DRG. Different payors and hospitals use different grouping systems. The relative weights for each system are revised periodically to take account of changes in practice patterns and technology that affect the average cost of providing different services.

41. A contract between a payor and an MCO may include a single base rate or multiple base rates, each pertaining to certain types of services. These base rates are subject to change at every contract renegotiation. Because of modifications to the relative values and the base rates over time, it is quite possible that the prices of different inpatient hospital services will

[102] http://www.cms.hhs.gov/AcuteInpatientPPS/ and http://en.wikipedia.org/wiki/Diagnosis-related_group, accessed on June 4, 2009.

[103] http://www.bkd.com/docs/industry/CMSImplementsDRGRevisions.pdf, accessed on June 4, 2009.

[104] See http://www.cms.hhs.gov/AcuteInpatientPPS/ and http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=dual,%20data&filterValue=FY09%20Final%20Notice%20Data&filterByDID=3&sortByDID=2&sortOrder=ascending&itemID=CMS1214025&intNumPerP.=10, accessed on June 4, 2009.

[105] I discuss the implication of outliers on payments in more detail below.

change at different rates. Indeed, the prices of some services can even decrease if their relative values decline substantially.

3. Percent of Charges

42. All providers maintain detailed lists of thousands of prices, or chargemaster, for all the services they provide. For example, one chargemaster item might be a certain size and brand of suture, while another might be a day in a bed in the ICU. Some payor contracts use a percent of chargemaster prices as the basis for payments to providers. The discount off charges may be a flat percentage for all services, or different discounts may apply to different types of services. Further, providers periodically change some of the prices on their chargemasters. When contracts are renegotiated, the discount rates offered to particular payors may also be altered. Additionally, contracts may include a sliding scale discount related to total volume of admissions and outpatient visits as well as additional discounts for timeliness of payments.[106]

4. Capitation

43. While less common, capitation is another possible payment methodology used in some payor contracts with providers. In a capitation payment model, a payor typically pays a fixed dollar amount per member per month for a defined set of services for all its members. Capitation may include inpatient, outpatient, and/or physician services.[107]

5. Performance Outcomes

44. Payor contracts with providers based on performance outcomes reward providers for meeting specific quality measures.[108] While pay-for-performance approaches are currently limited in use due to the dearth of performance measures and the difficulty in implementation, the methodology is gaining popularity. For example, Medicare has various pay-for-performance efforts underway including a Premier Hospital Quality Incentive Demonstration project in

[106] Kongstvedt, Peter R., Ed., *Essentials of Managed Health Care, Fifth Edition,* Sudbury: Jones and Bartlett Publishers, 2007, pp. 146-147.

[107] Kongstvedt, Peter R., Ed., *Essentials of Managed Health Care, Fifth Edition,* Sudbury: Jones and Bartlett Publishers, 2007, pp. 150-151.

[108] See Chapter 8, "Performance-Based Incentives in Managed Health Care: Pay-for-Performance," in Kongstvedt, Peter R., Ed., *Essentials of Managed Health Care, Fifth Edition,* Sudbury: Jones and Bartlett Publishers, 2007.

which 300 hospitals receive bonus payments for scoring in the top 10-20 percent of selected performance measures. After three years in the program, hospitals that do not meet certain quality threshold measures will receive reduced payments.[109] Additionally, CMS began a disincentive program in hospitals in 2008 in which they will not pay for certain negative outcomes that they deem to be events that should never happen, including certain hospital-acquired infections.[110] Certain private payors have also adopted similar measures.

45. Redacted [111]

6. Mixed-Model

46. Payor contracts with providers often combine some or all of the above payment methodologies. That is, certain services may be reimbursed under particular per diem rates while others are reimbursed according to case rates and still others as a discount off list charges. To the extent that changes in prices differ across these services, average changes in payment rates will not affect all payors uniformly.

B. Outpatient Services

47. Similar to the pricing of inpatient hospital services, payors also employ different payment methodologies for the pricing of outpatient services in their contracts with providers. The more common methodologies used for the pricing of outpatient services are percent of charges, ambulatory visit pricing, such as Ambulatory Payment Classifications ("APCs") and Ambulatory Patient Groups ("APGs"), bundled charges, and cost-based reimbursement.

[109] "Medicare 'Pay-for-Performance (P4P)' Initiatives," http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1343, accessed on June 5, 2009.
[110] "Eliminating Serious, Preventable, and Costly Medical Errors - Never Events," http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863, accessed on June 5, 2009.
[111] Redacted

1. Percent of Charges

48. Many payor contracts employ a percent of charges methodology to reimburse providers for outpatient visits by their members.[112] As with charges for inpatient visits, discounts may be set as a common amount for all services or may vary by service. Similarly, hospitals amend their chargemasters periodically, but don't uniformly change the thousands of individual line item charges that they contain. As a result, the charges for some outpatient services, but not for other outpatient services, may vary from contract to contract. As noted above, outpatient volume may be included in an additional sliding scale discount based on total annual inpatient and outpatient volume.[113]

2. Cost-Based Reimbursement

49. Payment for inpatient services shifted from a cost-based methodology beginning in the early 1980s with Medicare's move to a prospective payment system. Today, most payors, including Medicare, Medicaid and a number of Blue Cross Blue Shield plans, no longer use a cost-based reimbursement, though it is still used in some settings.[114] Cost-based reimbursement is a retrospective payment system in which payors reimburse for allowable costs, which are based on historical costs. In this type of payment system, providers are reimbursed according to what it costs to provide a service instead of what is charged for that service. Payors make interim payments as a percent of charges and then adjust payments once they have settled cost reports. While cost-based reimbursement is still used in some limited settings, most payors have abandoned this reimbursement methodology.[115]

3. Fee Schedules

50. Some payors use fee schedules to reimburse providers for outpatient visits. These fee schedules typically use Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") codes to assign fees to the many different outpatient

---

[112] Cleverley, William O., and Andrew E. Cameron, *Essentials of Health Care Finance, Sixth Edition*, Sudbury: Jones and Bartlett Publishers, 2007, p. 134.

[113] Kongstvedt, Peter R., Ed., *Essentials of Managed Health Care, Fifth Edition,* Sudbury: Jones and Bartlett Publishers, 2007, pp. 146-147.

[114] Cleverley, William O., and Andrew E. Cameron, *Essentials of Health Care Finance, Sixth Edition*, Sudbury: Jones and Bartlett Publishers, 2007, pp. 37-38.

[115] Ibid, pp. 37-38.

services. Many payors link some of their fee schedules by CPT code to Medicare's Resource-Based Relative Value Scale (RBRVS) payment system.[116]

4. Ambulatory Visits (APCs and APGs)

51. Outpatient services may also be grouped into service categories. These service categories may indicate a single payment rate for similar types of services, in which case an outpatient visit may involve multiple services, or they may reflect the entire bundle of services typically associated with a certain type of outpatient service (instead of setting separate rates for each particular service that a patient receives in a single outpatient visit), similar to DRGs on the inpatient side. APC codes are an example of the first type of outpatient classification system, as they group outpatient services that are similar both clinically and in their utilization of resources.[117] As mandated by the Balanced Budget Act of 1997, CMS created the Outpatient Prospective Payment System ("OPPS"), which was implemented in August 2000.[118] Ambulatory Payment Classifications ("APCs") are used by Medicare as part of its OPPS in order to categorize payments for outpatient hospital services.[119] They have also been adopted by some state Medicaid programs and private insurers.[120] A particular APC may define the payment rate for a set of more disaggregated procedure codes, known as HCPCS codes. A single APC may include multiple procedure codes, but a procedure code is assigned to only one APC. Further, an outpatient encounter may involve more than one APC.[121]

52. Ambulatory Patient Groups ("APGs") represent the more bundled approach. They are a visit-based payment system intended to reflect all the resources associated with an outpatient encounter in the same way as do DRGs for inpatient stays. CPT, HCPCS and ICD-9 codes

[116] Cleverley, William O., and Andrew E. Cameron, *Essentials of Health Care Finance, Sixth Edition*, Sudbury: Jones and Bartlett Publishers, 2007, p. 118.

[117] http://www.cms.hhs.gov/HospitalOutpatientPPS/, accessed on June 8, 2009.

[118] Ibid. See also, Medpac, "Outpatient Hospital Services Payment System," Revised October 2008, p. 1.

[119] Ibid.

[120] Kongstvedt, Peter R., Ed., *Essentials of Managed Health Care, Fifth Edition,* Sudbury: Jones and Bartlett Publishers, 2007, p. 157.

[121] Cleverley, William O., and Andrew E. Cameron, *Essentials of Health Care Finance, Sixth Edition*, Sudbury: Jones and Bartlett Publishers, 2007, pp. 24, 46-47.

are utilized to determine the relevant APGs for outpatient services.[122] By grouping more procedures, APGs are intended to reduce the incentive to provide additional services.

C. Other Factors Affecting Payments

1. Outlier Payments

53. Many payor contracts have outlier provisions that specify that a payor must pay on a basis other than the specified methodology if charges exceed a specific limit. Outlier payments (often called stop-loss payments in contracts with commercial MCOs) are intended to reimburse hospitals for patients that have unusually long or complex stays. Outlier payment policies are utilized by Medicare and many commercial payors for both inpatient and outpatient payment systems.[123] A hospital qualifies for an outlier payment when its charges related to caring for a patient stay (adjusted for the hospital's cost-to-charge ratio) exceed a certain threshold amount. Under Medicare, the outlier payment for an inpatient stay is calculated as 80 percent of the difference between the hospital's charges adjusted by the hospital's cost-to-charge ratio and the standard DRG payment adjusted for indirect medical education (IME) and disproportionate share payments and a threshold amount that is set annually by CMS.[124] Commercial payors often adopt similar payment provisions.[125]

54. For outpatient services, Medicare makes outlier payments to a hospital for those outpatient services for which the costs are at least 175 percent of and $1,575 more than the APC payment rate. For these cases, the outlier payment is calculated as 50 percent of the difference between the hospital's cost for that service and 1.75 times the APC payment rate.[126]

55. Outlier or stop-loss provisions in private MCO contracts can vary in form. In general, the provider is paid for the service based on the "regular" contract terms (such as a per diem or a

[122] ACS Government Healthcare Solutions, "Paying for Hospital Outpatient Services: A Guide for Medicaid Programs," March 2009, p.3.

[123] Cleverley, William O., and Andrew E. Cameron, *Essentials of Health Care Finance, Sixth Edition*, Sudbury: Jones and Bartlett Publishers, 2007, pp. 42-43, 116.

[124] http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1243p.pdf, accessed on June 4, 2009.

[125] http://www.allbusiness.com/management/483217-1 html, accessed on June 4, 2009. See also, Cleverley, William O., and Andrew E. Cameron, *Essentials of Health Care Finance, Sixth Edition*, Sudbury: Jones and Bartlett Publishers, 2007, p. 116.

[126] Medpac, "Outpatient Hospital Services Payment System," Revised October 2008, p. 3.

case rate). However, if billed charges for a patient exceed some specified threshold, the provider is paid by a discount off billed charges. Both the threshold and the subsequent discount off billed charges can vary by service within a single contract. Also, the stop-loss provision can be either "first dollar" or "second dollar." In a first dollar stop-loss, if the threshold is reached, the provider is paid the discount off billed charges for all billed charges, but not the "regular" per diem or case rate. In a second dollar stop-loss, the provider is paid the regular per diem or case rate, and the discounted charges for those billed charges that exceed the stop-loss threshold.

IV. CONTRACT FEATURES AFFECTING PAYMENTS FOR HEALTH CARE SERVICES

56. Contracts between health plans and employers, other groups, or individuals specify the varied benefit features and payment structures that affect the amounts that individual members must pay for their health insurance plans and health care services. These features include premiums, co-payments, co-insurance, annual deductibles, out-of-pocket maximums and non-covered services.

A. Premiums

57. In a fully insured plan, the fixed monthly or annual premium negotiated between the MCO and employer or other group reflects the expectation of underlying medical costs, administrative costs and a risk premium. The group may require that its members pay some portion or the entire premium. Since premium payments are a fixed amount for a specific time period (e.g., monthly or annual), they do not change with changes in a given provider's prices during the contract period. Moreover, while in the longer run, provider price increases enter into the determination of future premium levels, these premiums are set based on actuarial calculations that account for the prices of all of the large number of providers that are included in the MCO's network as well as the historic utilization patterns of the group in question.[127] Unless a group is heavily reliant on a single provider, that provider's price changes are unlikely to have a significant impact on the group's premiums.

[127] Policies for small groups (typically 2-50 members) are regulated separately and typically require "community rating" rather than "experience rating."

58. As explained earlier, a self-insured group is directly responsible for all of its medical costs as well as administrative fees to cover its TPA's services (though there may be a maximum if the group has stop-loss insurance). As such, these groups do not pay "premiums" to their MCOs. Regardless, they may still levy a premium on their members that reflects at least part of the cost of the health care services that they provide.

B. Co-payments

59. A co-payment ("co-pay") is a fixed payment that a patient must pay to a health care provider to receive a given service. A co-pay is usually a fixed dollar amount (e.g., $20) charged for each visit, although the fixed amount may depend on the type of service provided. Fixed co-pays are relatively common for physician services and pharmaceuticals, but are less common for hospital services (where deductibles and co-insurance, described below, are more prevalent). Since co-pays are a fixed dollar amount per visit, and do not vary with the price the provider charges, if a hospital were to increase its prices anti-competitively, a patient's co-pay amount would be unaffected.

60. While Plaintiffs have expressly excluded individuals with "fixed co-pays" from their class definition,[128] the complexity of the health care payment system makes it impossible to eliminate all such co-pays from the damages calculations without a careful analysis of each individual's payments. As an example, suppose an individual has a secondary insurance policy (perhaps through a spouse) that covers certain expenditures that his/her primary policy does not cover, such as fixed co-pays. In that case, since the secondary insurer makes a payment to the hospital, it is in the class, and that payment is part of the revenue base on which damages are calculated even though the payment is fixed, and not subject to any exercise of market power by ENH.

C. Co-insurance

61. Co-insurance is a payment that a patient pays to a health care provider for a given service. Co-insurance is generally a percentage of the provider's "allowed" charges and is most

[128] United States District Court for the Northern District of Illinois Eastern Division, In re: Evanston Northwestern Healthcare Corporation Antitrust Litigation, Master File No. 07 C 4446, *Plaintiffs' Memorandum of Law in Support of their Motion for Class Certification*, February, 13, 2009, p. 12.

commonly charged for inpatient hospital services.[129] The percentage varies across MCO plans, and may also vary among providers for the same patient in the case of tiered networks, or across groups covered by the same MCO, as different groups decide to impose different cost-sharing requirements on their members. In contrast to co-pays and deductibles, increases in the ENH chargemaster prices or in contract prices between ENH and MCOs will typically affect the size of the co-insurance payment by the patient. However, this is not always the case, since co-insurance amounts may be subject to an annual cap that applies either to the individual member or to the member's family. Also, as with co-payments and deductibles, if the patient has some form of supplemental or wrap-around insurance coverage, the patient may be reimbursed for the co-insurance payments, even though the patient initially pays this to the provider or the MCO. In addition, the amount of the price increase borne by patients who have a co-insurance payment will differ, since co-insurance percentages differ among MCOs, among enrollees in the same MCO, and for an individual enrollee in the case of tiered networks.

62. Redacted

D. Annual Deductibles

63. A deductible is a fixed amount per year which the patient or his/her family is responsible to pay prior to the insurance coverage taking effect. For instance, if a person is in a plan with a $1,000 annual deductible, that person is responsible for paying his health care costs in that

[129] Allowed charges are the charges agreed to by the provider and the MCO, rather than the providers' chargemaster charges.

[130] Redacted

[131] Redacted

year up to $1,000 (where the amount is cumulated over all eligible provider encounters). Some plans may exclude certain services from the deductible, such as well child visits, in which case the member doesn't pay the provider for the service even if the annual deductible has not been met.[132] However, the deductible is typically not paid to the provider at the time of service but is paid by the patient to the provider or MCO at a later point. After the deductible amount is met, the patient is only responsible for other payments that may apply according to his plan, such as co-pays, co-insurance or non-covered services, and the insurer covers the remainder of the costs.

64. If a patient or family meets their deductible for the year, changes in the ENH chargemaster prices or ENH contracts with managed care payors may not affect the total amount paid by the patient for health care deductibles in that year, even if the patient made a deductible payment to ENH. As an example, imagine an individual with a $1,000 annual deductible, who visits ENH in January. ENH charges $500 for the service, while the competitive price for the service is $450. Since it is early in the year, and the patient has not met his deductible limit, the patient pays the entire $500, including the entire $50 anticompetitive price increase. However, assume the patient ultimately receives total services (from any provider) that are cumulatively priced at $1,500 (at competitive prices). In this case, the $50 anticompetitive price increase by ENH has no impact on the patient's deductible payments. With or without the $50 price increase, his total out-of-pocket costs for deductibles would be $1,000. If the patient's remaining cost-sharing obligations consist of fixed co-pays, he is totally unaffected by the anticompetitive behavior, and the price increase is borne by the MCO (or perhaps the self-funded employer plan). Of course, if costs for the patient's cumulative yearly health care do not exceed $1,000, then the patient does pay the price increase. The patient might also pay only a portion of the anticompetitive price increase. For example, if costs for the patient's cumulative yearly health care expenses are $1,040, then the patient will pay $10 of the $50 price increase, and the MCO will pay the remainder.[133] However, if the patient has

[132] Redac

[133] Absent the $50 price increase, the patient's total health care costs would have been $990. Because of the $50 price increase, the patient has to pay the full $1,000 deductible – an increase of $10.

some type of supplemental or wrap-around insurance coverage, the patient may be reimbursed for the deductible payments, even though the patient initially pays this to the provider or the MCO.

65. Determination of whether an individual paid more in deductible payments because of an ENH price increase requires investigation of that individuals' contract with the MCO and investigation of the patient's total health care payments to all providers (not just ENH) for that year. If the deductible is cumulative over all family members, then the investigation requires information on the family's total health care payments from all providers (not just ENH) for that year. This may include health care payments by non-class members, since it is unlikely that all family members would have received health care from ENH (and thus be in the class). Further, an individual may be responsible for full payment of a service at ENH in one year in which the annual deductible has not been met but not be responsible for the same service at ENH in a different year if the deductible has been met prior to that service. Thus, individuals may go in and out of the class based on their deductibles.

E. Out-of-Pocket Maximums

66. Although members typically share in some portion of the cost of medical care, usually in the form of a co-payment, deductible, or co-insurance, contracts often specify a maximum annual amount that the member may be required to pay for covered expenses. Out-of-pocket maximums are essentially the opposite of deductibles. Whereas deductibles are the minimum amount that a patient must pay before her insurance takes effect, out-of-pocket maximums are the maximum amount that she must pay in a given year, after which the health insurer pays for all covered services in full. The maximum can apply either to the individual or to the family, and there may be maximums for both. The maximums may not apply to all services, however.[134] Such policies limit the financial liability of medical care for enrollees of a health plan. Enrollees who reach their out-of-pocket maximum would therefore be unaffected by any increase in prices related to charges for services obtained from ENH.[135]

[134] Redacted

[135] Redacted

F. Non-Covered Services

67. Contracts between MCOs and enrollees may exclude certain services from coverage.[136] If a patient receives a non-covered service, the patient is likely responsible for the entire cost of the service if she has no secondary coverage and does not qualify for charity care. Non-covered services vary with each MCO contract with an employer or individual. Therefore, even for all patients at ENH from a single provider, the list of non-covered services may vary across patients.

68. Services may also be considered non-covered because a particular provider is out-of-network. As described above, some MCO plans require their enrollees to obtain service from in-network providers. If the patient seeks an otherwise covered service from an out-of-network provider, the patient is responsible for the entire charged amount. Thus, an increase in ENH prices for a particular service may be paid for partially or completely by the MCO if the service is covered, and may be paid for partially or completely by the patient if the service is not covered. Again, if the patient has some form of supplemental or wrap-around insurance coverage, the patient may be reimbursed for the non-covered service payments by the supplemental insurer, even though the patient initially pays this to the provider.

V. DISTRIBUTION OF PAYMENTS FOR HEALTH CARE SERVICES

69. When a person seeks health care services, one party may be responsible for paying the entire cost of that service, or a number of parties may contribute to the payment for the health care services provided to the patient. Furthermore, the amount charged may vary, depending on which party is paying and the structure of the contract agreement between the responsible payor(s) and the provider. The division of charges is complex and depends on numerous factors, including a series of contracts unique to each contracting party.

Redacted

[136] Redacted

A. Single Payor

70. Whether or not a patient has some form of health insurance, a single payor may be responsible for the entire payment to a provider for health care services provided to a patient. A patient may pay the entire amount charged if he is uninsured or if he has insurance but has not met his annual deductible or goes out of network in a plan that requires members to seek care from in-network providers. A government-funded program, such as a managed Medicaid plan or a Medicare Advantage plan, may pay the entire bill if the patient qualifies for and participates in the program. Or a commercial insurer may pay for the full amount charged if a patient has already paid his annual deductible and it's a fully-covered service not subject to co-insurance or a co-payment or a patient has reached his out-of-pocket maximum for the year and the service is covered by the health plan.

71. In the event of a single payor, the payment amount and who pays it depends on both that payor's contract with the provider and the payor's contract with the insured's employer or other covering group, or on the provider's charity care policy in the event of an uninsured patient. As noted above, a person without commercial or government insurance may pay for health care either outright or with funds in a Health Savings Account or Healthcare Spending Account. The exact amount charged varies based on hospital charity care policy and the patient's income. Discounting may be available and applied using a range of methods.

B. Multi-Payor

72. A situation in which there is more than one person or entity contributing to the payment for a health care service is referred to as "cost sharing." Cost sharing may occur between an individual and a commercial insurer or government-sponsored program, between multiple commercial MCOs, between commercial MCOs and employers, or between commercial MCOs and various government programs.

1. Cost-Sharing between Individuals and Commercial Payors, Employers, or Government-Sponsored Plans

73. As described above, even when a patient has some form of health insurance, whether commercial or government-sponsored, the patient typically pays for some portion of the costs of his health care services, either through deductibles, co-payments, co-insurance, payment

for non-covered services, or a combination of these items, while the insurance plan or employer pays the rest.

74. The amount a patient pays, and whether this amount increases as the provider prices increase, depends on the form of the cost sharing provisions between that patient and his MCO (or government payor). Further, the amount the MCO pays depends on its contract with the provider, the cost sharing provisions specified in its health plan contract with the patient directly or with the patient's employer group, other factors noted above, such as whether the patient has met his annual deductible or out-of-pocket maximum, and whether there is more than one non-individual payor, such as two commercial plans or a commercial plan and a government-sponsored plan.

2. Cost-Sharing between Commercial Payors

75. Patients covered by commercial insurance may be covered by multiple insurance plans. A common situation where MCOs share in payment occurs with the purchase of wrap-around or supplemental insurance which covers some of the gaps in the primary insurance. Additionally, a dependent may have health insurance coverage through both of her parents' employers, a spouse may be covered by his own health plan and his wife's employer-sponsored health plan, or an individual may have two jobs that both provide health insurance. In these examples, the cost of the member's health care services is shared between the two commercial payors. The specific terms of MCO-provider contracts govern the coverage provided to such a person, often outlining the responsibilities of a primary and secondary insurer. The amount a provider receives for a service will depend on the negotiated rates by both payors with this provider and the terms of both of these payor contracts with the provider.[137]

76. The distribution of payments when a patient is covered by two commercial MCOs is complex and specific to the circumstances of the individual patient. In instances where a patient visit is covered by two MCOs, one MCO is designated as the "primary" payor and the other is designated as the "secondary" payor.[138] Once the designation of the primary and secondary

[137] http://www.idfpr.com/DOI/HealthInsurance/coord_benefits.pdf, accessed on June 5, 2009.

[138] If the multiple coverage is because the patient is a child and both parents are covered by separate MCOs, in Illinois the designation of primary and secondary payors is based on the so-called "birthday rule." Clearly this issue

payors is made, the payments made to the providers are governed by an additional set of rules. In general, the primary payor adjudicates the claim as it would a claim when it is the only MCO. Usually this involves the MCO paying the contracted amount to the provider, minus the patient portion of the charge (which could be in the form of a co-pay, co-insurance, deductible, non-covered service, etc.). The contracted amount is specific to that MCO and its contract with the provider, and the patient portion is specific to the arrangements between the MCO and the employer and employee/patient.[139] The patient portion may also depend on the previous experience of the patient or the patient's family (since, for instance, deductible payments can vary based on previous deductible payments).

77. When the patient is covered by two MCOs, however, the patient does not pay the patient portion specified by the contract with the first MCO. Rather, this amount is now paid by the secondary payor.[140] Thus, in this instance, the individual is not impacted at all by an increase in the payment terms between the primary MCO and ENH (even though other patients, covered by that same MCO plan at the same employer, may be impacted). Whether the secondary payor is impacted by a change in the ENH contract prices also depends on multiple factors. First, the contract between ENH and the primary payor determines whether the secondary payor is impacted. Thus, for some payments made by UnitedHealthcare, the impact issue is addressed by looking to charges in the Blue Cross contract. Second, in these cases the secondary payor pays based on the cost sharing provision between the primary payor and the individual. If this cost sharing is a fixed co-pay, there would be no impact on the secondary payor, even if ENH anti-competitively increased contract prices with the primary payor. Moreover, the secondary payor may not pay the entire patient portion on the claim, and indeed may pay none. Illinois state law dictates that the provider cannot be paid more in total than it would be if the secondary payor were the primary payor.[141] Thus, if the

---

is not common to all class members. The primary MCO is the MCO that covers the parent whose birthday falls chronologically first in the year. If the multiple coverage is because the patient is an adult with two jobs (and two MCO health care plans), in Illinois the MCO plan for the job at which the adult works the most hours is designated the primary payor. Again, this issue is not common to all class members. If the multiple health coverage is because the patient is an adult whose spouse also has health care coverage through a different MCO, the patient's own employer MCO plan is the primary payor and the spouse's MCO plan is the secondary payor. (http://www.idfpr.com/DOI/HealthInsurance/coord_benefits.pdf, accessed on June 5, 2009.)

[139] http://www.idfpr.com/DOI/HealthInsurance/coord_benefits.pdf, accessed on June 5, 2009.

[140] Ibid.

[141] Ibid.

contracted amount between the provider and the secondary payor for the claim is less than the amount paid by the primary payor, then the secondary payor is not required to pay anything. If the secondary payor's contracted amount is more than the amount paid by the primary payor, but less than the total contracted amount of the primary payor, the secondary payor is only required to pay the difference in the contracted amounts.[142] Thus, how much the secondary payor pays on a specific claim depends on its own contract with ENH, the primary payor's contract with ENH, as well as the cost sharing arrangements between the primary payor and the employer/patient.

3. Cost Sharing Between Commercial MCOs and Employers

78. Also common is cost sharing between MCOs and self-funded group plans (such as the Painters' Fund). As described above, most self-funded group plans contract with a commercial MCO for provider contracting and administrative services. That MCO pays the provider fees directly to the provider, and then passes the cost along to the employer or other group. In this case, it is the employer who ultimately bears the cost of the service, and it is the employer who bears any anticompetitive price increase. However, if the self-funded group plan imposes a co-insurance requirement on its members, part of this price increase may be borne by the patient. And, if the self-funded plan has stop-loss coverage, and the plan hits the stop-loss limit, the price increase may be paid by the stop-loss provider. Moreover, the manner in which the TPA's administrative fees relate to the provider charges varies, and as a result, changes in the provider's contract price with the TPA do not automatically translate into equal changes to the net prices paid by the self-funded employer plans.

79. The Painters' Fund is an example of a self-funded group plan that is administered through an MCO/TPA. For the entirety of the class period, the Painters' Fund has contracted with

[142] A numerical example is helpful. Assume MCO1 is the primary payor and MCO2 is the secondary payor. The contracted amount for the service between the provider and MCO1 is $1000. MCO1 has a 20% co-insurance provision in its contracts with enrollees. If MCO1 were the only payor, MCO1 would pay the provider $800 and the patient would pay $200. If MCO2 is a secondary payor on the claim, and the contracted price for the service between the provider and MCO2 is $1000 or more, then MCO1 would pay $800, MCO2 would pay $200, and the patient would pay nothing. If the contracted price for the service between the provider and MCO2 is $800 or less, then MCO1 pays this lower contracted amount (an amount not from its own contract with the provider, but from another MCO's contract). If the contract price for the service between the provider and MCO2 is between $800 and $1,000 (say, $900), then MCO1 will pay $800 and MCO2 will pay the difference between what MCO1 paid and its own contract price with the provider (in this example, $100).

BCBSI to access the BCBSI contract rates with providers (such as ENH).[143] All payments to ENH for services whose cost is borne by the Painters' Fund are made by BCBSI, not by the Painters' Fund. There is no record of any payment by the Painters' Fund to ENH in the ENH data, and it is impossible to discern from the ENH data alone which of the payments by BCBSI are for Painters' Fund members (and thus ultimately borne not by BCBSI, but by the Painters' Fund). Identifying BCBSI payments made on behalf of the Painters' Fund requires cross-referencing the individual Explanation of Benefit (EOB) forms maintained by the Painters' Fund. However, payments by BCBSI to ENH on behalf of the Painters' Fund do not equal the amount that the Painters' Fund paid BCBSI for these services since the Painters' Fund also paid administrative and network access fees to BCBSI. Such fees charged by a TPA to a self-funded plan can distort the impact on the plan of any changes in the provider's contract prices with the TPA.

4. Cost Sharing Between Commercial MCOs and Government Programs

80. Patients covered by a government program, such as Medicare or Medicaid, may also be covered by multiple insurance plans.[144] For example, a patient may have both Medicare and Medicaid coverage, a Medicare enrollee may also be eligible for some retiree benefits from her former employer's commercial health plan, or a traditional Medicare enrollee may purchase supplemental insurance with a commercial payor (e.g., a MediGap policy) that covers some of the costs of the gaps in coverage by the traditional Medicare program.

81. When the patient is covered by some government program that covers health care costs, payment incidence can also be complex. As discussed above, Medicare and Medicaid beneficiaries may be a member of a commercial MCO plan that administers the government program. This commercial MCO may bear some responsibility for payment of the provider charges, and the program may have co-pays, deductibles, and co-insurance. Also, the patient may be both a member of Medicare and enrolled in a supplemental Medicare coverage plan. In this case, some of the co-pay, deductible or co-insurance charged by Medicare or the

[143] Redacted

[144] http://www medicare.gov/purblications/pubs/pdf/02179.pdf, Section 3, pp. 9-28, accessed on June 5, 2009.

commercial Medicare MCO may be covered by the commercial supplement plan. Likewise, Medicare enrollees may be insured through an employer sponsored plan.[145]

82. Enrollees in traditional governmental plans (and the plans themselves) are not included in the proposed class definition,[146] and I understand that there has been no allegation that ENH prices to any government entity have increased because of any anticompetitive acts. However, isolation of those ENH charges and patient services that pertain to government program enrollees is not straightforward. In many cases where a patient visit reflects a payment by some form of government entity, there is also a payment by a non-government entity (either a commercial MCO or an individual or both). Moreover, some payments that are partially from a commercial entity, acting as a secondary payor, may reflect a service that is priced under a government program.

C. Effect of ENH Price Changes on Distribution of Payments

83. As discussed above, for a specific patient encounter with a health care services provider, multiple parties are often ultimately responsible for payment of the provider charges. The incidence of payment among these parties is determined by a series of complex and non-uniform contracts among a variety of players. Thus, it is likely to be very difficult to determine on a class-wide or formulaic basis how an increase in the price that a health care services provider charges for a specific service will affect (if at all) the payments by the multiple parties who may share in the cost of the service. Furthermore, because the cost of health care services is typically shared among many entities and because many of these entities are in the proposed class, there is an inherent conflict of interest among the class members.

[145] Ibid.

[146] United States District Court for the Northern District of Illinois Eastern Division, In re: Evanston Northwestern Healthcare Corporation Antitrust Litigation, Master File No. 07 C 4446, *Plaintiffs' Memorandum of Law in Support of their Motion for Class Certification*, February, 13, 2009, p. 12.

APPENDIX 2

Out-of-Pocket Maximums in Benefit Plans

1. As discussed earlier, many health insurance plans define an out-of-pocket maximum amount that caps the amount the covered individual (and/or the family of the covered individual) must pay for healthcare expenses in a given year. Once qualifying payments (in terms of deductibles, co-insurance or co-pays) hit this cap, the individual does not have to make any more payments, such as co-insurance payments, that would otherwise be required. [redacted]

   The presence of yearly out-of-pocket maximums means that many patients would not be impacted by an anti-competitive increase in ENH prices, even if the patient paid a percentage-based co-insurance amount based on that anticompetitive price.

2. The degree to which out-of-pocket maximums insulate individuals from any impact of "overcharges" in the ENH contract prices with MCOs depends on how common these types of terms are in individuals benefit plans, and how often individuals with these terms hit the yearly maximum. This information is only in the hands of the dozens of individual MCOs to which the class members belong, and is not available at present. However, by analysis of the ENH data, I can indirectly test both the frequency of these yearly maximums in insurance benefit plans, and the frequency that individual patients hit the maximum. If many patients have these types of benefit terms, if the out-of-pocket maximum is calculated over a calendar year, and if increasing numbers of patients hit their annual maximum throughout the year, then we should observe fewer patients making payments for their treatment at ENH as the year progresses. Also, since the last payment that puts the patient over the maximum threshold will likely be only partial payment of the total owed (i.e., co-insurance) amount, we should expect to see the average amount of patient payments decline as the year progresses.

3. [redacted]

Redacted

4. Redacted

APPENDIX 3

Analysis of Changes to the ENH Chargemaster

1. As discussed in the body of my report, changes to the ENH chargemaster are not "across the board," as Dr. Dranove assumes. Redacted [redacted] Of course, it could be the case that, while changes to the prices of most items on the ENH chargemaster are not "across the board," for those items that are commonly used, price changes are more uniform. I have analyzed this possibility and find that it is not true. Redacted [redacted]

2. Redacted [redacted]

[147] Redacted [redacted]

Redacted

APPENDIX 4

Description of the ENH Claims Data

1. The ENH data on inpatient and outpatient encounters contain millions of payment records covering patient visits occurring October 1, 2001 through April 30, 2008. The data contain information on the type of healthcare service provided, the date of service, and some information on the amount of payment received by ENH for the service (and from whom the payment was received). I understand these data to be the most complete and detailed information available regarding who paid ENH for healthcare services over much of the class period. Notwithstanding the size of these data files, however, it is not always possible to ascertain who paid ENH for healthcare services, and it is rarely possible to determine how the paid amount was determined. Thus, a formulaic method cannot determine who is in the proposed class or whether each entity that paid ENH for healthcare services was impacted by an increase in ENH contract prices or the ENH chargemaster.

2. The ENH data appear to report reliably the total amount received by ENH for each encounter and the total amount paid by insurers and by individuals.[148] Several other aggregate-level payment variables appear to take into account other factors that may be involved with a payment, such as a variety of discounts or adjustments, and whether or not a balance was maintained or the patient payment was sent out for collection. These variables tie together in a consistent manner. Redacted [redacted] It is then possible to segment patient visits according to the category of payors who made direct payments to ENH for this visit. Note that these data represent only the direct payment to ENH.

3. Redacted [redacted]

[148] Redacted [redacted]

Redacted

4. Redacted

5. Redacted

6. Thus, while the total amount paid by the patient to ENH for a specific visit apparently can be determined from these data, it is not possible to always distinguish reliably the subcomponents of this payment. As a result, it is not possible to determine definitively whether some or all of the patient payment was attributable to a fixed co-pay (that would

make the individual ineligible for class membership), a deductible (that may or may not vary with a change in ENH prices), coinsurance (which probably would vary with changes in ENH prices, but might not in all circumstances), a non-covered service (which probably would vary with changes in ENH prices, but might not in all circumstances), or because of some other reason.

7. In addition, these data only pertain to direct payments to ENH. Thus, if the patient was reimbursed for some of their payment to ENH (through a supplemental or wrap-around policy, for instance), the ENH data would not reflect that reimbursement. Or, if the patient made additional payment to the commercial insurer (in the form of a deductible, for instance), the ENH data would not reflect that payment. Similarly for commercial payors, the ENH data only reflect the direct payment to ENH. If the paying entity, say a commercial MCO, then passes the ENH charges to another entity, say a self-funded employer plan, then the ENH data would not reflect the incidence of that charge. Therefore, the ENH data are not useful in determining the incidence of ENH charges to various entities that are in the proposed class, and are therefore not useful in determining the incidence of any increase in ENH prices to members of the proposed class.

1. Explanation-Of-Benefit Forms

8. EOB forms are typically prepared by MCOs when a claim is submitted on behalf of an enrollee. The MCO determines the patient's status with respect to deductibles and out-of-pocket maximums, the applicable co-insurance amount, and the contracted rate with the provider if any, and then calculates how much both the MCO and the patient (and perhaps other MCOs) owe the provider. The EOB that typically provides the most accurate data on the amount that each entity is supposed to pay the provider. (In some cases, however, individuals may not pay the entire amount of their share of the provider charges.) With regard to patient payment responsibility, the forms not only present the total required patient payment, but explain the components of this total amount. Thus, the forms detail what portion of the patient payment may be a co-pay, coinsurance, a deductible or some other form of payment. For ENH patients who are members of an MCO, the EOBs—and not the ENH data— accurately record what the patient was charged for the healthcare service.

9. I reviewed EOB forms produced by named class member representatives and Painters' Fund members. Redacted [redacted] Every EOB that indicates ENH as the provider and that falls within the target date range can be matched to records in the ENH data files.[149] Redacted [redacted]

10. Redacted [redacted]

[149] Redacted [redacted]

11. Redacted

12. Redacted

13. Based on this analysis, I conclude that without extensive discovery to obtain EOBs for all members of the proposed class for all services received from ENH, and without an individual-specific analysis of these EOBs, reliable assessment of the injury incurred by members of the proposed class is not possible. Moreover, based on the incomplete submission of EOBs by the named plaintiffs, I believe it is unlikely that the complete record of relevant EOBs still exists.

CERTIFICATE OF SERVICE

Duane M. Kelley, an attorney, certifies that he caused a copy of the foregoing document to be served by electronic means on all Electronic Filing Users of record, this 12th day of June 2009.

/s/ Duane M. Kelley