**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF WISCONSIN**

| | |
|---|---|
| URIEL PHARMACY HEALTH AND WELFARE PLAN; URIEL PHARMACY, INC.; HOMETOWN PHARMACY; AND HOMETOWN PHARMACY HEALTH and WELFARE BENEFITS PLAN, on their own behalf and on behalf of all others similarly situated,<br><br>Plaintiffs,<br><br>v.<br><br>ADVOCATE AURORA HEALTH, INC. and AURORA HEALTH CARE, INC.,<br><br>Defendants. | Case No. 2:22-cv-610 |

**PLAINTIFFS' MOTION FOR CLASS CERTIFICATION**

Pursuant to Fed. R. Civ. P. 23, plaintiffs Uriel Pharmacy Health and Welfare Plan, Uriel Pharmacy, Inc., Hometown Pharmacy, and Hometown Pharmacy Health and Welfare Benefits Plan ("Plaintiffs"), by and through their undersigned counsel, respectfully move the Court for an order certifying the following class pursuant to Federal Rule of Civil Procedure 23(b)(3):

> All entities that purchased in-network Healthcare Services directly from Advocate Aurora Health, Inc. or Aurora Health Care, Inc. ("AAH") providers in Eastern Wisconsin at any time during the period from May 24, 2018 up to and including December 31, 2022 (the "Class Period"), to the extent such purchases were made pursuant to contracts between AAH and any of the following Network Vendors: Anthem/Blue Cross Blue Shield of Wisconsin, United Healthcare, Cigna Healthcare, Humana Inc., Wisconsin Physicians Services, Health Payment Systems, and/or Trilogy Health Solutions.[1] Excluded from the Class are AAH, and

[1] "Healthcare Services" are inpatient and outpatient facility claims (for use of a facility) and claims for professional services (for treatment by a healthcare professional). "Eastern Wisconsin" consists of the

their officers, directors, management, employees, subsidiaries, or affiliates, judicial officers and their personnel, and all federal governmental entities.

Plaintiffs also request that the Court appoint Plaintiffs as class representatives and appoint Berger Montague PC and Fairmark Partners LLP as Lead Class Counsel.

In support of this motion, Plaintiffs rely on (1) the evidence and argument in their accompanying memorandum of law, (2) the Declaration of Michaela L. Wallin and the exhibits thereto, (3) a proposed trial plan, and (4) any further evidence or argument to be presented to the Court in connection with this motion. A proposed order is filed herewith.

Dated: June 2, 2026

Respectfully submitted,

*/s/ David F. Sorensen*
Eric L. Cramer
David F. Sorensen
Caitlin G. Coslett
Michaela L. Wallin
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following Health Service Areas: Appleton, Brookfield, Burlington, Chilton, Cudahy, Elkhorn, Fond Du Lac, Fort Atkinson, Green Bay, Hartford, Kenosha, Kewaunee, Manitowoc, Marinette, Menomonee Falls, Milwaukee, Neenah, Oconomowoc, Oconto Falls, Oshkosh, Plymouth, Port Washington, Racine, Shawano, Sheboygan, Sturgeon Bay, Two Rivers, Watertown, Waukesha, West Allis, and West Bend. *See* Ex. 3, Dranove Rpt. ¶4 n.7 (defining Eastern Wisconsin). All Exs. are attached to the Coslett Decl.

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***Counsel for All Plaintiffs***

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*Counsel for Uriel Pharmacy, Inc., Uriel Pharmacy Health and Welfare Plan*

**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that on June 2, 2026, a true and correct copy of the foregoing was filed with the Court via the CM/ECF system, which will send a Notice of Electronic Filing to all counsel of record.

Dated: June 2, 2026

*/s/ David F. Sorensen*
David F. Sorensen

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF WISCONSIN**

| | |
|---|---|
| URIEL PHARMACY HEALTH AND WELFARE PLAN; URIEL PHARMACY, INC.; HOMETOWN PHARMACY; AND HOMETOWN PHARMACY HEALTH and WELFARE BENEFITS PLAN, on their own behalf and on behalf of all others similarly situated,<br><br>Plaintiffs,<br><br>v.<br><br>ADVOCATE AURORA HEALTH, INC. and AURORA HEALTH CARE, INC.,<br><br>Defendants. | Case No. 2:22-cv-610 |

**DECLARATION OF MICHAELA L. WALLIN IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION**

I, Michaela L. Wallin, subject to the penalties of perjury, do hereby declare that I am a shareholder in the law firm Berger Montague PC, counsel for Plaintiffs. I am an attorney duly authorized to practice law in the State of New York and am admitted to this Court. I submit this Declaration in support of Plaintiffs' Motion for Class Certification.

I declare under penalty of perjury that the following is true and correct:

1. Fairmark Partners, LLP and Berger Montague PC ("Proposed Co-Lead Class Counsel") have served as counsel for Plaintiffs and the proposed Class. Proposed Co-Lead Class Counsel have devoted thousands of hours and have advanced substantial funds without reimbursement in service of prosecuting this case on behalf of Plaintiffs and the proposed Class.[1]

[1] This case was originally brought by Fairmark Partners LLP in May 2022, and Berger Montague PC joined as counsel in April 2023. *See* ECF No. 29, 30, 44.

2. On behalf of Plaintiffs and the proposed Class, Proposed Co-Lead Counsel briefed and argued complex motions and disputes, including prevailing over Defendants' motion to dismiss at the outset of the case; conducted extensive party and nonparty discovery; and retained preeminent economic experts to render opinions on key issues in the case and analyze reams of data collected in discovery.

3. In terms of party discovery alone, Proposed Co-Lead Counsel have, among other tasks, taken and defended dozens of depositions; conducted extensive discovery negotiations with defendants and nonparties; reviewed and analyzed hundreds of thousands of documents; and issued and assisted Plaintiffs in responding to written discovery, including interrogatories, requests for production of documents, and requests for admission. Proposed Co-Lead Counsel also engaged in extensive nonparty discovery efforts.

4. Plaintiffs also actively supervised and contributed to this case's prosecution, including guiding discovery, responding to written discovery requests, collecting and producing tens of thousands of documents though an extensively negotiated search process involving an outside discovery vendor and consultation with counsel, producing witnesses for Rule 30(b)(6) depositions of Plaintiffs, and preparing those witnesses to testify as Rule 30(b)(6) witnesses for Plaintiffs.

5. The following documents, attached hereto, are cited in Plaintiffs' Memorandum of Law in Support of their Motion for Class Certification. Many of these documents are being filed under seal because they contain information that was designated as confidential under the protective order in this case, by either a party or nonparty.

6. Attached as Exhibit 1 is a true and correct copy of the Expert Report of Jeffrey J. Leitzinger, Ph.D. dated November 21, 2025 (filed under seal).

7. Attached as Exhibit 2 is a true and correct copy of the Expert Rebuttal Report of Jeffrey J. Leitzinger, Ph.D. dated March 23, 2026 (filed under seal).

8. Attached as Exhibit 3 is a true and correct copy of the Expert Report of David Dranove, Ph.D. dated November 21, 2025 (filed under seal).

9. Attached as Exhibit 4 is a true and correct copy of the Expert Rebuttal Report of David Dranove, Ph.D. dated March 23, 2026 (filed under seal).

10. Attached as Exhibit 5 is a true and correct copy of the Expert Report of Patrick S. Romano, M.D., M.P.H. dated November 21, 2025 (filed under seal).

11. Attached as Exhibit 6 is a true and correct copy of the Expert Rebuttal Report of Patrick S. Romano, M.D., M.P.H. dated March 23, 2026 (filed under seal).

12. Attached as Exhibit 7 is a true and correct copy of Titus Muzi Interview Notes dated June 5, 2018 (HURON_068646-49) (filed under seal).

13. Attached as Exhibit 8 is a true and correct copy of Amendment No. 12 To the Physician Hospital Organization Participation Agreement Between Humana Wisconsin Health Organization Insurance Corporation, Humana Insurance Company and Aurora Health Care, Inc. (AAHEDWI00597913-27) (filed under seal).

14. Attached as Exhibit 9 is a true and correct copy of the transcript of Richard Klein's deposition on May 9, 2025 (filed under seal).

15. Attached as Exhibit 10 is a true and correct copy of the transcript of Larry Lenz's 30(b)(6) deposition on October 16, 2025 (filed under seal).

16. Attached as Exhibit 11 is a true and correct copy of Innosight Discussion Document dated May 24, 2018 (AAHEDWI00756315-58) (filed under seal).

17. Attached as Exhibit 12 is a true and correct copy of Advocate Aurora Health Discussion Document dated June 5, 2018 (HURON_054337-47) (filed under seal).

18. Attached as Exhibit 13 is a true and correct copy of Aurora Health Care Managed Care Overview (AAHEDWI00450873-98) (filed under seal).

19. Attached as Exhibit 14 is a true and correct copy of Advocate Aurora Health, Inc. Narrative Response to Specification 10 of Civil Investigative Demand (AAHEDWI00621359-63) (filed under seal).

20. Attached as Exhibit 15 is a true and correct copy of Standard Contract Terms (AAHEDWI00658806-07) (filed under seal).

21. Attached as Exhibit 16 is a true and correct copy of Email from Barry Eldridge to Paul Nobile dated December 17, 2019 (BCBSWI_AAH_00022781-82) (filed under seal and also publicly, with redactions).

22. Attached as Exhibit 17 is a true and correct copy of Email from Scott Gerhart to Amy Patrick and Andrea Lathers dated December 7, 2019 (BCBSWI_AAH_00024689-691) (filed under seal and also publicly, with redactions).

23. Attached as Exhibit 18 is a true and correct copy of Letter from Aurora Health Care to United HealthCare Insurance Company dated November 27, 2018 (AAHEDWI00299219-20) (filed under seal).

24. Attached as Exhibit 19 is a true and correct copy of Email from Jeff Anderson to Richard Heim and Don Calcagno dated December 18, 2018 (AAHEDWI00007080-85) (filed under seal).

25. Attached as Exhibit 20 is a true and correct copy of Letter from Aurora Health Care to Humana, Inc. dated January 10, 2019 (AAHEDWI00095705-07) (filed under seal).

26. Attached as Exhibit 21 is a true and correct copy of Email from Larry Lenz to Jeff Anderson dated January 18, 2019 (AAHEDWI00023436-42) (filed under seal).

27. Attached as Exhibit 22 is an excerpt of a true and correct copy of the transcript of Andrea Lathers's 30(b)(6) deposition on May 27, 2025 (filed under seal and also publicly, with redactions).

28. Attached as Exhibit 23 is a true and correct copy of Email from Joanne Beck to Kristi Coklas dated October 30, 2020 (UHG-Uriel-00000494-95) (filed under seal).

29. Attached as Exhibit 24 is an excerpt of a true and correct copy of the transcript of Jeremy Ott's 30(b)(6) deposition on July 11, 2025 2025

30. Attached as Exhibit 25 is a true and correct copy of Message from Jeff Anderson to Richard Klein and Titus Muzi (AAHEDWI00598196) (filed under seal).

31. Attached as Exhibit 26 is a true and correct copy of Order Granting In Part Motion To Strike, Granting Class Certification, and Setting Case Management Conference, *UEBT v. Sutter Health*, No. CGC-14-538451 (Sup. Ct. Cal. Aug. 14, 2017) ("*UEBT v. Sutter* Class Order").

32. Attached as Exhibit 27 is an excerpt of a true and correct copy of the transcript of Aaron Jackson's 30(b)(6) deposition on July 18, 2025.

33. Attached as Exhibit 28 is an excerpt of a true and correct copy of the transcript of Paul Maxwell's 30(b)(6) deposition on June 5, 2025 (filed under seal and also publicly, with redactions).

34. Attached as Exhibit 29 is a true and correct copy of North Central Region: Milwaukee, Supply Chain Risk Evaluation (HUMANA019081) (filed under seal).

35. Attached as Exhibit 30 is a true and correct copy of Email from Titus Muzi to Richard Klein regarding Contract Amendment dated December 4, 2018 (AAHEDWI00573956-57) (filed under seal).

36. Attached as Exhibit 31 is a true and correct copy of North Central Region: Green Bay, Supply Chain Risk Evaluation (HUMANA019080) (filed under seal).

37. Attached as Exhibit 32 is a true and correct copy of UnitedHealthcare Local Wisconsin/Michigan 2021 Business Plan (UHG-Uriel-00000368) (filed under seal).

38. Attached as Exhibit 33 is a true and correct copy of Wisconsin Nexus ACO July 2022 FAQ for Sales and Account Management (UHG-Uriel-00020038-46) (filed under seal).

39. Attached as Exhibit 34 is a true and correct copy of Email from Titus Muzi to Richard Klein regarding DNV Survey and Process dated December 4, 2018 (AAHEDWI00573958-64) (filed under seal).

40. Attached as Exhibit 35 is a true and correct copy of Email from Scott Gerhart to Justin Brown dated February 20, 2019 (BCBSWI_AAH_00025938-39) (filed under seal and also publicly, with redactions).

41. Attached as Exhibit 36 is a true and correct copy of Email from Larry Lenz to Titus Muzi and Daniel Stahlkopf dated January 28, 2020 (AAHEDWI00158954-60) (filed under seal).

42. Attached as Exhibit 37 is a true and correct copy of Email from Titus Muzi to Richard Klein dated November 29, 2018 (AAHEDWI00573949-50) (filed under seal).

43. Attached as Exhibit 38 is a true and correct copy of Email from Jeff Anderson to Michael Dean dated June 13, 2019 (AAHEDWI00008411-14) (filed under seal).

44. Attached as Exhibit 39 is a true and correct copy of Email from Larry Lenz to Titus Muzi dated June 8, 2020 (AAHEDWI00152452-63) (filed under seal).

45. Attached as Exhibit 40 is a true and correct copy of Aurora Health Care 2021 UHC Contracting dated October 28, 2018 (AAHEDWI00435658-69) (filed under seal).

46. Attached as Exhibit 41 is a true and correct copy of Email from Jeff Anderson to Self regarding Cigna Meeting dated October 19, 2018 (AAHEDWI00025038-40) (filed under seal).

47. Attached as Exhibit 42 is a true and correct copy of Email from James Ramsey to Daniel Stahlkopf and Jill Fyock dated August 4, 2023 (AAHEDWI00868418-20) (filed under seal).

48. Attached as Exhibit 43 is a true and correct copy of Email from Daniel Stahlkopf to Brent Estes dated April 23, 2021 (AAHEDWI00083070-74) (filed under seal).

49. Attached as Exhibit 44 is a true and correct copy of Aurora Health Care Managed Care Contracting (AAHEDWI00450947-969) (filed under seal).

50. Attached as Exhibit 45 is a true and correct copy of Email from Kaitlin Fink to Aaron Jackson dated February 28, 2020 (CG_0063481-483) (filed under seal and also publicly, with redactions).

51. Attached as Exhibit 46 is an excerpt of a true and correct copy of the transcript of Paul Spencer's 30(b)(6) deposition on September 15, 2025 (filed under seal).

52. Attached as Exhibit 47 is a true and correct copy of Advocate Aurora Health Renewal Interests (UHG-Uriel-00006550) (filed under seal).

53. Attached as Exhibit 48 is a true and correct copy of the transcript of Richard Klein's 30(b)(6) deposition on October 21, 2025 (filed under seal).

54. Attached as Exhibit 49 is a true and correct copy of Aurora Quartz Medicare Advantage Path to Purchase (AAHEDWI00029647-688) (filed under seal).

55. Attached as Exhibit 50 is a true and correct copy of Email from Richard Klein to Titus Muzi dated December 22, 2020 (AAHEDWI00031964-965) (filed under seal).

56. Attached as Exhibit 51 is a true and correct copy of Email from Larry Lenz to Daniel Stahlkopf dated July 15, 2020 (AAHEDWI00046419-425) (filed under seal).

57. Attached as Exhibit 52 is a true and correct copy of Email from David Stahlkopf to Mimi Foote dated May 27, 2021 (AAHEDWI00082402-404) (filed under seal).

58. Attached as Exhibit 53 is a true and correct copy of Email from Larry Lenz to Jeff Anderson dated January 18, 2019 (AAHEDWI00082436-440) (filed under seal).

59. Attached as Exhibit 54 is a true and correct copy of Email from Titus Muzi to Jeff Anderson dated January 24, 2019 (AAHEDWI00127810-818) (filed under seal).

60. Attached as Exhibit 55 is a true and correct copy of Press Release from Cal. Dep't of Justice, *Attorney General Bonta Announces Final Approval of $575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices* (Aug. 37, 2021).

61. Attached as Exhibit 56 is a true and correct copy of the transcript of Richard Klein's deposition dated March 19, 2026 (filed under seal).

62. Attached as Exhibit 57 is a true and correct copy of Wisconsin Managed Care Overview (AAHEDWI00630735-772) (filed under seal).

63. Attached as Exhibit 58 is a true and correct copy of Commercial Physician Reimbursement (AAHEDWI00759865-875) (filed under seal).

64. Attached as Exhibit 59 is a true and correct copy of Email from Daniel Stahlkopf to Titus Muzi dated June 24, 2020 (AAHEDWI00823181-183) (filed under seal).

65. Attached as Exhibit 60 is a true and correct copy of UHC Commercial Update (AAHEDWI00947831-841) (filed under seal).

66. Attached as Exhibit 61 is a true and correct copy of Retail Imaging Strategy (AAHEDWI00983339-364) (filed under seal).

67. Attached as Exhibit 62 is a true and correct copy of Email from Daniel Stahlkopf to Titus Muzi dated June 24, 2020 (AAHEDWI01188952) (filed under seal).

68. Attached as Exhibit 63 is a true and correct copy of Email from David Brzozowski to Larry Lenz dated September 28, 2022 (AAHEDWI01373683-684) (filed under seal).

69. Attached as Exhibit 64 is a true and correct copy of Strategic Pricing Assessment – Wisconsin Hospital/Physician Chargemasters and Illinois Physician Chargemaster (AAHEDWI01378772-803) (filed under seal).

70. Attached as Exhibit 65 is a true and correct copy of Email from Jeffrey Grzybowski to Daniel Stahlkopf dated September 26, 2022 (AAHEDWI02010094-096) (filed under seal).

71. Attached as Exhibit 66 is a true and correct copy of 2018 Employer Health Insurance and Other Products Insights (AAHEDWI02574124-162) (filed under seal).

72. Attached as Exhibit 67 is a true and correct copy of Employer Health Insurance and Employer Programs Report January 2023 Results (AAHEDWI02574179-221) (filed under seal).

73. Attached as Exhibit 68 is a true and correct copy of Aurora Brand Update: Wave 5 (AAHEDWI02602381-422) (filed under seal).

74. Attached as Exhibit 69 is a true and correct copy of Order Granting Motion for Final Approval, *Sidibe v. Sutter Health*, No. 12-cv-04854-LB, Dkt. 1763 (N.D. Cal. Nov. 6, 2025).

75. Attached as Exhibit 70 is a true and correct copy of Consumer Pulse Live: Aurora Brand Update February 2018 (AAHEDWI02613840-861) (filed under seal).

76. Attached as Exhibit 71 is a true and correct copy of Email from Kyle Monroe to Debora Kunferman dated July 18, 2021 (Alliance_UrielPharm_00001585).

77. Attached as Exhibit 72 is a true and correct copy of Email from Andrea Lathers to Amy Patrick dated June 29, 2020 (BCBSWI_AAH_00024854-855) (filed under seal and also publicly, with redactions).

78. Attached as Exhibit 73 is a true and correct copy of Email from John Foley to Sandi Camp dated March 3, 2014 (BCBSWI_AAH_00025759-760) (filed under seal and also publicly, with redactions).

79. Attached as Exhibit 74 is a true and correct copy of the transcript of Paul Blomeyer's deposition dated July 15, 2025 (filed under seal).

80. Attached as Exhibit 75 is a true and correct copy of 20180522 Sylvia Metzer Interview Notes (HURON_068476-482) (filed under seal)..

81. Attached as Exhibit 76 is a true and correct copy of Advocate Aurora Health 101 (HURON_080281-351) (filed under seal).

82. Attached as Exhibit 77 is a true and correct copy of UHC Preliminary Proposal Range (MILLIMAN_00001-039) (filed under seal).

83. Attached as Exhibit 78 is a true and correct copy of Letter from Juliet Spector to Daniel Bailey (ProHealth_Uriel_0007534-536) (filed under seal and also publicly, with redactions).

84. Attached as Exhibit 79 is the true and correct copy of Email from Heather Olivia to Larry Lenz and Daniel Stahlkopf dated July 26, 2023 (AURORA00011858-863) (filed under seal and also publicly, with redactions).

85. Attached as Exhibit 80 is a true and correct copy of Email from Matthew Clark to Stephen Schooff (Uriel-Sub0002739-750) (filed under seal).

86. Attached as Exhibit 81 is a true and correct copy of WPS's Answer to Aurora's Amended Complaint, Amended Counterclaims, and Reply to Counter-Counterclaims, *Aurora Health Care, Inc. v. Wisconsin Physicians Serv. Corp.*, No. 05-cv-011279 (Wis. Circuit Ct. July 10, 2006).

87. Attached as Exhibit 82 is an excerpt of a true and correct copy of the transcript of Jeffrey Squier's deposition dated September 24, 2025.

88. Attached as Exhibit 83 is an excerpt of a true and correct copy of the transcript of Naomi Wedin's 30(b)(6) deposition dated January 20, 2025 (filed under seal and also publicly, with redactions).

89. Attached as Exhibit 84 is an excerpt of a true and correct copy of the transcript of Peter Bacon's 30(b)(6) deposition dated June 23, 2025.

90. Attached as Exhibit 85 is the true and correct copy of Advocate Aurora Health Managed Care Contracting (AAHEDWI00630685-732) (filed under seal).

91. Attached as Exhibit 86 is an excerpt of a true and correct copy of the transcript of Joanna Beck's 30(b)(6) deposition dated July 31, 2025 (filed under seal).

92. Attached as Exhibit 87 is a true and correct copy of the transcript of Jim Skogsbergh's deposition dated June 26, 2025 (filed under seal).

93. Attached as Exhibit 88 is a true and correct copy of the transcript of Jeff Anderson's deposition dated June 11, 2025 (filed under seal).

94. Attached as Exhibit 89 is an excerpt of a true and correct copy of the transcript of Shelley Turk's 30(b)(6) deposition dated June 16, 2025 (filed under seal and also publicly, with redactions).

95. Attached as Exhibit 90 is the true and correct copy of Email from Titus Muzi to Larry Lenz and Daniel Stahlkopf dated December 5, 2019 (AAHEDWI00344442-445) (filed under seal).

This declaration was executed on the 2nd day of June, 2026.

*/s/ Michaela L. Wallin*
Michaela L. Wallin

# Exhibit 16

Message

**From**: Barry.Eldridge@bcbsmo.com [Barry.Eldridge@bcbsmo.com]
**Sent**: 12/17/2019 2:19:46 PM
**To**: Paul.Nobile@anthem.com
**CC**: Scott.Gerhart@anthem.com; andrea.lathers@bcbswi.com; amy.patrick@anthem.com
**Subject**: FW: WI - 2021 Site of Steerage

Paul,

FYI: I understand this will be covered in a Plan President meeting this week. See Amy's summary below. She met with Andrea and I today so we could discuss WI options under the Site of Steerage initiative. Let me know – or reach out to Andrea – if you have questions.

Thanks,
Barry Eldridge
Wisconsin State Planner
Anthem Blue Cross and Blue Shield in Wisconsin
(314) 795-9255



**From:** Patrick, Amy M. <amy.patrick@anthem.com>
**Sent:** Tuesday, December 17, 2019 2:14 PM
**To:** Eldridge, Barry <Barry.Eldridge@bcbsmo.com>; Lathers, Andrea <andrea.lathers@bcbswi.com>; Ali, Asra A. <asra.ali@anthem.com>
**Subject:** WI - 2021 Site of Steerage

Hello,

Thank you all for taking the time to meet this afternoon. Here is a summary of our discussion:

*Aurora is one of the largest providers in WI. In addition, Aurora is our partner in the WCIC joint venture. Aurora is a provider in all WI networks and will also be a provider in the new HPN.

*95% of WI providers belong to a hospital system. The majority of both ASCs and Imaging Centers are hospital/provider owned.

**Site of Service – Independently Owned ASCs**

- Our contract with Aurora states that we cannot steer members away from Aurora by financial benefit or benefit design.
- Aurora owns ASCs, which are considered provider/hospital owned
- Any site of service steerage to ASCs would need to include all ASCs, both independently owned and provider/hospital owned
- This would still allow member cost savings because it would steer members away from OP hospital facilities
- Amy and Asra will research to see if operationally, we can include all ASCs
- If we are not able to accommodate site of service steerage to all ASCs, then WI will need to be exempt from this recommendation because it would violate the contract with Aurora

**Site of Service – Independently Owned Imaging Centers**

- Our contract with Aurora states that we cannot steer members away from Aurora by financial benefit or benefit design.
- WI has worked with AIM to have a SoS redirection program for Aurora to utilize hospital/facility owned Imaging Centers at different rates.
- There are only a handful of independently owned imaging centers in WI.
- Any site of service steerage to imaging centers would need to include all imaging centers, both independently owned and provider/hospital owned
- If this is not able to be accommodated, then WI will need to be exempt from this recommendation because it would violate the contract with Aurora

**Blue HPN**

[redacted]

- Aurora will be part of the HPN.

If there are any questions or if I have missed anything, please let me know.

Thanks,

Amy

**Anthem, Inc.**

**Amy Patrick**, *Product Management Director*
O: (224) 456-0798| M: (847) 858-6095
amy.patrick@anthem.com

# Exhibit 17

Message

**From**: Scott.Gerhart@anthem.com [Scott.Gerhart@anthem.com]
**Sent**: 12/7/2019 10:17:37 AM
**To**: amy.patrick@anthem.com; andrea.lathers@bcbswi.com
**Subject**: RE: Anthem Mandate: Site of Service Steerage (ASC and Radiology Center)

[redacted]

**From:** Patrick, Amy M. <amy.patrick@anthem.com>
**Sent:** Friday, December 6, 2019 12:12 PM
**To:** Lathers, Andrea <andrea.lathers@bcbswi.com>; Gerhart, Scott <Scott.Gerhart@anthem.com>
**Subject:** RE: Anthem Mandate: Site of Service Steerage (ASC and Radiology Center)

Thanks, Andrea. That is what I was thinking as well.

[redacted]

Thanks!

Amy

**Anthem, Inc.**

**Amy Patrick,** *Product Management Director*
O: (224) 456-0798 | M: (847) 858-6095
amy.patrick@anthem.com

**From:** Lathers, Andrea <andrea.lathers@bcbswi.com>
**Sent:** Friday, December 06, 2019 12:07 PM
**To:** Patrick, Amy M. <amy.patrick@anthem.com>; Gerhart, Scott <Scott.Gerhart@anthem.com>
**Subject:** RE: Anthem Mandate: Site of Service Steerage (ASC and Radiology Center)

Hi Amy,
I don't see a way around this for Aurora. I can tell you for WI the ASC's that are owned by our systems have different rates than the outpatient hospital. We would love to see the Site of Service Steerage happen in WI, but the steerage would need to be for any ASC. That will still supply cost savings to members and Anthem. It will help with the overall goals of moving people to an ASC which is a lower cost option than the outpatient hospital.
Thanks,
Andrea

**From:** Patrick, Amy M.
**Sent:** Friday, December 6, 2019 11:36 AM

**To:** Lathers, Andrea <andrea.lathers@bcbswi.com>; Gerhart, Scott <Scott.Gerhart@anthem.com>
**Subject:** RE: Anthem Mandate: Site of Service Steerage (ASC and Radiology Center)

Hello!

We met last week to discuss the 2021 recommendation of steerage (through benefit design) to independently owned ASCs.

One obstacle in WI was the contracting with Aurora which doesn't allow steerage away from their ASCs. Although Aurora has their own ASCs these are considered hospital owned.

Per the message below, the Site of Steerage recommendation will be a mandate for 2021.

Do you see any strategies or solutions that would allow this steerage away from Aurora's ASCs?

Thanks!

Amy

**Anthem, Inc.**

**Amy Patrick,** *Product Management Director*
O: (224) 456-0798 | M: (847) 858-6095
amy.patrick@anthem.com

-----Original Appointment-----
**From:** Ali, Asra A. <asra.ali@anthem.com>
**Sent:** Tuesday, November 19, 2019 2:56 PM
**To:** Ali, Asra A.; Patrick, Amy M.; Georgelos, Kristin E.; MacNerland, Selette; CRIDLIN, KAREN; Reichart, Sharon E.; Noonan, Theresa L.; Garcia, Anniet; Whiting, Kristin; Stewart, Hal
**Cc:** Dickinson, Melissa E.; Dominique, Cynthia; Stanton, Tracey B; Occhipinti, Michael; Dolecki, Karen (HMC); Burgh, Betsy
**Subject:** Anthem Mandate: Site of Service Steerage (ASC and Radiology Center)
**When:** Monday, December 09, 2019 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
**Where:** 866-308-0254,,,1701324443#
**Importance:** High

[redacted]

Thanks.

Join Skype Meeting

Trouble Joining? Try Skype Web App

Help

# Exhibit 22


LEXITAS™

[redacted]

Q. Okay. We'll -- we'll talk a lot more about that later.

But just going back to the mechanics of how it operated, you said -- and correct me if I'm wrong. You said that because of that contractual provision, if you're going to create a narrow network, you had to include Aurora, which might mean that both Froedtert and Ascension may not be interested in joining; is that right?

A. Correct.

Q. Okay. So would you say that that provision impeded Anthem in fostering price competition between those two -- those three providers?

MS. JOHNSON PALMER: Objection. Form. Foundation.

THE WITNESS: Yes.

BY MR. CROOKS:

Q. And why is that the case?

A. So the goal of the narrow network is to have a lower cost of care and then drive membership into those other -- into that particular provider's organization. We refer to it as heads in beds.

In order to -- in order to try and have another health system in a network that Aurora is in, that health system would have to agree to certain prices. And from the health system's perspective, because Aurora has such a large presence in southeast Wisconsin, the competition between an Aurora and an Ascension or an Aurora and a Froedtert, those providers typically feel like they are -- they're losing membership to Aurora because of the large

presence.

Q. Okay. And so absent the all-plans clause, when Anthem's assembling a network, it could say to Froedtert or it could say to Ascension, hey, if you give me more of a discount, I'll put you in and take Aurora out; is that right?

A. Correct.

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: Correct.

MS. JOHNSON PALMER: Hypothetic al.

THE WITNESS: Correct.

BY MR. CROOKS:

[redacted]

[redacted]

[redacted]

Q. Okay. But you couldn't do that in southeast Wisconsin because of this contractual provision?

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: Correct.

BY MR. CROOKS:

Q. Okay. Did Anthem view that as a contributor to high cost of care?

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: Yes.

BY MR. CROOKS:

Q. In the sense that it affected network design, as we've been talking about; correct?

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: Correct.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Q. Okay. Do you know whether Aurora's prices were higher for the healthcare it provided than other providers?

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: I do not.

BY MR. CROOKS:

Q. Okay.

A. Well, let me take that back. In relation to the Anthem contracts, I can answer that question. But what Aurora has negotiated with other carriers, I can't answer that question.

Q. I appreciate that. I'm just talking about the Anthem contracts.

A. So the Anthem contracts, yes, Aurora had a higher reimbursement rate in southeast Wisconsin compared to their peers.

[redacted]

[redacted]

Q. Okay. And so what is she asking about here?

A. She's asking if tiered networks can be done in Wisconsin.

Q. Okay. And then Mr. Eldridge responds, "I believe the reason is the Aurora contract states they have to be in the first tier, regardless of the criteria."

Did I read that correctly?

A. Yes.

Q. Do you agree with that statement?

A. Yes.

Q. Okay. And are tiered networks

something that Anthem would offer in Aurora -- I'm sorry, would offer -- would offer in Wisconsin but for Aurora's contractual restraint?

MS. JOHNSON PALMER: Objection. Form. Hypothetical.

THE WITNESS: At the time, yes. We were looking at offering tiered networks and felt from a business perspective that we couldn't do it with the Aurora contract language.

BY MR. CROOKS:

Q. Okay. And that contract language is what we read before in the 2005 contract?

A. Correct.

Q. Okay. In your -- as Anthem's representative, is it your belief that tiered networks can be an important cost-saving tool?

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: Yes.

BY MR. CROOKS:

Q. Does Anthem view them as an important cost-saving tool in states other than Wisconsin?

MR. CHAPPELL: Object to form.

MS. JOHNSON PALMER: Objection. Form. Foundation.

THE WITNESS: Yes.

MR. CHAPPELL: Beyond the scope.

BY MR. CROOKS:

Q. And Anthem would have implemented them in Wisconsin if not for the Aurora restraint?

MS. JOHNSON PALMER: Objection. Form. Hypothetical.

THE WITNESS: I think that we would have attempted to. Yes.

BY MR. CROOKS:

Q. Okay. And is it your understanding that employers, at least some large employers, would want to include that tiered offering in their -- in what they offer to their employees?

MS. JOHNSON PALMER: Objection. Form. Foundation.

THE WITNESS: Yes. I think that the cost and quality piece is always something that an employer is looking at

to drive members to a higher quality, low cost provider.

[redacted]

[redacted]

Q. What does that mean?

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: It means that we could not implement the site-of-service policy without -- without breaching the Aurora agreement.

BY MR. CROOKS:

Q. And this particular site-of-service policy is about ambulatory surgery centers; right?

A. Correct.

Q. Do you remember whether Aurora -- I'm sorry, whether Anthem actually introduced this site-of-service policy in Wisconsin?

A. I --

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: I do not recall

if we did or not. I don't believe so.

BY MR. CROOKS:

Q. Do you have any recollection of site-of-service policies that Anthem implemented elsewhere that could not be implemented in Wisconsin because of Aurora's contract?

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: Yes. This particular policy was implemented in other Anthem states but not in Wisconsin.

BY MR. CROOKS:

Q. And the reason for that was what?

A. The Aurora contract did not allow it.

[redacted]

[redacted],

Q. Okay. And then if you could turn back to slide 3. Under "Aurora" -- and this

is Bates ending in 3949. Under "Aurora," it says "Dominant system, contractually must be invited to participate."

Do you see that?

A. Yes.

Q. Okay. Would you agree that Aurora is a dominant system?

MS. JOHNSON PALMER: Objection. Form.

THE WITNESS: Yes.

BY MR. CROOKS:

Q. Okay. And none of the other hospitals listed here among the southeast Wisconsin systems is described as dominant.

Am I right about that?

A. Correct.

Q. And so would you agree that Aurora is the most dominant system in southeastern Wisconsin?

MS. JOHNSON PALMER: Objection to form.

THE WITNESS: Yes.

BY MR. CROOKS:

Q. Okay. And why is that?

A. The size and magnitude of the health

system.

[redacted]

[redacted]

Q. Okay. Would it be possible for Anthem to remove Aurora from all of its products and still be commercially viable?

A. No.

Q. And so is that because of network adequacy rules?

MS. JOHNSON PALMER: Objection to form. Foundation.

THE WITNESS: Network adequacy rules and then just the marketplace and employers.

BY MR. CROOKS:

Q. Commercial liability?

A. Yeah.

Q. Employers wouldn't want to only offer insurance plans that don't include Aurora; is that right?

A. Correct.

[redacted]

[redacted]

Q. Okay. But you are confident, sitting here today, to testify that Anthem could not remove Aurora from all of its products and remain commercially viable?

MS. JOHNSON PALMER: Objection to form. Foundation.

THE WITNESS: Correct.

[redacted]

[redacted]

Q. Okay. So while those exceptions obviously gave you greater flexibility than you had before they were in the contract, would you prefer having those exceptions or having the all-plans clause removed?

MS. JOHNSON PALMER: Objection to form. Calls for speculation. Hypothetical.

THE WITNESS: I'd prefer to have our standard language.

BY MR. CROOKS:

Q. Which does not have the all-plans clause?

A. Correct.

[redacted]

[redacted]

Q. And if you had that ability, would it benefit patients?

MS. JOHNSON PALMER: Objection. Form. Foundation.

THE WITNESS: I believe it would.

BY MR. CROOKS:

Q. How so?

A. I believe that patients would be able to look a provider up on our website to see whether or not they had a high quality score, a high -- a low cost score, if they had -- if they met the criteria for their particular benefit plan that they had for a -- you know, if they had a -- we talked a little bit about some of those bundled services and things, like a knee or a hip at an ASC, and they've got a better benefit. They can see some of that data when they're looking to select a physician or a place to have a service done.

Q. And so the list you just gave, you would describe all of those as benefits to patients?

A. I believe so.

Q. And is it your belief, Ms. Lathers, that the all-plans clause, even with the exceptions that were added over time, inhibited Anthem's ability to offer patients those benefits?

MS. JOHNSON PALMER: Objection. Form. Foundation. Calls for speculation.

THE WITNESS: Yes.

BY MR. CROOKS:

Q. And we talked earlier about how the lack of tiered networks and the restrictions on narrow networks inhibited competition between providers on rates.

Do you remember that?

A. I do.

Q. Okay. And so similar to the patient benefits about choice and flexibility, is it Anthem's belief that absent the all-plans clause, there would be greater rate competition between hospitals for inclusion

in, say, a narrow network or a tiered network?

MS. JOHNSON PALMER: Objection. Form. Foundation. Calls for speculation.

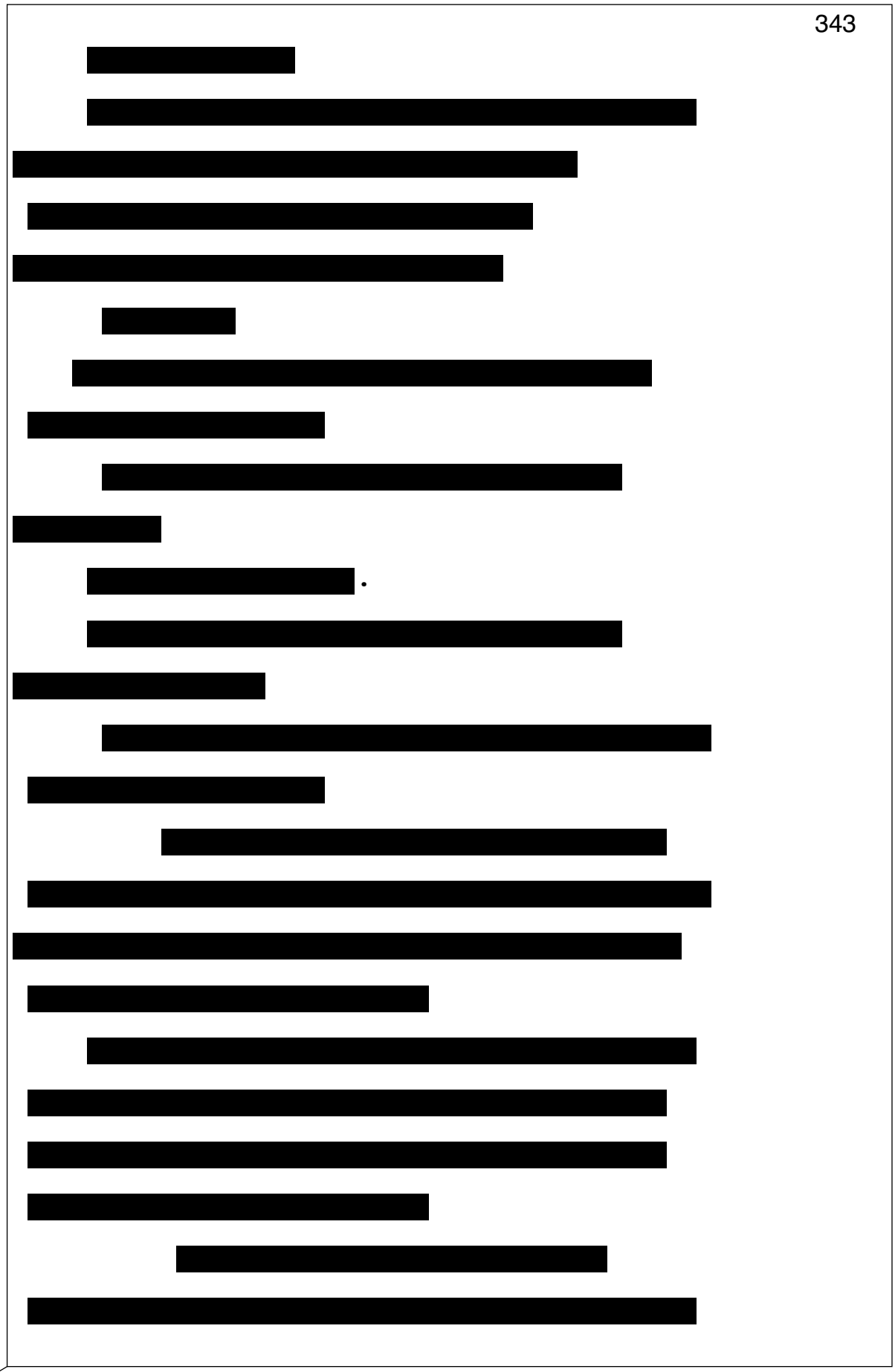
THE WITNESS: Yes.

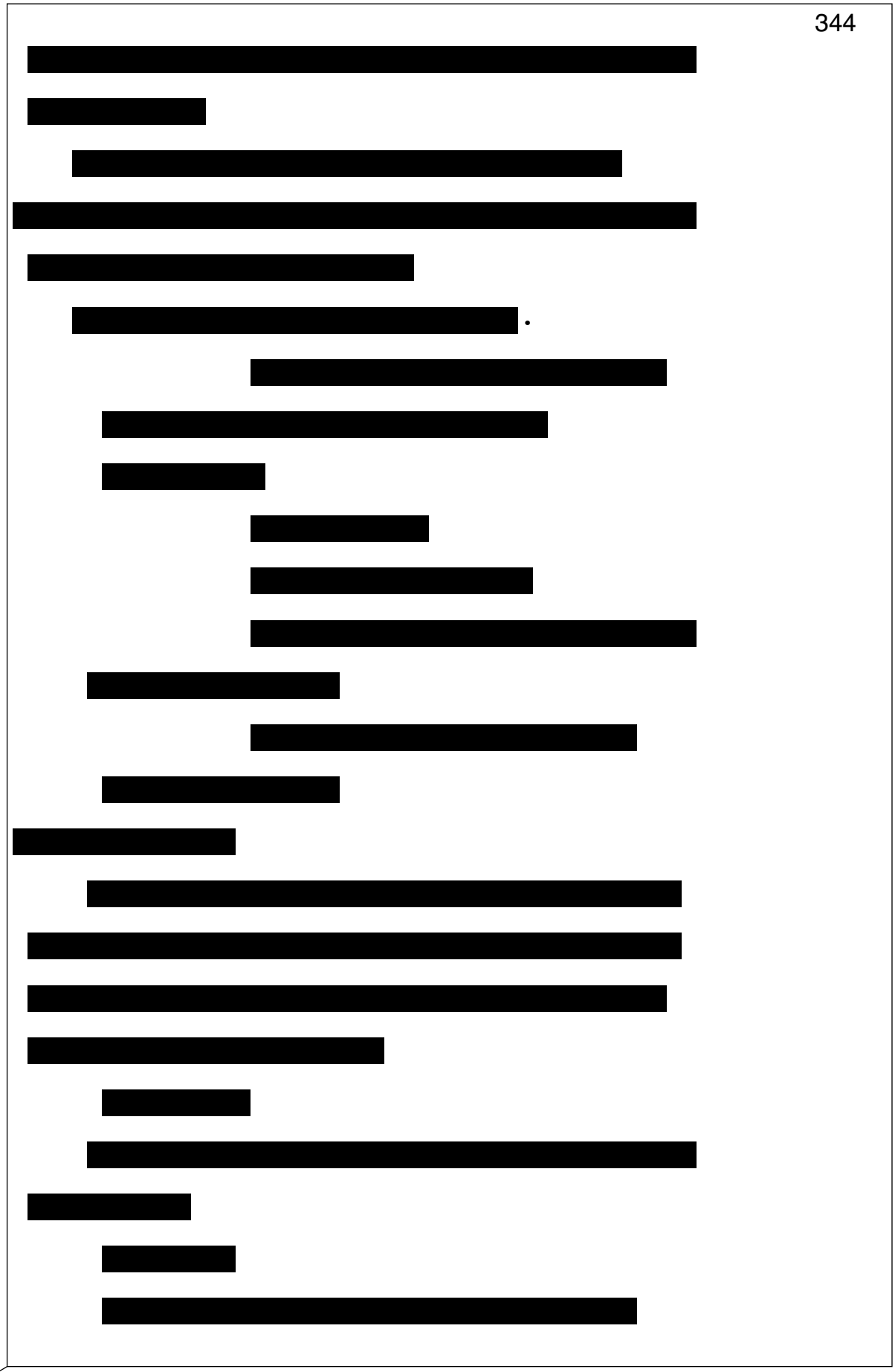
BY MR. CROOKS:

Q. Okay. And do you believe that with that competition, prices would be lower for businesses and for patients?

MS. JOHNSON PALMER: Same objections.

THE WITNESS: Yes.





[redacted]

Q. Okay. And how about the network design that we've been talking about today which requires a lot of input from Aurora, both in the design of the network and the benefit differential?

Would you describe those as operational irregularities?

MS. JOHNSON PALMER: Objection. Form. Foundation. Hypothetical. Speculative.

THE WITNESS: Yes.

BY MR. CROOKS:

Q. These are things you don't have to do with other hospital systems, but you do have to do with Aurora?

A. Yes.

[redacted]

[redacted]

Q. Okay. And isn't it the case that in 2012, 2016, 2017, 2020, as we saw today, that Anthem wanted to get out of -- from under the all-plans clause?

MS. JOHNSON PALMER: Objection. Form. Misstates the record. Foundation.

THE WITNESS: Yes.

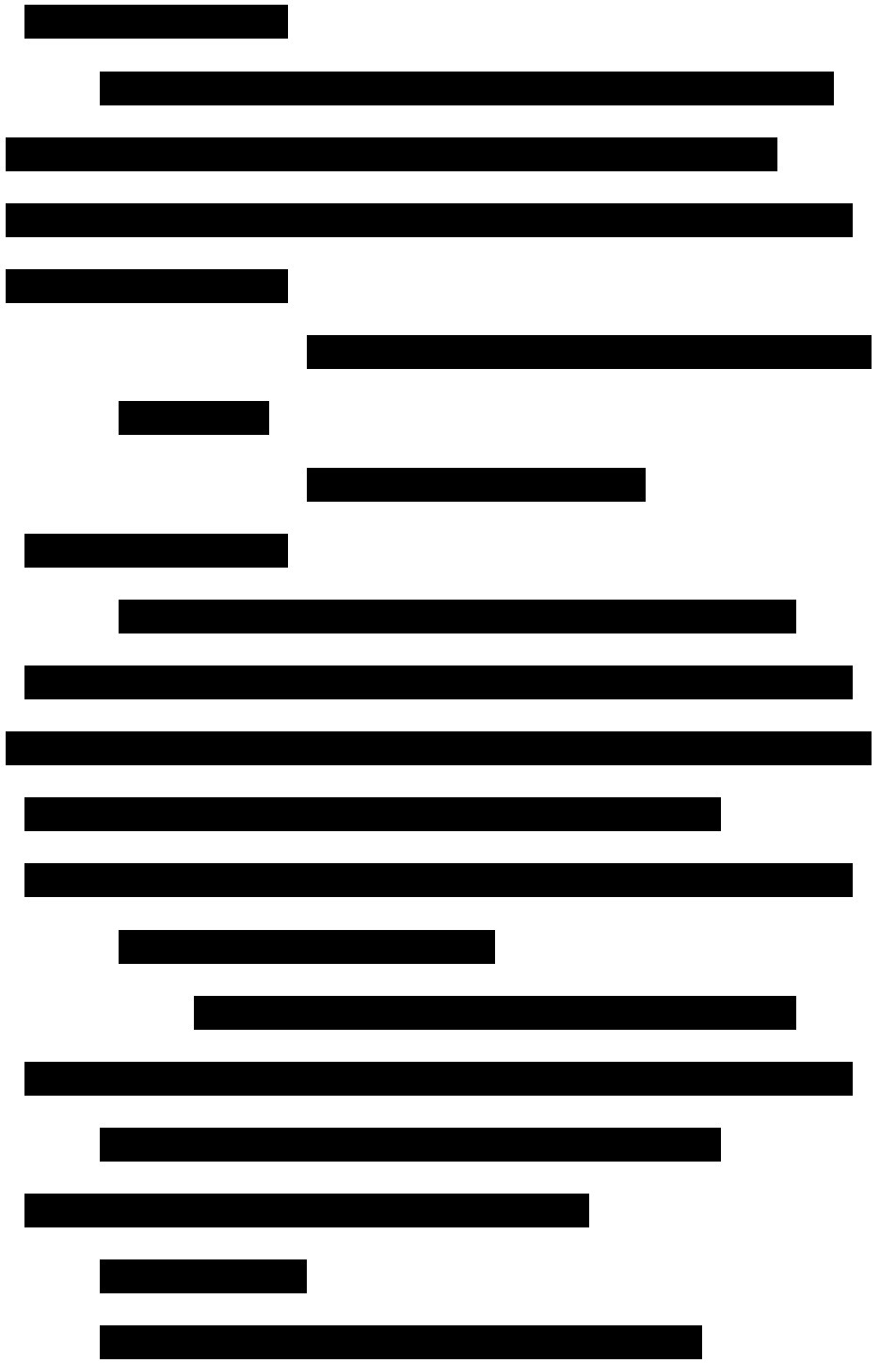
BY MR. CROOKS:

Q. And so the 15-year contract also had the effect of keeping that provision in place longer than it would have under a shorter contract; is that right?

MS. JOHNSON PALMER: Same objections. Foundation and assumes facts.

THE WITNESS: It was language

that, throughout the renegotiation and amendments that we did with Aurora, language that we always brought up to try to get rid of.



# Exhibit 24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[redacted]

Q. Okay. When she says, employers feel strongly about their ability to use their benefit plans to help them control healthcare costs -- I think we may have talked about some of these, and if it's -- if that's the case, just -- we can talk about the same thing, but what are some ways that employers may use their benefit plans to help control the healthcare costs?

A. I think there is a lot of different ways they could. I think what's specifically being referenced here is around steerage that we had talked about before where an employer may want to incentivize their members to utilize a lower cost, higher quality -- quality alternative than -- that may be in play in the -- in the general network as it's structured.

Q. Okay; and is it your understanding that at this time, in February 2021 WPS was -- and its -- its employer or customers were not able to use steering to drive patients away from Aurora?

A. That was my understanding.

[redacted]

[redacted]

Q. Okay. I mean, at this time Ms. Oliva is certainly of the belief or at least she's stating that employers want to steer in order to control healthcare costs; correct?

MR. TSAI: Objection, form.

A. Absolutely.

BY MR. CROOKS:

Q. I'm sorry?

A. I would agree.

Q. And at this point in time that dynamic could not exist with respect to Aurora because of the All Plans provision?

A. That was our interpretation.

[redacted]

Q. Okay, so she's saying that Aurora was willing to offer a 5% discount for WPS' exchange product, would it be willing to do the same here in exchange for being in Tier 1.

Am I understanding that correctly?

A. Yes.

Q. Okay; and I hate to belabor the point, but the idea is Aurora may be willing to do that because being in Tier 1 with the 90% co-insurance would encourage more patients to go there, so perhaps they'd be willing to offer a 5% discount off the price; is that right?

A. I can't speak to what Aurora's thinking, but I think that's a fair assumption.

Q. That's the purpose of an offer like this?

A. Yes.

Q. Okay, and, again, Aurora would not have been required to offer any discount to be in Tier 1 under the 2012 All Plans clause.

It was automatically included; correct?

A. That's my understanding.

[redacted]

[redacted]

Q. Okay, and just to clarify one other thing. You testified earlier in response to a question from Mr. Tsai that steerage creates a, quote, tremendous opportunity to help patients save money.

Am I right about that?

A. I think that's fair.

Q. Okay, and just one more time. The All Plans clause, as it existed before it was modified in 2022-23, prevented steering; is that right?

A. That was our interpretation, yes.

Q. And that was part of the reason why for multiple times over the years WPS had asked Aurora to remove or alter that clause; is that right?

A. It's one of the reasons.

[redacted]

Q. Okay, and are you familiar with whether it's any of the systems whose contracts you looked at a short while ago or other systems in Wisconsin that have anything that resembles the All Plans clause that Aurora had before it was removed in 2022-23?

A. Nothing that went to that extent. There were some that have similar requirements to have them be included at the top tier in network offerings, but I don't know if any of the language was quite to the extent that was in the original Aurora agreement.

[redacted]

Q. Okay. Do you believe that there are any, quote, Aurora-necessary markets, markets in which Aurora has market power and a dominate market position in Wisconsin?

MR. TSAI: Objection to the extent it calls for expert testimony, lacks foundation.

A. I think there are markets where not having Aurora would be detrimental to your ability to offer a market viable product.

BY MR. CROOKS:

Q. A commercially viable product; is that fair?

A. That's fair.

[redacted]

[redacted]

Q. And you do think there are such regions or markets where that's the case?

A. I think there is probably segments within southeast Wisconsin where it would be challenging to get meaningful market share without their inclusion.

[redacted]

# Exhibit 26

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN FRANCISCO

# Document Scanning Lead Sheet

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Case Number: CGC-14-538451

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ORDER

UFCW & EMPLOYERS BENEFIT TRUST ON BEHALF OF VS. SUTTER HEALTH et al

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SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN FRANCISCO

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|---|---|
| UFCW & EMPLOYERS BENEFIT TRUST, et al.,<br>Plaintiff,<br>vs.<br>SUTTER HEALTH, ET AL.,<br>Defendants. | Case No. CGC – 14-538451<br><br>**ORDER GRANTING IN PART MOTION TO STRIKE, GRANTING CLASS CERTIFICATION, AND SETTING CASE MANAGEMENT CONFERENCE** |

**Introduction**[1]

Plaintiff UFCW & Employers Benefit Trust (UEBT) brought this putative class action alleging that defendants Sutter Health and its affiliated corporations (Sutter) violated California's Cartwright Act and Unfair Competition Law by illegally inflating hospital pricing and compelling Network Vendors (described below) to enter into anticompetitive healthcare provider agreements.

Millions of people in Northern California enroll in group health plans providing access to healthcare services from a select group of healthcare providers (including hospitals) at established rates. The benefits are paid by either the employer or a healthcare benefits trust, sometimes out of its own funds (making the employer or trust a "Self-Funded Payor"). Network Vendors negotiate with healthcare providers for the prices of the services and products they sell,

[1] This background is drawn largely from the complaint.

and assemble the providers into larger Provider Networks. Self-Funded Payors then contract with Network Vendors to obtain access to their Provider Networks and consequently, their negotiated prices.

Sutter is the largest healthcare provider in Northern California. The five major Network Vendors in Northern California are Blue Shield of California, Anthem Blue Cross, Aetna, Cigna, and United Healthcare (also known as PacifiCare). Plaintiff UEBT, a Self-Funded Payor, alleges Sutter uses its dominant economic power to compel Network Vendors to agree to anticompetitive terms in their provider agreements. These agreements contain (1) non-par contract provisions (or "all or none" provisions), (2) anti-tiering provisions through which Sutter refuses to participate in narrow networks, (3) provisions which block price transparency. These agreements constrain the types of Provider Networks that the Network Vendors can offer to their customers, and consequently harm Self-Funded Payors, who must pay substantially inflated prices for their enrollees' healthcare.

UEBT now moves for class certification. I heard argument July 28, 2017. The motion is granted. I set a case management conference in the Conclusion.

**Class Definition**

UEBT defines the class as:

> [A]ll self-funded payors that are (a) citizens of California for purposes of 28 U.S.C. § 1332(c)(1) or (d)(10) or (b) arms of the State of California and that compensated Sutter for general acute care hospital services or ancillary products at any time from January 1, 2003 to the present at prices set by contracts between Sutter and Aetna, Anthem, Blue Shield, Cigna, PacifiCare or United Healthcare.

Reply ISO Class Cert. at 17–18. This is almost, but not quite, the definition proposed in the complaint. Complaint ¶ 126.

**Evidence**

UEBT offered declarations from its counsel, their expert Jeffrey Leitzinger, and the client. UEBT also provided declarations from Network Vendors attesting to the anticompetitive contract structure described above. Sutter provided declarations from its counsel, its expert Margaret Guerin-Calvert, and the client.

**Motion to Strike & Summary of Expert Declarations**

Dr. Leitzinger found that (1) "the aggregate amount of overcharges incurred by the proposed Class as a result of the alleged anticompetitive conduct can be calculated on a class-wide, formulaic basis" and (2) "evidence that is common to members of the proposed Class can be used to show that all or nearly all proposed Class members likely incurred at least some overcharge." Leitzinger Corrected Dec. ("Leitzinger") ¶ 6. Leitzinger used multiple regression analysis to estimate the overcharge in prices as a result of Sutter's alleged anticompetitive practice by looking at hospital reimbursement rates compared with billed charges, and isolating variables to account for other possible influences on the data. *Id.* at ¶¶ 43–56. He found common proof showing antitrust impact in the form of (1) the manner in which reimbursement is calculated, (2) evidence of parity across Network Vendors in reimbursement terms, (3) evidence of commonality across provider agreements in contract terms and broad overcharges, and (4) claims data from Network Vendors showing higher average reimbursement rates for Sutter compared with other California hospitals in inpatient and/or outpatient and emergency hospital services. *Id.* ¶¶ 73–79.

Ms. Guerin-Calvert's opposing declaration finds flaws in Leitzinger's analyses. She contends that he improperly aggregates products (treating inpatient and outpatient services as the

same, when they are statistically significantly different, for example), measures only average impact across services, fails to control for other factors that drive hospital pricing, and fails to articulate any plausible theory for how contract provisions affected healthcare pricing. Guerin-Calvert Second Corrected Dec. ("Guerin-Calvert") ¶¶ 6–12. In short, there is too much diversity in the claims at issue, and a common methodology cannot show impact for all (or nearly all) class members. *Id.* at 62.

In reply, Leitzinger seeks to refute each of Guerin-Calvert's criticisms of his regression model, and explains why his analysis does account for variation across class members. He says the purpose of his regression model is to show the feasibility of calculating aggregate class-wide overcharges, not to prove common impact. Leitzinger Reply ¶ 4. Economists use averages to analyze aggregate pricing impact all the time, and his model also effectively controlled for things other than Sutter's challenged conduct. *Id.* ¶ 11.

Turning then to impact, Leitzinger then set forth "further evidence of common impact," explaining that there was commonality across contracts, hospitals, plan designs, and over time. *Id.* ¶¶ 18, 49–51, 105–22.

At an ex parte hearing on May 31, I permitted Guerin-Calvert to file a sur-reply declaration. Order Granting Sutter's Ex Parte Motion (entered June 1, 2017). I wrote that UEBT could move to strike portions of the sur-reply declaration "to the extent it goes beyond impeachment of plaintiff's expert reply materials." *Id.* UEBT now does so, arguing that Guerin-Calvert's sur-reply declaration improperly contains new evidence, i.e., she performed new analyses, constructs new variables, proposes new price measures, and develops a new theory and analysis on the impact of prices on class members, none of which served to impeach Leitzinger's testimony. UEBT says Exhibits 4–9 and 11–15 are new analyses that should be stricken.

The sur-reply declaration does include additional analyses, but generally for the purposes of impeachment. Exhibit 4 takes two data sets that Leitzinger used, and attempts to show that extending the same analysis to observe differences in other variables reveals there is a wider range of reimbursement rates than what Leitzinger concluded. Guerin-Calvert Sur-Reply Dec. ¶ 4 n. 3. Exhibit 5 does the same expansion to show that there is more variation than Leitzinger contends. *Id.* Exhibits 6 and 7 serve to counter Leitzinger's analysis of outpatient reimbursement ratios to show that Sutter's charges grew more slowly over the relative period than those of other providers. *Id.* ¶ 6. This attacks Leitzinger's assertion that Sutter's reimbursement rate remained flat while the rate or other providers declined. *Id.* Exhibit 8 assertedly provides a different look at overcharges across time periods from that provided by Leitzinger. *Id.* ¶ 7 n. 10. Exhibit 9 attacks Leitzinger's choice of a certain year as the "dummy" year. *Id.* ¶ 7. Exhibits 11A and 11B, 12–13 suggest that had Leitzinger taken pricing for specific services and geographic areas into account, the average reimbursement rates and allowed amounts per claim would be different than what Leitzinger asserts. *Id.* ¶¶ 11, 13. Exhibit 15 is an example designed to show that Leitzinger fails to account for caps on claims. *Id.* ¶¶ 14, 16.

Exhibits 12–14 appear to be based on data or analyses that were not previously relied upon or raised in Leitzinger's reply declaration. Accordingly, they could have been raised in Guerin-Calvert's opposition declaration. These are stricken from the sur-reply, along with corresponding paragraph 13 in the sur-reply declaration.

**Market Structure**

A. Sutter has noted that plaintiffs have no analysis of the market structure and by implication market power in this antitrust case, and that their expert has nothing to say on

geographical markets or whether Sutter has market power in any of them (or it). Transcript of Argument (Tr.) at 63. But markets are not defined for their own sake; they are defined so as to evaluate in their context whether a defendant has for example power to control prices. *Cohlmia v. St. John Med. Ctr.*, 693 F.3d 1269, 1282 (10th Cir. 2012). It is that power which matters. Market definition also allows the evaluation of whether a restraint was reasonable or not, and provides the focus for proof that harm was done to competition as such, not just to a market participant such as a plaintiff. E.g., *Marsh v. Anesthesia Serv. Med. Grp., Inc.*, 200 Cal. App. 4th 480, 496 n.5 (2011). Raising the issue now, Sutter implies that without market definition, class wide impact cannot be shown, Tr. at 63 *et seq.* But that does not follow. As discussed below, supracompetitive pricing can be shown with regression analyses. True, market power can be a predicate to anticompetitive injury, but where anticompetitive injury is shown directly as with supracompetitive pricing there may be no need to show market power as such to establish class wide impact.[2] And on the merits plaintiffs allege that Sutter has the "power to raise price significantly above the competitive level without losing all of [its] business)," which *is* market power.[3]

B. As discussed below, the parties have very different views of the product market, and in anticipation of that it worth here making a few notes. For plaintiffs the market is not one in which patients decide where to go for services, such as where to go for hip surgery, or for outpatient services such as setting broken bones and x-rays. Patients are not class members. The market is available to Network Vendors who are 'in the market' as it were for *networks or collections* of services available at hospitals across northern California. Class members sign up for the choices Network Vendors have been offered. Tr. at 24; Motion at 4:9-17. Because this

[2] For what it's worth, the alleged geographical market is probably Northern California. Tr. at 18-19.
[3] *Redwood Theatres, Inc. v. Festival Enterprises, Inc.*, 200 Cal. App. 3d 687, 704 (1988). See evidence cited below at p. at 7:7-10.

agglutination of services is offered through hospitals, plaintiffs focus on what they term competition at the hospital level, Tr. 96-97; and this is why they reject the service-by-service approach urged by Sutter and its expert. Under plaintiffs' theory of the case, it doesn't matter if an x-ray is cheaper at a non-Sutter hospital; if plaintiffs are right on the merits, the patient will still go to the (assertedly) more expensive Sutter hospital for the x-ray as a function of restraints at the hospital level. Here, there is no pertinent service by service market. UEBT has evidence that Sutter is sufficiently pervasive in the areas over which plaintiffs must have access to hospitals that it is not possible to have a plan that excludes Sutter. Wheler Dec. Ex 5 at ABCLH396710. See also evidence at Motion at 4 note 4.

**Certification**

*Basics*

It is UEBT's burden to show an ascertainable and sufficiently numerous class, a well-defined community of interest, and substantial benefits from certification that makes a class action superior to alternatives. *Brinker Restaurant Corp. v. Super. Ct.*, 53 Cal. 4th 1004, 1021 (2012) (citing C.C.P. § 382). The "community of interest requirement embodies three factors: (1) predominant common questions of law or fact; (2) class representatives with claims or defenses typical of the class; and (3) class representatives who can adequately represent the class." *Id.* See generally *In re Cipro Cases I & II*, 121 Cal. App. 4th 402, 409–10 (2004); *Martinez v. Joe's Crab Shack Holdings*, 231 Cal. App. 4th 362, 372 (2014).

Frequently, the predominance issue is controlling. *Dep't of Fish & Game v. Superior Court*, 197 Cal. App. 4th 1323, 1334 (2011); *In re Cipro Cases I & II*, 121 Cal. App. 4th at 410. That is the case here.

> The predominance factor requires a showing 'that questions of law or fact common to the class predominate over the questions affecting the individual members.' [Citation.] 'The ultimate question in every case of this type is whether ... the issues which may be jointly tried, when compared with those requiring separate adjudication, are so numerous or substantial that the maintenance of a class action would be advantageous to the judicial process and to the litigants.'
>
> *In re Cipro Cases I & II,* 121 Cal.App.4th at 410.

The balancing inherent in the predominance analysis contemplates the existence of individual issues, including perhaps on damages, in properly certified classes; as always, the issue is whether the common or individual issues *predominate*. This is not a question of counting issues, for indeed "a single common question can suffice." *In re Processed Egg Prod. Antitrust Litig.*, 312 F.R.D. 171, 179 (E.D. Pa. 2015), citing *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 359 (2011). Rather, predominance often comes down to manageability.[4] Courts evaluate the matter through the lens of the plaintiffs' theory of the case—that is, whether the plaintiffs' "theory of recovery" presents sufficient common issues. *Jaimez v. DAIOHS USA, Inc.,* 181 Cal. App. 4th 1286, 1298 (2010). Antitrust cases in particular lend themselves to class actions with predominating common issues, at least "where the defendants are alleged to have engaged in collusive, anticompetitive conduct resulting in artificially high market-wide prices for a product." *In re Cipro Cases I & II*, 121 Cal. App. 4th at 411. See also, e.g., *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 815 (7th Cir. 2012) (predominance is key issue and is often satisfied in antitrust cases).

[4] *In re New Motor Vehicles Can. Exp. Antitrust Litig.*, 522 F.3d 6, 20 (1st Cir. 2008) (the court must "formulate some prediction as to how specific issues will play out in order to determine whether common or individual issues predominate in a given case"); *Dep't of Fish & Game v. Superior Court*, 197 Cal. App. 4th at 1332–33 ("'A class action can be maintained even if each class member must at some point individually show his or her eligibility for recovery or the amount of his or her damages, so long as each class member would not be required to litigate substantial and numerous factually unique questions to determine his or her individual right to recover.' (*Acree v. General Motors Acceptance Corp.* (2001) 92 Cal.App.4th 385, 397, 112 Cal.Rptr.2d 99.) 'Individual issues do not render class certification inappropriate so long as such issues may effectively be managed.' [citing] *Sav-on Drug Stores, Inc. v. Superior Court* (2004) 34 Cal.4th 319, 334...").

The landscape of this case, with its many services, prices, and discounts, presents a more complex economic picture than the sale of one drug, but the *Cipro* case suggests that certification may nevertheless be warranted in complex markets. *In re Cipro Cases I & II,* 121 Cal. App. 4th at 413 ("markets characterized by individually negotiated prices, varying profit margins, and intense competition, as well as to indirect purchasers who buy the product from middlemen in a largely unaltered form"). See also *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 816 (7th Cir. 2012), a case heavily relied on by both sides, which suggests that even in the "market for hospital services [which] seems to be particularly complex," certification may be proper.

*Certification Factors*

**1. Numerosity**

The class includes well over 1500 California self-funded health plans that pay Sutter for the healthcare charges incurred by their employee-members, instead of purchasing insurance to cover those costs. Motion Class Certification (Motion) at 1, 16. Leitzinger ¶ 28 and Ex. 5. Sutter does not dispute numerosity.

**2. Ascertainability**

"Whether a class is ascertainable is determined by examining (1) the class definition, (2) the size of the class, and (3) the means available for identifying class members." *Hale v. Sharp Healthcare*, 232 Cal. App. 4th 50, 58 (2014) (internal quotation marks and citations omitted); *Miller v. Bank of America, N.A.*, 213 Cal. App. 4th 1, 7 (2013). See generally *Nicodemus v. Saint Francis Mem'l Hosp.*, 3 Cal. App. 5th 1200, 1214 (2016). The central concerns addressed by the ascertainability requirement are to have objective criteria so that (1) class members know if they are in the class or not, and for res judicata evaluations after

judgment, and (2) to enable notice. E.g., *Byrd v. Aaron's Inc.*, 784 F.3d 154, 163-165 (3d Cir. 2015).[5]

UEBT contends that data provided by the five major Network Vendors identifies all self-funded health plans that purchased general acute care hospital services or ancillary products from Sutter during the class period. Motion at 16. These plans can be reviewed to identify those that were California citizens for the relevant time period. Publicly available data maintained by the California Secretary of State facilitates this examination. *Id.* at 17.

Sutter argues that class members cannot be readily identified without unreasonable expense or time. Opposition to Class Certification motion (Opposition) at 28. Sutter has already identified instances where an entity was included on the plaintiffs' class list but was not the actual payor, or was not a California citizen. *Id.* at 29.

Class members can be identified from the Network Vendors' records. There may be individual class members that are, as Sutter points out, just subsidiaries covered by a parent company's health benefit plan, or where their claims or right to sue were transferred. Opposition at 29. But that potential confusion is resolved because the proposed class definition now calls for "self-funded payors" instead of "self-funded health plans." Reply ISO Class Certification (Reply) at 17. Those self-funded payors will be able to determine whether or not they belong in the class, because they will know if they are a California citizen or not. The fact that an

[5] Sutter's argument could be understood as an objection that it is administratively infeasible to identify each individual class member. But we should not wade into the disagreements on this issue such as those between the Third and Ninth (and other) Circuits. Compare *Briseno v. ConAgra Foods, Inc.*, 844 F.3d 1121, 1127 (9th Cir. 2017), *In re Petrobras Sec.*, 862 F.3d 250, 268 (2d Cir. 2017). It does not appear that California courts have endorsed the administratively infeasible element; for our purposes, we can say that meeting California's ascertainability element furthers the notice requirements. *Nicodemus v. Saint Francis Mem'l Hosp.*, 3 Cal. App. 5th 1200, 1214 (2016). As is true for the Ninth Circuit, when notice is issued California courts just require the best notice practicable. *Briseno*, 844 F.3d at 1128–29; CRC 3.766 (e); *Duran v. Obesity Research Inst., LLC*, 1 Cal. App. 5th 635, 647 (2016).

individualized inquiry may be needed to identify some of the class members does not defeat ascertainability. *Nicodemus v. Saint Francis Mem'l Hosp.*, 3 Cal. App. 5th 1200, 1214 (2016).

In an argument developed mostly in its Sur Reply (at 8), Sutter contends that it is not permissible to include governmental entities in the class. See also Opposition at 29. These issues do not affect the fundamental issues on certification, or of ascertainability specifically, and can be dealt with in later proceedings.

The class is ascertainable.

**3. Community of interest**

**A. Predominance**

The "ultimate question for predominance is whether the issues which may be jointly tried, when compared with those requiring separate adjudication, are so numerous or substantial that the maintenance of a class action would be advantageous to the judicial process and to the litigants." *Duran v. U.S. Bank National Assn.*, 59 Cal. 4th 1, 28 (2014) (internal quotation marks and citations omitted). The Eleventh Circuit has a nice practical formulation of the test:

> [I]f common issues truly predominate over individualized issues in a lawsuit, then the addition or subtraction of any of the plaintiffs to or from the class [should not] have a substantial effect on the substance or quantity of evidence offered.... If, on the other hand, the addition of more plaintiffs leaves the quantum of evidence introduced by the plaintiffs as a whole relatively undisturbed, then common issues are likely to predominate.[6]

UEBT's theory of liability is that Sutter implemented its anticompetitive scheme through substantially identical contract provisions with Network Vendors that restricted their ability to offer narrow networks, tiered products, and transparency to the self-funded health plans. Motion at 18. The common issues putatively include (1) whether Sutter engaged in challenged practices, (2) what impact Sutter's contracting practices had on hospital competition, (3) what impact Sutter's practices had on class members' payments, (4) what the amount of damages is for

[6] *Brown v. Electrolux Home Prod., Inc.*, 817 F.3d 1225, 1235 (11th Cir. 2016), quoting *Vega v. T-Mobile USA, Inc.*, 564 F.3d 1256, 1270 (11th Cir. 2009).

impacted class members, and (5) whether or not claims are barred by the statute of limitations. *Id.* at 20–21. This can be shown through common proof of the provider agreements, testimony from each Network Vendor explaining how the contracts inhibited their creation of cost-effective networks and restricted their ability to promote price competition, and an economic expert report that analyzed impact and found class-wide overcharges. *Id.* at 19. Even if the anticompetitive policies were not always enforced, there is still a common issue of whether Sutter restrained enough of the market to harm competition and inflate healthcare pricing. *Id.* This can also be shown through common proof of Sutter engaging in challenged practices. *Id.* at 20.

(i) **Contract provisions**

UEBT presented the contract provisions across all provider agreements for all Network Vendors in Appendix A. The language across the agreements for these material provisions are substantially similar. The contract provisions at issue include (1) all or nothing terms requiring the Network Vendor to include all Sutter providers in their plans, (2) non-participating provider rates at no less than 95% of billed charges, (3) parity among all Sutter providers, (4) no participation in tiered products, plans, or benefit designs, and (5) a confidentiality clause that prohibits disclosures unless authorized in writing, promoting price secrecy. *See* Appendix A.

The Network Vendors are in agreement that these contract provisions restricted their ability to promote price competition and create more cost-effective networks:

*All or nothing terms*. Sutter requires Network Vendors to include all Sutter providers in any plans, to the extent that *any* Sutter provider is included.[7] This made narrow networks

[7] Melody Dec. (Anthem) ¶ 12; De La Torre Dec. (Anthem) ¶ 13; Joyner Dec. (Blue Shield) ¶¶ 15–17, 19; Barnes Dec. (Blue Shield) ¶¶ 6–7; Katz Dec. (Cigna) ¶ 13; Hamilton Dec. (Cigna) ¶ 4; Welsh Dec. (Aetna) ¶ 13; Lacroix-Milani Dec. (HealthNet) ¶ 34; Lundbye Dec. (United) ¶ 8.

commercially unviable by eliminating any savings that would have accompanied exclusion of higher-priced Sutter providers.[8]

*Non-participating provider rates*. Sutter required that payors pay Sutter a substantial percentage (95 % or higher, as seen from the provider agreements) of the billed charges to any Sutter provider who was not participating in the network.[9] This had the effect of carrying on the all-or-nothing contracting practice.[10] Even if Sutter permitted some of its hospitals to participate in narrow networks, the non-par provision negated any savings.[11]

*Parity and anti-tiering*. Sutter blocks or undermines Network Vendors' attempts to create tiered products, or at least place Sutter in a top tier.[12] Sutter also requires Network Vendors to agree to equal treatment of all Sutter providers that participate in the plan.[13] Overall, this restricts Network Vendors' ability to both steer members to lower-priced providers, or expose Sutter to any competition to get Sutter to moderate its high prices.[14]

*Price secrecy*. Sutter imposes confidentiality provisions in its agreements that prohibit disclosure of Sutter's pricing.[15] Sutter also consistently opposes Vendor attempts to create cost comparison tools for members.[16]

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[8] Melody Dec. (Anthem) ¶ 14; Ramseier Dec. (Anthem) ¶ 7; Joyner Dec. (Blue Shield) ¶ 35.
[9] Melody Dec. (Anthem) ¶ 17; De La Torre Dec. (Anthem) ¶¶ 15–16; Joyner Dec. (Blue Shield) ¶¶ 34–35, 37, 39; Barnes Dec. (Blue Shield) ¶ 16; Katz Dec. (Cigna) ¶¶ 17–18; Hamilton Dec. (Cigna) ¶ 5; Lundbye Dec. (United) ¶ 9.
[10] Melody Dec. (Anthem) ¶ 18; Katz Dec. (Cigna) ¶ 15; Lundbye Dec. (United) ¶¶ 10–12.
[11] Melody Dec. (Anthem) ¶¶ 20–23; De La Torre Dec. (Anthem) ¶ 14; Joyner Dec. (Blue Shield) ¶ 40.
[12] Melody Dec. (Anthem) ¶¶ 25–26, 29; De La Torre Dec. (Anthem) ¶¶ 22–23; Ludkins Dec. (Anthem) ¶¶ 3, 10; Joyner Dec. (Blue Shield) ¶ 51; Barnes Dec. (Blue Shield) ¶ 20; Katz Dec. (Cigna) ¶ 19; Hamilton Dec. (Cigna) ¶ 10; Welsh Dec. (Aetna) ¶¶ 17–18, 21; Lacroix-Milani Dec. (HealthNet) ¶ 45.
[13] Melody Dec. (Anthem) ¶ 27; De La Torre Dec. (Anthem) ¶¶ 19–20; Welsh Dec. (Aetna) ¶ 47; Lacroix-Milani Dec. (HealthNet) ¶¶ 37–39; Lundbye Dec. (United) ¶ 17.
[14] Melody Dec. (Anthem) ¶ 30; De La Torre Dec. (Anthem) ¶ 26; Ramseier Dec. (Anthem) ¶ 10; Joyner Dec. (Blue Shield) ¶¶ 43, 54.
[15] Melody Dec. (Anthem) ¶¶ 33–34; De La Torre Dec. (Anthem) ¶¶ 30–31; Ramseier Dec. (Anthem) ¶ 7; Joyner Dec. (Blue Shield) ¶¶ 63, 65; Barnes Dec. (Blue Shield) ¶ 25; Katz Dec. (Cigna) ¶¶ 24–26; Hamilton Dec. (Cigna) ¶ 7; Welsh Dec. (Aetna) ¶ 15; Lundbye Dec. (United) ¶ 14.
[16] Melody Dec. (Anthem) ¶ 37; De La Torre Dec. (Anthem) ¶¶ 33–37; Katz Dec. (Cigna) ¶¶ 27–28; Welsh Dec. (Aetna) ¶¶ 37–38.

There is evidence that Network Vendors (and consequently, their self-funded payor members) were subject to the same or substantially similar restrictive contract provisions with Sutter, which consequently inhibited price competition in the marketplace. The nature and circumstances of the various provider agreements at issue raise common factual and legal issues for all self-funded payors who paid for healthcare services under these agreements.

(ii) **Impact**

Class actions are appropriate "[i]f plaintiffs have stated claims of illegality and impact which can be proved predominantly with facts applicable to the class as a whole, rather than by a series of facts relevant to only individual or small groups of plaintiffs." *Rosack v. Volvo of America Corp.*, 131 Cal. App. 3d 741, 752 (1982).[17] "In some cases, it is justified for courts to assume that consumers were injured when they purchased products in an anticompetitive market, even though the price and terms of sale for the price-fixed product were individually negotiated." *Global Minerals & Metals Corp. v. Super. Ct.*, 113 Cal. App. 4th 836, 855 (2003). A case warmly embraced both sides suggests that not every single class member must be shown to have suffered impact.[18]

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[17] See also, e.g. *Kizer v. Tristar Risk Management,* No. G052558, 2017 WL 3172823, at *6 (Cal. Ct. App. June 26, 2017 as modified July 26, 2017) ("Ordinarily, class treatment of a claim is appropriate if the facts necessary to establish liability are capable of common proof, including the so-called "fact of damage,"), quoting *Safeway, Inc. v. Superior Court of Los Angeles Cty.*, 238 Cal. App. 4th 1138, 1154 (2015).

[18] *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 818 (7th Cir. 2012) ("all or most of the [class] suffered some antitrust injury as a result of [allegedly illegal acts]. That was all that was necessary to show predominance for purposes of Rule 23(b)(3)."). See also, *In re Nexium Antitrust Litig.*, 777 F.3d 9, 21 (1st Cir. 2015) ("We do not think the need for individual determinations or inquiry for a *de minimis* number of uninjured members at later stages of the litigation defeats class certification."). At argument, plaintiffs' counsel argued that for the very few class members that under plaintiff's theory of the case may not have suffered actual dollar damages, they nevertheless suffered a sort of antitrust injury of being deprived of a sort of opportunity. Tr. at 12: 14:12 . This is not discussed in the opening papers and I ignore it. Nevertheless, I do find that the potential existence of a very small number of class members who may not be entitled to any recovery does not defeat certification. *In re Cipro Cases I & II*, 121 Cal. App. 4th at 418 (the "fact that certain members of the class may not have been injured at all does not defeat class certification").

Impact is frequently a key issue in antitrust cases, *Messner*, 669 F.3d at 808, and is often the key issue in the certification context,[19] as it is here. See e.g., Tr. 48. Here, there is evidence that Sutter's prices were well above the average in Northern California.[20] Almost all[21] class members were subject to those prices.

### *A. Experts: Rules in Certification Motions*

The outcome of the present motion depends chiefly on expert testimony. I review here the basic rules on the use of that evidence in this context.

I begin by noting that, as a general matter, trial judges are fact finders in the context of certification motion. Weil & Brown, et al., CALIFORNIA PRACTICE GUIDE: CIVIL PROCEDURE BEFORE TRIAL ¶ 14:99.5 (Rutter: 2017). "This extends to the resolution of expert disputes concerning the import of evidence concerning the factual setting-such as economic evidence as to business operations or market transactions." *Blades v. Monsanto Co.,* 400 F.3d 562, 575 (8th Cir. 2005).

However, there are varied standards for a trial court's evaluation of expert testimony in this context. It may be subject to (1) a preliminary review for general reliability, (2) a full *Sargon* examination as we might have in an Evid. C. § 402 hearing before trial, e.g., *Sargon Enterprises, Inc. v. Univ. of S. Cal.,* 55 Cal. 4th 747 (2012), or (3) in addition, consideration of whether I am *persuaded* by either the plaintiffs' or defendants' expert. See generally, William B. Rubenstein, NEWBERG ON CLASS ACTIONS, Use of expert testimony at the class certification

[19] Pierre Cremieux et. al., "Proof of Common Impact in Antitrust Litigation: The Value of Regression Analysis," 17 GEO. MASON L. REV. 939 (2010) ("class certification in an antitrust case often turns on the plaintiffs' ability to demonstrate impact from the alleged violation using common proof on a class-wide basis").
[20] E.g., Joyner Decl.¶¶ 26, 56-60; Del La Torre Decl. ¶ 5.
[21] A few class members may not have been affected, Motion at 14:6-9 (referring to a group of 3 rural Sutter hospitals, 99%+ class members estimated to have been affected).

stage § 7:24 (5th ed. 2016, as of June 2017 Update).[22] The problem, as Newberg notes, is that the merits are not resolved at the certification stage but experts often proffer opinions on those merits. It is not clear what the rule is in California state courts, but, like Newberg, I draw inspiration from the hints of the Supreme Court in *Wal-Mart*[23] that trial courts should apply *at least* the intermediate position I outlined, that is, to rely on the expert opinion if it meets the standards of *Daubert* (or, in state court, *Sargon*). Although I do not "resolve conflicts among the experts," I must nevertheless ensure expert opinions are "supported by the record," not based on "guess, surmise or conjecture," *Dep't of Fish & Game v. Superior Court,* 197 Cal. App. 4th at 1350–51; *In re Cipro Cases I & II,* 121 Cal. App. 4th at 412.

While the opinions have to be admissible in that sense, trial judges evaluating certification motions do more: as I have noted, they are fact finders too. They need to be persuaded. But the fact of which they need to be persuaded is not, exactly, the fact that the jury at trial will decide. To use an example from this case, the jury will be asked to decide if all class members were impacted by Sutter's actions; but I need only be persuaded that there is admissible common evidence of impact, presumably enough to support plaintiffs' prima facie case. As *Messner* puts it,

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[22] The treatise notes that for example the Eight Circuit uses a limited review, *Blades v. Monsanto Co.,* 400 F.3d 562, 575 (8th Cir. 2005). See also, e.g., *Tait v. BSH Home Appliances Corp.*, 289 F.R.D. 466, 494 (C.D. Cal. 2012) (adopting Eighth Circuit test in *In re Zurn Pex Plumbing Products Liab. Litig.*, 644 F.3d 604 (8th Cir.2011), to the effect that trial courts should scrutinize the reliability of the expert testimony in light of the criteria for class certification and the current state of the evidence). A complete *Daubert* review is generally undertaken in the Seventh Circuit. *Messner v. Northshore Univ. HealthSystem,* 669 F.3d 802, 812 (7th Cir. 2012); *Am. Honda Motor Co. v. Allen,* 600 F.3d 813, 815–16 (7th Cir. 2010) ("We hold that when an expert's report or testimony is critical to class certification…a district court must conclusively rule on any challenge to the expert's qualifications or submissions prior to ruling on a class certification motion. That is, the district court must perform a full *Daubert* analysis before certifying the class if the situation warrants."). The treatise also notes that the Ninth Circuit not only requires a trial court to find the expert opinion is admissible, but also that it is persuasive. E.g., *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970, 982 (9th Cir. 2011) ("the district court seemed to end its analysis of the plaintiffs' evidence after determining such evidence was merely admissible.").

[23] *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 354 (2011) (to the suggestion that *Daubert* did not apply, the Court responded, "We doubt that is so….").

> plaintiffs' "burden at the class certification stage [was] not to prove the element of antitrust impact," but only to "demonstrate that the element of antitrust impact *is capable of proof at trial* through evidence that is common to the class rather than individual to its members." *Behrend v. Comcast Corp.*, 655 F.3d at 197....[24]

It is also not clear whether my review is affected by the procedural fact of whether or not the expert opinion was the subject of a motion to strike or exclude. Without such a motion, expert opinions might simply be delivered at trial without *Sargon*-based scrutiny.[25] In class certification contexts the issue is often generated by a motion to exclude, e.g., *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 811–12 (7th Cir. 2012). No such motion was made here, and indeed at argument it was unclear whether Sutter thought Leitzinger's opinion was weak, unpersuasive, or literally inadmissible. I conclude it doesn't matter whether Sutter formally moved to exclude.[26] I am nevertheless required to scrutinize the expert opinion as outlined in this section. *Dep't of Fish & Game v. Superior Court,* 197 Cal. App. 4th at 1350–51; *In re Cipro Cases I & II,* 121 Cal. App. 4th at 412.

The critical expert issues here are a function of the disputes between the parties' experts. For example, plaintiffs' Leitzinger claims is it is reasonable to rely on reimbursement rates as a proxy for price, and that the four to seven factors he discusses provide reliable proof of common impact (more on these below); defendants' Guerin-Calvert disagrees, and if she's right, I should presumably disregard Leitzinger's evidence. While I am not permitted to 'resolve conflicts among the experts,' nevertheless I have been presented with evidence—by experts—that the other expert's opinions are assertedly unreliable, which is an issue courts *are* supposed to decide.

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[24] *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 818 (7th Cir. 2012).

[25] E.g., M. Simons, CALIFORNIA EVIDENCE MANUAL § 4:1 ("*If* an objection is lodged" proponent shows expert is qualified, etc.) (emphasis supplied).

[26] Because admissibility is almost always a function of the purpose for which evidence is proffered, one can imagine an opinion inadmissible at trial under e.g. *Sargon*, but admissible at the certification stage to show commonality.

There is no bright line here,[27] but fundamentally courts to look at whether (1) the *foundations* of an opinion are a reasonable basis for the opinion (i.e., the opinion is not based on speculation), *Sargon,* 55 Cal. 4th at 770, and (2) under Evid. C. § 802 , the reasons, as a matter of *logic*, are sound. Id. at 771, 772; *Taylor v. Trimble,* No. B276723, 2017 WL 3187388, at *6, note 15 (Cal. Ct. App. July 27, 2017). Contradictory expert testimony may be perfectly acceptable. *Id.* at 772.[28]

Some of issues presented by the competing expert declarations are whether a *range* of figures is a permissible basis for a conclusion, or whether the range is so broad it would be speculative to rely on it. For example, parity across networks vendors is described in Leitzinger ¶ 75, and attack by Guerin-Calvert in her declaration at ¶146. Leitzinger responds that he has still shown substantial parity. Leitzinger Reply at ¶ 106. *How much* parity is enough is a subject the court cannot decide absent some further showing that the figures of one or the other expert are, in the disciplines in which they practice, unsupportable. Generally, I do not have that showing,[29] and the parties' papers have not assisted in figuring out how to handle the many disagreements between the two experts. Plaintiffs just relegate them to the jury, dubbing them common issues which do not block certification. Sutter treats each disagreement—and (depending how one counts her comments) Guerin-Calvert's declarations include hundreds of areas in which she disputes Leitzinger—as proof that Leitzinger's opinions are all unsupportable.

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[27] *Sargon Enterprises, Inc. v. Univ. of S. Cal.,* 55 Cal. 4th 747, 769 (2012), quoting Judge Friendly, see 1 Wigmore, Evidence 409–410 (3d ed. 1940).

[28] Distinguish the *Kelly–Frye* (or, now, just *Kelly*) scenario where "a lack of general scientific acceptance" dooms the new scientific technique. *People v. Barney,* 8 Cal. App. 4th 798, 819 (1992). See generally, *People v. Jackson,* 1 Cal. 5th 269, 315 (2016).

[29] For an example of where judges can make such findings, many courts accept a "95 percent degree of confidence" for certain statistical results, *Bell v. Farmers Ins. Exch.,* 115 Cal. App. 4th 715, 753 (2004); *Woodfox v. Cain,* 772 F.3d 358, 380 (5th Cir. 2014) (99-95%), but not margins of error approaching 32 percent. 115 Cal. App. 4th at 756. See also, e.g., *ATA Airlines, Inc. v. Fed. Exp. Corp.*, 665 F.3d 882, 895 (7th Cir. 2011) (95%). The disagreements on e.g. parity cannot be resolved with these widely accepted rules.

### *B. Experts: Their Disputes*

I discuss here the core expert disagreement between the parties.[30]

#### a. *Services v. Hospital Level Analysis*

Perhaps the most important dispute between the parties is one where they do not quite join the issue. It is whether this antitrust case must be litigated at the services or hospital level, that is, whether for example the impact of bad acts[31] must be measured at a service-by-service level, or at a hospital level. Plaintiffs' theory is that the central bad acts operated at the hospital level: the 'all or nothing' requirements and anti-tiering provisions directed all patents to only Sutter hospitals, and the anti-price transparency provision affected all prices. Plaintiffs contend the 'market' at stake is that among hospitals, Motion at 20:6 ("Hospital competition"). I have described this above at pp. 5-6 ('Market Structure'). Expert findings that about 99% of the class members paid higher reimbursement rates at Sutter hospitals as opposed to non-Sutter hospitals presumably supports that view of the market, Motion at 20:20; Reply at 4:7 *et seq.*

Sutter does not directly take this on; its opposition assumes, or perhaps relies on a putatively common sense argument, that the effects on competition must be shown at the services level. See e.g. Opposition at 16:16-25; Sur Reply at 1. Sutter's services level argument is ultimately made in aid of the argument that plaintiffs cannot on a class-wide basis show *impact* of the bad acts. But I separate out these two issues, i.e. the level of competition (noted here) and impact (discussed later).

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[30] Not further discussed below is Leitzinger's use of OSHPD (Office of Statewide Health Planning and Development) data. Leitzinger addresses the issue at Leitzinger Reply ¶ 53 *et seq.*, noting that Guerin-Calvert's attack is predicated on her services-by-services approach to antitrust impact and damages in this case. (I separately address that approach above at pp. 5-6 ('Market Structure') and in the next section ('Services v. Hospital Level')). While Leitzinger disagrees with her criticisms, he nevertheless ran a further iteration of the overcharge model with Guerin-Calvert's suggested measure, and found no material difference. *Id.* at ¶ 61. OSHPD data is a reasonable basis for his opinions.

[31] This is my shorthand for Sutter's allegedly anticompetitive behavior in extracting from the network vendors contractual agreements as alleged in the complaint. See Motion at 3:3-12.

Sutter paints a picture with 5200 different services at 24 hospitals in 20 asserted geographical markets and asserts that in any class action plaintiffs would have to show that each of the services, as well as each of the "mixes" of services procured, would have to be shown on a case by case basis to be priced supracompetitively. Sur Reply at 1; 5:9-10. This can be described as an exceedingly complex system. Guerin-Calvert at ¶74. Sutter makes the point that the fact that the price of one service at one hospital is higher than at a competing hospital does not mean prices will be higher for some other service. Id. This is indisputably true, but it does not describe plaintiffs' theory of the case; indeed, Sutter's argument *assumes* a service level argument.

Plaintiff's theory is that the bad acts affected *hospital* competition, and that in turn prices for materially all[32] services were affected. Class members were as result assertedly confined to securing plans with Sutter hospitals. The complaint alleges a Sutter strategy whereby class members were compelled to choose Sutter hospitals for any medical services, not that they were compelled on a service-by-service basis and as a result ended up at a Sutter hospital.

In the abstract, one might have competition (and impacts on it) at a variety of levels: from the hospital level to services (or groups of services[33]) down to subservices and indeed to anything else for which an invoice can be created, such as crutches, bandages, and so on. This abstract truth does not require an analysis of services at any particular level. See Reply at 8 & authorities at *id.*, n. 12. As a matter of econometric and other market analysis, it is plausible that either party's view of market mechanisms will turn out to be valid. If the jury does not believe that Sutter's acts illegally constrained competition at the hospital level, or on summary judgment

[32] That is, enough services such that almost all class members were affected. Plaintiffs have noted a few class members who, under their theory, do not appear to have been affected. See notes 18, 21, above.
[33] E.g. the series of services associated with obstetrics, hip surgery, and so on, each of which is further divisible into a series of subservices.

it appears there is no evidence of it, plaintiffs will lose this case. But in this certification context, unless Sutter can demonstrate that plaintiffs' theory of recovery is infeasible because, for example, it misconstrues the law,[34] I am constrained to follow it.[35] (Sutter does not argue that as a matter of law the antitrust case cannot focus on hospital level competition.)

b. *Reimbursement Rates as Proxy for Price*

A central point expressly made by Sutter, and emphasized at argument, is that Leitzinger's use of reimbursement rates (RR) is not a valid proxy for price, in which case most of his analyses concomitantly fail. Opposition at 19:18 *et seq.*

As the parties agree, hospitals have 'list' or 'full' or 'billed' charge list of their services. Leitzinger ¶ 26; Leitzinger Reply ¶¶ 14, 64 *et seq*. The agreements with network vendors however, provide for discounts from list, and the difference is measured as the reimbursement rate (reimbursement amount divided by the list price, id. at ¶ 49). The parties also appear to agree that the list or billed charges are unaffected by the bad acts alleged,[36] and so Leitzinger has assumed billed charges reflect, by contrast, ordinary (legal) market forces.[37] Leitzinger Reply ¶ 114. Thus he concludes that the use of RR is valid to measure the effect of the alleged bad acts. Leitzinger at ¶¶ 27, 29.[38] He has described why RR can be a better approach than strict services pricing—because "services" under even the same code can vary widely, and thus "apples to

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[34] That is, in some cases the merits must be addressed because, for example, a motion for certification fails to address element of a cause of action, and the elements must be determined. *Linder v. Thrifty Oil Co.*, 23 Cal. 4th 429, 443 (2000) (enmeshed merits); *Dailey v. Sears, Roebuck & Co.*, 214 Cal. App. 4th 974, 99 (2013) (same).

[35] *Brinker Rest. Corp. v. Superior Court*, 53 Cal. 4th 1004, 1021 (2012) (following "theory of recovery advanced by the proponents of certification"), citing *Sav-on Drug Stores, Inc. v. Superior Court*, 34 Cal. 4th 319, 327 (2004).

[36] Leitzinger ¶ 49, Leitzinger Reply ¶ 116; Guerin-Calvert ¶ 53 (list prices based on cost and "market-based methods"); Tr. at 55 (Sutter counsel referring to list charge as set by "competition, … cost of the services, the capital needs of the hospital…..[and] sufficient margin to operate".

[37] That is, Leitzinger has assumed that the list prices reflect the value of services, and there is reasonable support for that assumption. Leitzinger Reply ¶ 64. See note 36. Sutter's description of the many factors that go into devising the list prices is consistent with this. The considerations include "local competitive circumstances, demands for its services, patient demographics, capital needs, and local costs." Opposition at 8:20-26.

[38] The difference, or delta, between list and reimbursed amounts could of course be the function of factors other than Sutter's bad acts, but that is what the multiple regression analysis is for. Leitzinger ¶ 56.

apples" comparisons can be difficult, Leitzinger Reply ¶ 14, and he in effect checked his work with a few examples using what he calls a coefficient of variation (CV), Leitzinger Reply ¶ 77.

Sutter challenges this with what is presented as common sense approach: Sutter notes that price and RR are not the same, and that one can have a low RR off a high list price (5% off $100, price = $95) and a high RR off a low list (50% off $40 = $20) showing that high RR does not correlate with high price. E.g., Sur Reply at 2-3. Divorced from any constraints on list price, this is right. But if list prices reflect [legal] market forces then they are not arbitrary; within a market, list prices will tend to approximate each other and discrepancies in RR will show something else. Exactly what the discrepancies will show is a separate discussion (i.e., as a result of a multiple regression analysis, perhaps it will show impact or aggregated damages from bad acts), but it is enough for now to note that the use of RR can be a reasonable proxy for price. As Leitzinger notes, others in the health care industry also use RR. Leitzinger Reply ¶¶ 65-68.

c. *Viability of Leitzinger's impact analysis*

Sutter in its opposition, and its expert in her first declaration, misunderstood how plaintiffs proposed to prove impact on a class wide basis. They thought Leitzinger's main regression analysis was to be used. Guerin-Calvert Dec. ¶¶ 6–7; 15. Not so; that regression is used only to show the feasibility of calculating aggregated damages attributable to the bad acts. Leitzinger at 3; Leitzinger Reply ¶¶ 28, 30.[39] Regression analysis is a statistical tool frequently used in the courts.[40] It allows one to estimate the impact of one of many independent variables on a dependent variable.[41] "Courts frequently recognize that 'regression analysis can be used to

[39] There is serious doubt that regression analysis can be used to prove common impact. Leitzinger doesn't contend otherwise, and agrees that the use of averages may masks the specific impact on a given service or class member. Leitzinger Reply ¶ 26.

[40] Franklin M. Fisher, "Multiple Regression in Legal Proceedings," 80 COLUM. L. REV. 702 (1980). See e.g., *In re Neurontin Mktg. & Sales Practices Litig.*, 712 F.3d 21, 42 (1st Cir. 2013).

[41] Fisher, "Multiple Regression in Legal Proceedings" above note 40 at 705-706.

isolate the effect of an alleged conspiracy on price, taking into consideration other factors that might also influence price, like cost and demand."[42]

For common proof of impact, Leitzinger uses four other factors. Leitzinger at 5, ¶72. He concludes that about 99.1% of the class members can thusly be demonstrated to have suffered some impact from Sutter's actions. Id. at ¶¶ 86-87; Leitzinger Reply ¶¶ 18 *et seq.*

The four factors are (i) common manner in which reimbursement rates are calculated, (ii) claims data showing nearly all class members paid higher RR for Sutter services as opposed to competitor services; (iii) parity across network vendors seen as a function of the common Sutter contract provisions, Leitzinger ¶ 75, (iv) a modified overcharge model showing overcharges at almost all Sutter hospitals. Leitzinger at ¶72. Leitzinger Reply ¶ 18 et seq. In response to Guerin-Calvert's criticisms of his four factors (Guerin-Calvert ¶¶ 135 *et seq.*), Leitzinger adds (without conceding that his original presentation was incomplete) three other factors in his reply declaration, Leitzinger Reply at ¶¶ 18 et seq. These are (v) overcharges at both the inpatient and outpatient services level, (vi) persistent overcharges over time, and (vii) persistent overcharges across plan types. Id.

I discuss these in order.

(i) Common calculation of reimbursement rates. Guerin Calvert does not dispute that this is so, although she disagrees concerning its import. Guerin Calvert ¶ 139.

(ii) Nearly all class members paid higher RR for Sutter services. Guerin-Calvert's criticisms of this factor are apparently the same as her criticism of the use of RR generally.

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[42] *In re Processed Egg Prod. Antitrust Litig.*, 312 F.R.D. 171, 193 (E.D. Pa. 2015), *quoting In re Aftermarket Auto. Lighting Products Antitrust Litig.*, 276 F.R.D. 364, 371 (C.D.Cal.2011) *and In re Plastics Additives Antitrust Litig.*, No. 03–2038, 2010 WL 3431837, at *15 n. 13 (E.D.Pa. Aug. 31, 2010). See e.g., *In re Urethane Antitrust Litig.*, 768 F.3d 1245, 1260 (10th Cir. 2014). See generally, Daniel L. Rubinfeld, "Reference Guide on Multiple Regression," REFERENCE MANUAL ON SCIENTIFIC EVIDENCE 303 (3d ed. 2011), available at <http://www.au.af.mil/au/awc/awcgate/fjc/manual_sci_evidence.pdf>, recommended by Judge Posner in *ATA Airlines, Inc. v. Fed. Exp. Corp.*, 665 F.3d 882, 889 (7th Cir. 2011).

(iii) Parity. Guerin-Calvert suggests this does not account for price treatment over time. Guerin Calvert ¶ 140 *et seq.* Leitzinger addresses this in his additional three factors, (v)-(vii) below. The other criticisms suggest that Leitzinger did not account for every single variation in contract prices; a perhaps clearer criticism is that the apparent parity nevertheless ranges across at least a 20% range (Guerin-Calvert ¶ 150), an issue that Sutter counsel mentioned at argument. Tr. 82. But it is not obvious that this figure is so large that it fails to support Leitzinger's conclusion. That is, the disagreement on the permissible range for this factor appears to be one relegated to legitimate if conflicting expert opinion. See Leitzinger Reply ¶¶ 21, 106.

(iv) Modified overcharge model. Guerin Calvert's criticisms includes her general objection to the use of RR, and that there is a "*substantial* variation," Guerin Calvert ¶ 152 (emphasis supplied) in the overcharges as among groups of hospitals. Again, I am not in position to conclude that the *extent* of variation is beyond the pale, incapable of supporting Leitzinger's conclusions such that the conclusion must be speculation. Leitzinger agrees that simply showing overcharges does not show class wide impact. Leitzinger Reply ¶ 27-28. But he argues that sensitivity analyses within the aggregate overcharge models shows that overcharges persist over time. Leitzinger Reply ¶ 29 at p.10; ¶ 121. Guerin Calvert's position to the contrary seems to be based on a flaw, that of multicollinearity,[43] Leitzinger Reply ¶ 44 & n.32, which Sutter does not dispute.

(v) Overcharges at both the inpatient and outpatient services level. Leitzinger undertook this analysis in response to Guerin-Calvert's comment (Guerin-Calvert ¶¶ 71 *et seq.,* 106) that he had failed to do so. Leitzinger states that the investigation is not necessary, Leitzinger Reply ¶

[43] This is the "existence of correlations among the independent variables in a regression model." "Reference Guide on Multiple Regression," above note 42, at 289. This may inject serious uncertainty into the result, *id.* at 324.

47, but shows that the investigation produces the same results as found in his original opinion. Leitzinger Reply ¶ 36, 46 *et seq.*, 87.

(vi) Persistent overcharges over time. See discussion under factor (iv).

(vii) Persistent overcharges across plan types. Leitzinger Reply at ¶ 122. Again, this investigation was conducted in response to a criticisms by Guerin-Calvert that Leitzinger had failed to consider differences in plan types. He has now done so and reasonably concludes that differences in plan types do not generally affect his conclusions. Guerin-Calvert Sur Reply Decl.¶¶ 14 *et seq.* has objections to his work, specifically, that Leitzinger has not accounted for certain factors. Generally, however, she does not show that Leitzinger's overall conclusions on the overcharges across plan types would have been different had he accounted for those factors.

d. *Role of Kaiser*

Guerin-Calvert criticizes Leitzinger for not addressing the competitive role of the Kaiser Heath Care system, Guerin-Calvert ¶ 48. Leitzinger discusses the issue in his Leitzinger Reply ¶ 98 *et seq*. Leitzinger reasonably suggests that Kaiser, which in effect offers a combination of insurance and medical services, appears to compete with the network vendors who supply that combination, and not so much medical services providers as such. Nevertheless, he ran a test sensitivity analysis and found no impact. Leitzinger Reply ¶ 100.

Impact can be shown on a class wide basis.

**(iii)** Damages analysis

*Aggregate damages*

It is commonplace to observe that individual inquiries into damages do not defeat certification. E.g., *Brinker Rest. Corp. v. Superior Court*, 53 Cal. 4th 1004, 1022 (2012); *Messner v. Northshore Univ. HealthSystem,* 669 F.3d 802, 815 (7th Cir. 2012); *Kizer v. Tristar*

*Risk Management*, No. G052558, 2017 WL 3172823, at *6 (Cal. Ct. App. June 26, 2017 as modified July 26, 2017) (class may be certified even though class members must individually establish the amount of damages; *id.* at note 3: "Simple variance in the amount of overtime class members worked, including some class members working no overtime, would be a damages issue that would not justify denying class certification"). Nevertheless, individual damages issues can be part of the predominance analysis; that is, it is conceivable that problems in allocating damages are unmanageable and so show that individual issues in a practical sense predominate over the common issues.[44]

UEBT argues that a single damages formula can be used to prove aggregate damages applicable for the entire class. Motion at 21. The damages will be based on overcharge percentages calculated for Sutter hospitals, the dollar amount each class member spent at each hospital, and each member's reimbursement rate at each hospital. *Id.* Once the jury has made an aggregated damages award, defendants have no interest in allocation. *In re Urethane Antitrust Litig.*, 768 F.3d 1245, 1269 (10th Cir. 2014) ("Dow has no interest in the method of distributing the aggregate damages award among the class members"). We can use "a nonadversary administrative claims procedure with a lowered standard of proof" "that does not directly concern the defendant." *In re Cipro Cases I & II*, 121 Cal. App. 4th 402, 417 (2004).

The issues thus devolves to the extent to which plaintiffs can show damages on an aggregated basis. If they can, a non-bifurcated class can be certified; if not, then perhaps a liability-only class should be certified.[45]

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[44] Cf., *Roach v. T.L. Cannon Corp.*, 778 F.3d 401, 408 (2d Cir. 2015) (discussing impact of *Comcast Corp. v. Behrend*, 569 U.S. 27 (2013)).

[45] *Mullins v. Direct Digital, LLC*, 795 F.3d 654, 671 (7th Cir. 2015), *cert. denied*, 136 S. Ct. 1161 (2016) ("where the defendant's liability can be determined on a class-wide basis, but aggregate damages cannot be established and there is no common method for determining individual damages.....courts often bifurcate the case into a liability phase and a damages phase").

Sutter's opposition takes aim at common proof of impact, noting in passing that Leitzinger offers evidence of average alleged overcharges. Opposition at 17. The Opposition does not argue that there is no competent evidence of aggregate damages, but the Sur Reply does object to the "allocation method," Sur Reply at 7:8-9. As I note above, it is not clear that Sutter should be heard to object on *allocation*, but I take Sutter to object to the calculation of aggregate damages because Sutter does object that plaintiffs cannot determine the amount of overcharges, Sur Reply at 7:11-12, and then makes what might be seen as subsidiary arguments in support of that position. (I do address damages allocation as such below.)

Leitzinger depends on his basic regression analysis to show aggregate damages. E.g., Leitzinger Reply at ¶4. Plaintiffs say whether his analysis convinces a jury is a common issue; if not then presumably they lose the case. Reply at 9:8-12. In its suggestion that I should stop my analysis after identifying *any* proffered method to calculate aggregate damages, plaintiffs' approach is simplistic.

The issue is whether I am persuaded that Leitzinger's approach is feasible. For reasons discussed above, his approach, defended at e.g. Leitzinger Reply ¶¶ 62 *et seq.*, specifically, the use of multiple regression analysis[46] to isolate the impact of the allegedly bad acts on data using RR as a proxy for price, is supported both as a matter of (i) using reliable data[47] and methods as well as the (ii) logic of its inferences. See generally, 6 William Rubenstein, NEWBERG ON CLASS ACTIONS § 20:61 at p.722-23 (5th ed. 2016) (regression analysis used in damages analysis, to determine if effect is present and to measure its extent).

A good example of the conflict we have here is that concerning the specific variables used for the regression analyses. Compare Leitzinger Reply at ¶¶ 17, 83. Because there are an

[46] Guerin-Calvert condemns this at Guerin-Calvert ¶ 205.
[47] Guerin-Calvert also criticizes Leitzinger's use of OSHPD data. Guerin-Calvert at ¶¶ 170 *et seq.* & ¶ 198. I have discussed this above, note 30.

infinite number of variables one *might* employ to model explanations aside from the assertedly illegal conduct at issue, it is always possible to criticize the selection made by an expert; thus it is unlikely that, without evidence that a given selection is inconsistent with practice in the discipline, a court will second-guess an expert's selection. Guerin-Calvert's other criticisms appear addressed to the common impact issue, not the aggregated damages issue. Guerin-Calvert ¶ 176 et seq. Later (*id.* at ¶ 193 *et seq.)* she takes Leitzinger to task for averaging across a wide variety of highly dissimilar services, which I have addressed[48] and failing to account for inpatient and outpatient services, which I have also addressed.[49] Guerin-Calvert ¶ 233. Guerin-Calvert does not show that the use of more or different explanatory variables would have generated a result different from that presented by Leitzinger. *Compare, e.g., Palmer v. Shultz*, 815 F.2d 84, 101 (D.C. Cir. 1987) (suggesting impeachment requires a showing that "the missing factor" would provide a different result).

What we do not have here is a conflict demonstrating Leitzinger made a basic error, such as the unsupportable selection of explanatory (or "independent") variables, or the failure to use common explanatory variables, compare, *ATA Airlines, Inc. v. Fed. Exp. Corp.*, 665 F.3d 882, 893 (7th Cir. 2011), or basic mistakes such as confusing capital expenditures with costs. Id., 665 F.3d at 895. A disagreement on the precise selection of explanatory variables usually does not make an opinion inadmissible.[50]

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[48] This ignores plaintiffs' theory of the case, see discussion above at e.g. pp. 5-6.

[49] This is addressed above, pp. 24-25 (overcharges at both inpatient and outpatient).

[50] *In re Urethane Antitrust Litig.*, 768 F.3d 1245, 1260–61 (10th Cir. 2014)("validity of a regression analysis depends on selection of the appropriate independent variables. [Citations] Consequently, the exclusion of major variables or the inclusion of improper variables may diminish the probative value of a regression model. [Citations] But such defects do not generally preclude admissibility, and courts allow use of a regression model as long as it includes the variables accounting for the major factors"). See also, *Bazemore v. Friday*, 478 U.S. 385, 400 & n.10 (1986) ("while the omission of variables from a regression analysis may render the analysis less probative than it otherwise might be, it can hardly be said, absent some other infirmity, that an analysis which accounts for the major factors "must be considered unacceptable as evidence of discrimination." *Ibid.* Normally, failure to include variables

In short, I am persuaded Leitzinger's approach to aggregate damages is supportable.[51]

*Damages Allocation*

Whether or not Sutter will be involved in damages allocation, courts at the certification stage nevertheless consider if plaintiffs have presented a class-wide method to allocate damages. 6 William Rubenstein, NEWBERG ON CLASS ACTIONS § 20:62 (5th ed. 2016). Sutter's Opposition does not address the matter. Leitzinger discusses the issue at Leitzinger ¶ 91, and provides examples of how this would work at Leitzinger Reply ¶¶ 124 *et seq.*

(iv) **Other individual issues**

Sutter contends there are other individual issues. (i) A payer's claim may be barred by the statute of limitations, Opposition at 20, raising individual issues of when class members became aware of Sutter's challenged practices; (ii) a payer's claim may be barred by release, or perhaps must be arbitrated. *Id.* at 21, 23. Sutter and Network Vendors periodically arbitrate their disputes, which are sometimes settled and so the subject of a release which might have a variety of terms. But there is no evidence of any pertinent arbitration agreement, release, or statute of limitations issue which might depend on a some individual proof.[52] These putatively individual issues are at this point only conjecture and don't block certification. *In re Nexium Antitrust Litig.*, 777 F.3d 9, 21 (1st Cir. 2015).

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will affect the analysis' probativeness, not its admissibility." Note 11 reads, "There may, of course, be some regressions so incomplete as to be inadmissible as irrelevant; but such was clearly not the case here.")

[51] *Kleen Prod. LLC v. Int'l Paper Co.*, 831 F.3d 919, 929 (7th Cir. 2016), *cert. denied*, 137 S. Ct. 1582 (2017) ("plaintiffs are permitted to use estimates and analysis to calculate a reasonable approximation of their damages") See also, 6 William Rubenstein, NEWBERG ON CLASS ACTIONS § 20:60 (5th ed. 2016) (reasonable estimate sufficient).

[52] I asked the parties about these in my written questions before argument. None had a comment.

### (v) Summary on Predominance of Common Questions

In short, common questions predominate as to Sutter's alleged anticompetitive practices, the impact of those practices on healthcare pricing paid by class members, and damages, both as to impact and the calculation of aggregate overcharges.

## B. Typicality and Adequacy

A representative plaintiff must have claims that are similar, although not necessarily identical, to the remainder of the class. *Classen v. Weller*, 145 Cal. App. 3d 27, 46 (1983). "Adequacy of representation depends on whether the plaintiff's attorney is qualified to conduct the proposed litigation and [whether] the plaintiff's interests are . . . antagonistic to the interests of the class." *McGhee v. Bank of America*, 60 Cal. App.3 d 442, 450 (1976). "But only a conflict that goes to the very subject matter of the litigation will defeat a party's claim of representative status." *Richmond v. Dart Indus., Inc.*, 29 Cal. 3d 462, 470 (1981). See also, e.g., *Kizer v. Tristar Risk Management,* No. G052558, 2017 WL 3172823, at *5 (Cal. Ct. App. June 26, 2017 *as modified* July 26, 2017), quoting *Martinez v. Joe's Crab Shack Holdings*, 231 Cal. App. 4th 362, 375 (2014) ("The test of typicality 'is whether other members have the same or similar injury, whether the action is based on conduct which is not unique to the named plaintiffs, and whether other class members have been injured by the same course of conduct").

As with all other self-funded health plans, UEBT purchased from Sutter at prices set by contract between Sutter and a Network Vendor. The prices paid were set by contract, with similar pricing across all Network Vendor contracts. All of these prices were impacted by Sutter's challenged practices, which applied uniformly to all Network Vendors.

Sutter argues that UEBT is not typical because as a trust, it lacks capacity to sue, and there are unique defenses such as UEBT's failure to preserve documents and evidence, and lack

of interest in proving the facts that other class members must show to prevail, because UEBT itself never requested a narrow or tiered network from Sutter.

I have previously addressed the capacity to sue argument. Order Denying Defendants' Motion for Judgment on the Pleadings (entered June 30, 2017) at 4. UEBT has an interest in proving Sutter's anticompetitive practices, because UEBT was allegedly forced to pay artificially high prices resulting from those practices, as were other class members. This is so regardless of whether UEBT requested or received a narrow or tiered network.[53]

On the documents, UEBT concedes that there was an "inadvertent loss" of 2 years of "low-level employees'" emails, but that loss potentially only impacted emails during 2007 to 2009 for two custodians. Reply at 16. But those documents would presumably have been copied to superiors whose emails were preserved, or to consultants or trustees whose emails are not on the UEBT system. Such an error, unless in bad faith, is not sufficient to disqualify UEBT as a class representative.

Sutter also complains that UEBT's executive director doesn't know much about the suit. Opposition at 25. This isn't disqualifying. *In re Processed Egg Prod. Antitrust Litig.*, 312 F.R.D. 171, 181 (E.D. Pa. 2015) ("as Plaintiffs unabashedly note, "A class representative need only possess 'a minimal degree of knowledge necessary to meet the adequacy standard'") quoting *New Directions Treatment Servs. v. City of Reading*, 490 F.3d 293, 313 (3d Cir. 2007).

Typicality and adequacy are established.

[53] At any rate, UEBT contends that it did request a narrow or tiered network from Sutter and Blue Shield. Reply at 16.

### C. Superiority

Manageability of individual issues is a core factor in the evaluation of the superiority criterion for certification. *Duran*, 59 Cal. 4th at 29. I have addressed the role of individual issues above.

Without the class action thousands of individual suits would be required. Sutter is right that a number of the putative class members, including UEBT, have enough at stake to litigate a complex antitrust case on their own, but for many more it is not worth the candle. It is also true that some members might be nervous about a damages allocation method which cannot at this stage be used to predict how much any class members will secure, assuming liability is established. But those who wish to go it alone, given their large potential recoveries, are always free to do so: they can opt out. Compared to the mass of the possible individual actions, the class action device is superior.

**Conclusion**

The motion is granted. I anticipate a further order on class certification which includes a precise definition of the class and list of claims and defenses to be tried as a class action.[54] A case management conference is set for **September 5, 2017 at 2:00 p.m.** to discuss the discrepancies between class definitions offered by plaintiffs' counsel; whether governmental entities should be included in the class (and to set a briefing schedule on the matter if necessary); identify the further work needed to identify class members, and corresponding notice procedures to enable opt-outs; to attend to the other requirements of CRC 3.766; the provision of

[54] Compare e.g. F.R.C.P. 23(c)(1)(B)'s requirements on class certification orders.

a more complete trial plan; and any other matters that counsel believe we should address at this stage.

Dated: August 14, 2017

Curtis E.A. Karnow
Judge Of The Superior Court

**CERTIFICATE OF ELECTRONIC SERVICE**
(CCP 1010.6(6) & CRC 2.260(g))

I, DANIAL LEMIRE, a Deputy Clerk of the Superior Court of the County of San Francisco, certify that I am not a party to the within action.

On AUG 14 2017, I electronically served THE ATTACHED DOCUMENT via File & ServeXpress on the recipients designated on the Transaction Receipt located on the File & ServeXpress website.

Dated: AUG 14 2017

T. Michael Yuen, Clerk

By: _____
DANIAL LEMIRE, Deputy Clerk

# Exhibit 27


LEXITAS™

[redacted]

Q. What does the "Risk Rank" mean?

A. I would describe it, I guess, as the potential risk to Common Ground and its membership if that particular situation were to occur.

Q. And if you could scroll to the right, please, looking at the last column, it says Aurora Cancels and then Aurora Terminates Our Contract.

Do you see that?

A. Yes.

Q. And the Risk Rank is 1, right?

A. Yes.

Q. So does this show that at the time the number 1 risk for Common Ground's network strategy was Aurora terminating their contract?

MS. NAPIER: Objection.

MR. YOUNG: Objection to the form.

A. The number 1 risk of these five scenarios that are contemplated, yes.

[redacted]

[redacted]

Q. Fair to say that at the time that Common Ground entered into this agreement in 2013, it viewed Advocate Aurora as an important system to include in its health plan?

MS. NAPIER: Objection.

MR. YOUNG: Objection to form.

A. Common Ground viewed Aurora as a

necessary provider.

# Exhibit 28


LEXITAS™

[redacted]

Q. Is it your understanding that Advocate Aurora was the provider with the largest percentage of dollars spent for Humana offerings overall?

MS. PALMER: Objection to form.

A. In southeast -- in southeast Wisconsin, yes.

BY MS. WALLIN:

Q. Is it fair to say that Advocate Aurora was a critical input in Humana's health plan offerings in southeastern Wisconsin?

MS. PALMER: Objection to form.

A. It is.

[redacted]

# Exhibit 35

Message

**From**: Scott.Gerhart@anthem.com [Scott.Gerhart@anthem.com]
**Sent**: 2/20/2019 8:46:03 AM
**To**: Justin.Brown@anthem.com
**CC**: Jan.Persinger@anthem.com
**Subject**: RE: Transparency Feedback Needed By EOD Tomorrow
**Attachments**: Transparency Feedback 02192019.xlsx; Steerage.docx; Program-Benefit Steerage.docx

Aurora has anti-steerage language and that they must be in the highest level of benefits, [redacted] Here's the updated grid and Aurora's language.

**From:** Persinger, Jan
**Sent:** Wednesday, February 20, 2019 5:25 AM
**To:** Brown, Justin R. <Justin.Brown@anthem.com>; Gerhart, Scott <Scott.Gerhart@anthem.com>; Huether, Jamie <Jamie.Huether@anthem.com>; Lee, David <David.Lee@anthem.com>; Lorch, Mike <Mike.Lorch@anthem.com>; Pugliese, Jim <Jim.Pugliese@anthem.com>
**Subject:** RE: Transparency Feedback Needed By EOD Tomorrow

To clarify the most important question I need answers to for the meeting - involves which providers have anti-steerage and or anti-tiering language that you perceive to be problematic, punitive, or limits care choices for consumers. **That's the focus of the meeting and so need to know from you at a high level which facilities, integrated delivery systems or professional groups are concerning in your markets. The transparency connection is simply that Jennifer pulled preliminary responses from questions on the annual transparency survey- yet we worried it was not completely up to date or accurate.**
Thanks,
Jan

**From:** Brown, Justin R.
**Sent:** Tuesday, February 19, 2019 1:13 PM
**To:** Gerhart, Scott <Scott.Gerhart@anthem.com>; Huether, Jamie <Jamie.Huether@anthem.com>; Lee, David <David.Lee@anthem.com>; Lorch, Mike <Mike.Lorch@anthem.com>; Pugliese, Jim <Jim.Pugliese@anthem.com>
**Cc:** Persinger, Jan <Jan.Persinger@anthem.com>
**Subject:** Transparency Feedback Needed By EOD Tomorrow
**Importance:** High

Team:

Jan has a meeting on Thursday morning to talk about Provider Transparency. I need by EOD tomorrow the following information--- please populate the attached.

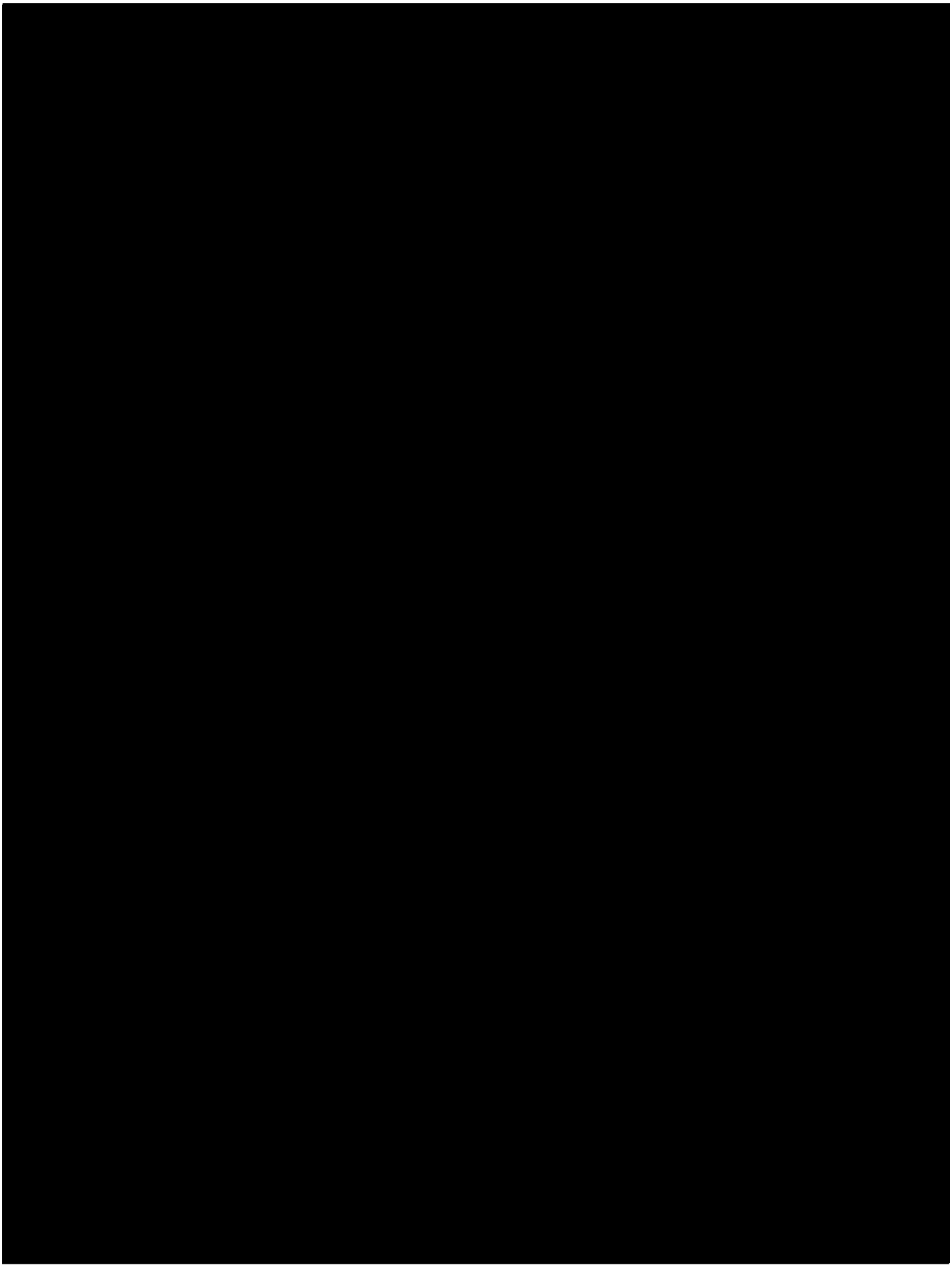
1) Which providers are most problematic in your market (Facility/Professional).
2) What areas are problematic for said Providers?
3) Do they have any contract limitation preventing Anthem from displaying information on Transparency tool, whether they are Anthem owned or a Third Party (i.e. CastLight).

Thanks,

Anthem, Inc.

**Justin R. Brown**, *Director, Central Region Provider Solutions*
*4241 Irwin Simpson Road, Mason, Ohio 45040*
O: (513) 336-3599 | M: (614) 203-6412 | justin.brown@anthem.com

# Exhibit 45



To Brian's point, we know Aurora is a more expensive provider, and I see the argument that our premium comparison should reflect moving Aurora utilization in the base data towards ThedaCare rates. ThedaCare Inpatient is obviously a better contract (ThedaCare's $10,374 2021 base rate with carved out case rates/per diems for some DRGs vs. Aurora's $12,943 base rate is likely at least a 25% difference). Outpatient I don't have a great read on – I'm willing to say ThedaCare's outpatient costs are likely still a bit lower, but since I don't have a good way to convert Aurora experience to ThedaCare billed charge levels it makes it difficult to come up with any kind of actual comparison. ThedaCare's professional contract is also likely a bit better. If you still have the Payer Compass comparison somewhere we can refine these numbers, but for now I did a range based on possible composite contract differentials (knowing that the inpatient/outpatient/professional split is somewhere around 20%/40%/40% respectively). For now I've used all of Rating Area 11 data to be consistent with Dan's prior calculation. You can see the scenarios in the attached workbook.

Based on Dan's work, it looked like Dean's Bronze premium was 11.7% lower than CGHC's (if you can point me towards his work that references 8% I can update the comparison, but the premium amounts I used were from here: S:\2021 Pricing\Geographic Expansion\Recommendations for Pricing Committee\Green Lake\2020 Premium Info - Green Lake.xlsx). Based on my high level assumptions, assuming all of the current Aurora experience moved to a lower cost provider, we'd still need an additional 5% - 9% premium decrease. Please note: none of this has been reviewed, I can certainly have Dan do so if you'd prefer.

Anyway, main takeaways:

- The high profitability of Waupaca/Waushara in 2019 is not necessarily completely due to lower Aurora utilization (could be health status, could be premium/claims age factor mismatch, etc.)
- Based on 2019 experience, 46% of Rating Area 11's medical spend was to Aurora providers. To the extent that we think some (or all) of that 46% would move to lower cost providers in Green Lake, I generally agree we would be able to lower premiums for that portion of claims, but I don't think it would be enough to make up all of the difference Dan is currently estimating.

Please let me know if you have questions, would like to discuss further, or would like a more detailed analysis.

Thanks,

**Kaitlin Fink**
Senior Healthcare Economics Analyst
Direct (414) 269-4683

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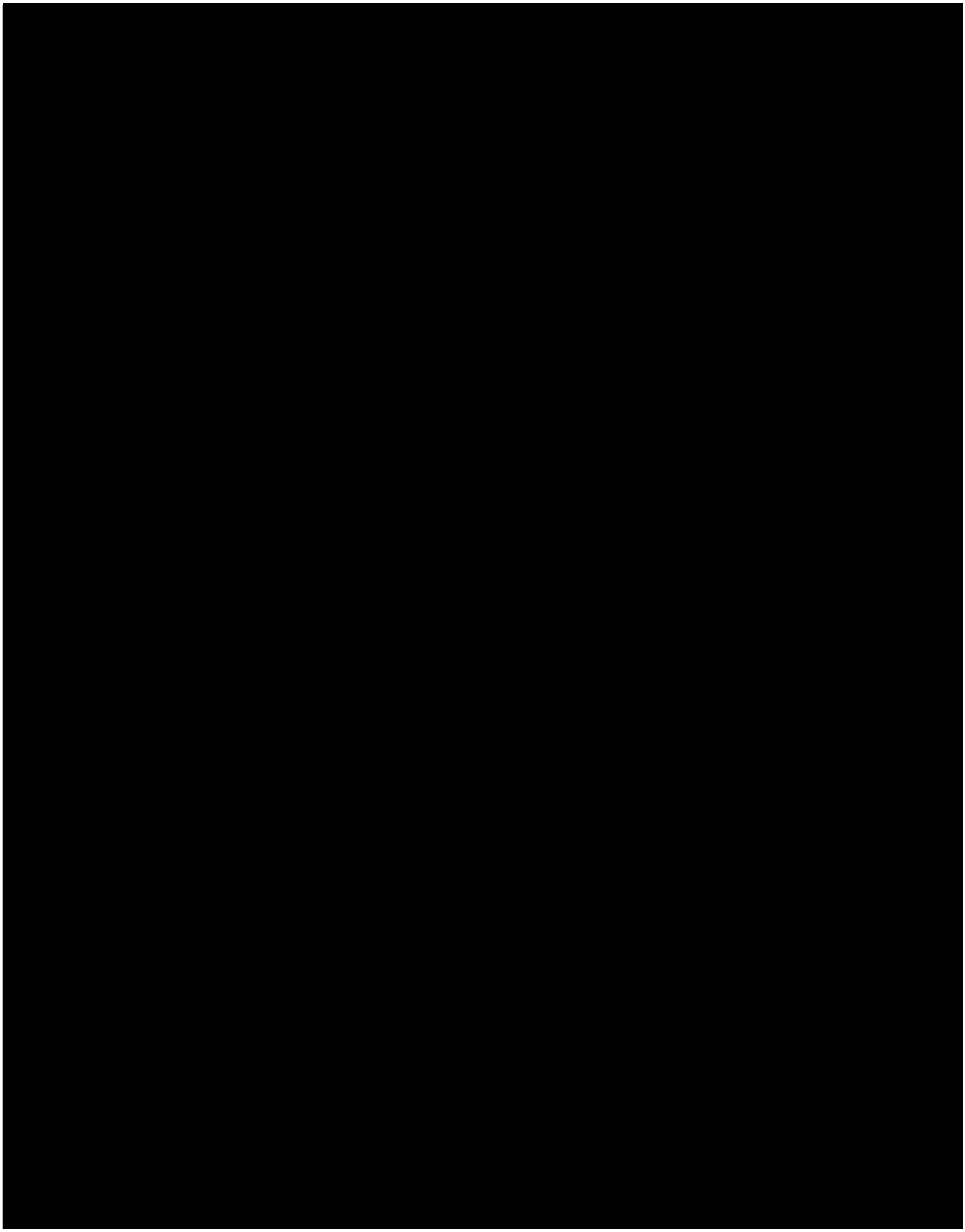

# Exhibit 55

**ROB BONTA**
*Attorney General*

# Attorney General Bonta Announces Final Approval of $575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices

Press Release / *Attorney General Bonta Announces Final Approval of $575 Mill...*

Friday, August 27, 2021

Contact: (916) 210-6000, agpressoffice@doj.ca.gov

**OAKLAND** – California Attorney General Rob Bonta today lauded Judge Massullo's final approval of a landmark $575 million settlement with Sutter Health (Sutter). The settlement agreement was reached in 2019, and resolves allegations by the Attorney General's office, the United Food and Commercial Workers and Employers Benefit Trust (UEBT), and class action plaintiffs that Sutter's anticompetitive practices led to higher healthcare costs for consumers in Northern California compared to other places in the state. The settlement requires Sutter to pay $575 million in compensation, prohibits anticompetitive conduct, and requires Sutter to follow certain practices to restore competition in California's healthcare markets.

"This is a groundbreaking settlement and a win for Californians," **said Attorney General Bonta.** "Sutter will no longer have free rein to engage in anticompetitive practices that force patients to pay more for health services. Under the terms of our agreement, Sutter's transparency must increase, and practices that decrease the accessibility and affordability of healthcare must end. A competitive healthcare market is essential to ensuring patients and families aren't bearing the brunt of healthcare costs while one company dominates the market."

Sutter is the largest hospital system in Northern California. The Sutter network consists of some 24 acute care hospitals, 36 ambulatory surgery centers, and 16 cardiac and cancer centers. It also includes some 12,000 physicians and over 53,000 employees. In addition, Sutter negotiates contracts on behalf of the Palo Alto Medical Foundation and many affiliated physician groups.

This settlement is the result of litigation that began in 2014 when UEBT filed a class action lawsuit that challenged Sutter's practices in rendering services and setting prices. They sought compensation for and an end to what they alleged were unlawful, anticompetitive business practices, which caused them to pay more than necessary for healthcare services and products. In March 2018, the Attorney General's office filed a similar lawsuit against Sutter on behalf of the people of California, seeking injunctive relief to compel Sutter to correct its anticompetitive business practices moving forward. The separate lawsuits were combined by the court into one case. In October 2019, one day before the trial, the parties reached an agreement to settle. The settlement was filed with the court on December 19, 2019, and in March, Judge Massullo granted preliminary approval.

Today's finalized settlement requires Sutter to:

- **Pay $575 million** to compensate employers, unions, and others covered under

the class action, and to cover costs and fees associated with the legal efforts;

- **Limit what it charges patients for out-of-network services,** helping ensure that patients visiting an out-of-network hospital do not face outsized, surprise medical bills;
- **Increase transparency** by permitting insurers, employers, and self-funded payers to provide plan members with access to pricing, quality, and cost information, which helps patients make better care decisions;
- **Halt measures that deny patients access to lower-cost plans,** thus allowing health insurers, employers, and self-funded payers to offer and direct patients to more affordable health plan options for networks or products;
- **Stop all-or-nothing contracting deals,** thus allowing insurers, employers, and self-funded payers to include some but not necessarily all of Sutter's hospitals, clinics, or other commercial products in their plans' network.
- **Cease anticompetitive bundling of services and products** which forced insurers, employers, and self-funded payers to purchase for their plan offerings more services or products from Sutter than were needed. Sutter must now offer a stand-alone price that must be lower than any bundled package price to give insurers, employers, and self-funded payers more choice;
- **Cooperate with a court-approved compliance monitor** to ensure that Sutter is following the terms of the settlement for at least 10 years. The monitor will receive and investigate complaints and may present evidence to the court; and
- **Prevent anticompetitive practices by clearly defining clinical integration to include patient quality of care**. The settlement makes clear that for Sutter to claim it has clinically integrated a system, it must meet strict standards beyond regional similarities or the mere sharing of an electronic health record, and must be integrating care in a manner that takes into consideration the quality of care to the patient population. This is important because clinical integration can be used to mask market consolidation efforts by hospital systems, when in fact

there is no true integration of a patient's care. For example, saying that hospitals are regionally close or that hospitals are sharing electronic health records is not enough, there must be close coordination that will lead to less costly, higher quality care for local communities.

A report by the University of California Berkeley showed that over-consolidation drives up prices for consumers. According to the study, outpatient cardiology procedures in Southern California cost nearly $18,000 compared to almost $29,000 in Northern California. For inpatient hospital procedures, the cost in Southern California is nearly $132,000 compared to more than $223,000 in Northern California, a more than $90,000 difference. A 2016 study found that a cesarean delivery in Sacramento, where Sutter is based, costs more than $27,000, nearly double what it costs in Los Angeles or New York, making Northern California one of the most expensive places in the country to have a baby.

A copy of the final approval order and judgment are available here and here.

# # #

# Exhibit 69

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

San Francisco Division

DJENEBA SIDIBE, et al.,

Plaintiffs,

v.

SUTTER HEALTH, et al.,

Defendants.

Case No. 12-cv-04854-LB

**FINAL APPROVAL ORDER**

Re: ECF Nos. 1754, 1761

## INTRODUCTION

This antitrust consumer class action involved multiple motions to dismiss, extensive discovery, two class-certification motions, a Rule 23(f) petition, three summary-judgment motions, a four-week trial that resulted in a defense verdict, and three appeals to the Ninth Circuit. In March 2025, after jury selection for a second trial but before opening statements, the parties reached a settlement. On May 22, 2025, the court approved the settlement preliminarily. The plaintiffs move for final approval of the settlement and for attorney's fees and costs. After a fairness hearing on November 6, 2025, the court grants the motion for final approval and awards the requested fees and costs.

## STATEMENT

### 1. The Lawsuit

The named plaintiffs are individuals who purchased health insurance and employers who provided health insurance for their employees.[1] The plaintiffs filed their first complaint on September 17, 2012, represented solely by The Mehdi Firm. After multiple rounds of motions to dismiss and orders dismissing earlier complaints, Constantine Cannon and other firms joined as plaintiffs' counsel.[2] Following dismissal of the third amended complaint for failure to allege relevant geographic markets, the plaintiffs appealed, and the Ninth Circuit reversed.[3] Discovery spanned 2016 to 2021 and was coordinated with two related state-court cases: *UFCW & Employers Benefit Trust v. Sutter Health*, CGC-14-538451 (Cal. Super. Ct. Apr. 7, 2014) (the UEBT action), and *California ex rel. Xavier Becerra v. Sutter Health*, CGC-18-565398 (Cal. Super. Ct. Mar. 29, 2018).[4] Discovery was extensive, involving over 2.5 million documents from parties, nonparty health plans, and third parties and 155 depositions over 223 deposition days. Obtaining discovery from the nonparty health plans was particularly time-consuming, requiring additional counsel, economists, and data analysts.[5]

Expert discovery was substantial. The plaintiffs retained three experts, including Dr. Tasneem Chipty, who issued eleven expert reports on class certification, relevant markets, liability, antitrust impact, and damages.[6] Sutter retained seven experts and produced twenty-three reports.[7] Expert depositions spanned twenty-eight days.[8]

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[1] Order – ECF No. 962 at 1. Citations refer to the Electronic Case File (ECF); pinpoint citations are to the ECF-generated page numbers at the top of documents.

[2] Dismissal Orders – ECF Nos. 35, 64.

[3] Order – ECF No. 83; *Sidibe v. Sutter Health*, 667 F. App'x 641 (9th Cir. 2016).

[4] Order – ECF No. 158.

[5] Kim Decl. – ECF No. 1754-1 at 10 (¶¶ 45–48).

[6] *Id.* at 11 (¶ 49).

[7] *Id.* (¶ 50).

[8] *Id.* (¶ 51).

Two rounds of class-certification occurred. Initially, the court certified a Rule 23(b)(2) injunctive-relief class but denied a Rule 23(b)(3) damages class, finding Dr. Chipty's analysis insufficient for class-wide antitrust injury and damages.[9] For the second motion, Dr. Chipty expanded her analysis, incorporating data from all five health plans, regression analyses using Center for Medicare and Medicaid Services (CMS) data, and other sources. On July 30, 2020, the court certified a Rule 23(b)(3) class of premium payers.[10] On August 30, 2020, the court appointed Constantine Cannon as lead trial counsel and The Mehdi Firm as co-lead class counsel.[11] On November 5, 2020, the court approved the plaintiffs' notice plan, executed by mail, email, and print and digital publication. The opt-out deadline was March 8, 2021.[12]

Three summary-judgment motions were filed. On April 12, 2019, Sutter's early summary-motion was denied (except for the Davis market).[13] The motion involved substantial expert discovery from Dr. Chipty and Sutter's expert, Dr. Gautam Gowrisankaran.[14]After fact discovery ended on July 27, 2020, the plaintiffs moved for partial summary judgment on the distinct-products element of their tying claim, which the court granted.[15] Sutter's summary-judgment motion argued that its practices were not anticompetitive, it did not willfully maintain monopoly power in tying markets or pose a dangerous probability of monopolization in tied markets, and the plaintiffs lacked class-wide damages for the 2008–2010 claims. The court granted Sutter summary judgment on the Sherman Act § 2 claim and 2008–2010 damages, denying the remainder.[16] These motions involved extensive briefing and hundreds of exhibits.[17]

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[9] Order – ECF No. 698 at 50–53.

[10] Order – ECF No. 823.

[11] Kim Decl. – ECF No. 1754-1 at 12 (¶¶ 53–54).

[12] Order – ECF No. 901.

[13] Order – ECF No. 673.

[14] Kim Decl. – ECF No. 1754-1 at 13 (¶¶ 58–59).

[15] Order – ECF No. 886.

[16] Order – ECF No. 962.

[17] Kim Decl. – ECF No. 1754-1 at 13–14 (¶ 61).

In late 2019, Sutter settled the state cases, which involved direct purchasers, for damages and injunctive relief relating to Sutter's contracting practices with insurers, benefitting the indirect purchasers in this action through a monitored injunction.[18] Preparation for trial in this case occurred three times: for October 4, 2021, December 2021/January 2022, and the actual four-week trial in February 2022.[19] Pretrial filings exceeded 18,000 pages, including *Daubert* and in limine motions.[20] After a defense verdict, the plaintiffs appealed. The appellate record included thirty-three volumes of trial materials.[21] The Ninth Circuit reversed on two issues: exclusion of pre-2006 evidence and a revised CACI jury instruction. *Sidibe v. Sutter Health*, 103 F.4th 675 (9th Cir. 2024). It affirmed the "relevant purchaser" instruction and denial of sanctions. *Sidibe*, No. 22-15634, 2024 WL 2826520 (9th Cir. June 4, 2024). It denied Sutter's petition for rehearing and rehearing en banc.[22] After the mandate issued, the parties updated pretrial filings, and the court issued a final pretrial order.[23] Jury selection occurred on February 27, 2025.[24] On March 2, 2025, the parties settled.[25]

**2. The Settlement Process**

The parties engaged Gregory Lindstrom of Phillips ADR Enterprises for mediation over five weeks, executing the settlement agreement on April 24, 2025.[26] The plaintiffs moved for preliminary approval on April 25, 2025, which the court granted on May 22, 2025.[27] A final fairness hearing was held on November 6, 2025.

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[18] *Id.* at 14 (¶ 62).

[19] Docket. The parties picked a jury in December 2021, with a trial date of January 6, 2021. Because of the Omicron surge, the Northern District of California cancelled all jury trials in January.

[20] Orders – ECF No. 1166–67, 1282, 1318, 1363, 1382, 1420.

[21] Kim Decl. – ECF No. 1754-1 at 17 (¶ 77).

[22] Order – ECF No. 1624.

[23] Order – ECF No. 1734.

[24] Minute Entry – ECF No. 1733.

[25] Notice of Settlement – ECF No. 1737.

[26] Settlement Agreement, Ex. A to Kim Decl. – ECF No. 1761-2 at 6–36.

[27] Order – ECF No. 1750.

**3. The Settlement Agreement**

The certified and settlement class is "All entities in California Rating area 1, 2, 3, 4, 5, 6, 8, 9 or 10 (the 'Nine Rating Areas' or 'Nine RAs'), and all individuals that either live or work in one of the Nine RAs, that paid premiums for a fully insured health insurance policy from Blue Shield, Anthem Blue Cross, Aetna, Health Net or UnitedHealthcare from January 1, 2011 to March 8, 2021."[28]

The settlement amount is $228.5 million, to be deposited into a court-approved escrow account within twenty calendar days of this order. Interest from deposit to the Effective Date will be split evenly between the class and Sutter. Proceeds will be distributed pro rata.[29] The release covers:

> Sutter, its past or present parents, subsidiaries, divisions, affiliates, providers (including, but not limited to, hospitals, foundations, doctors, ambulatory surgery centers and any other providers), officers, directors, employees, agents, attorneys, and any of their legal representatives (and the predecessors, heirs, executors, administrators, successors, purchasers, and assigns of each of the foregoing) from any and all claims, whether federal or state, known or unknown, asserted or unasserted, regardless of legal theory, arising from or related to the facts, activities, or circumstances that were alleged in the complaints filed by Plaintiffs, including in the Fourth Amended Complaint, or otherwise alleged in this Action including during the first trial of this matter in 2022, or arising from or related to any purported anticompetitive effect resulting from the conduct alleged by Plaintiffs in this Action, including conduct alleged during the first trial of this matter in 2022.[30]

The release includes a waiver of unknown claims under Cal. Civ. Code § 1542.[31]

Class Counsel's requested fees and costs (to be deducted from the fund) require court approval and include approximately $10 million for notice and administration of the Settlement (discussed below), $28,185,752 in expenses (including $17 million for experts), attorney's fees (without a multiplier and not exceeding one-third of the settlement fund), service awards to Class Representatives ($20,000 each for testifying Class Representatives, $15,000 each for non-testifying Representatives, totaling $95,000 for five representatives).[32]

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[28] Settlement Agreement, Ex. A to Kim Decl. – ECF No. 1761-2 at 10.

[29] *Id.* at 18–21 (§ III.A.1, 5).

[30] *Id.* at 24 (§ VI.A.1).

[31] *Id.* at 24–25 (§ VI.A.2).

[32] *Id.* at 25 (§ VII.1); Mot. – ECF No. 1754; Mot. – ECF No. 1761-1 at 15; Kim. Suppl. Decl. – ECF No. 1762.

The court previously established an opt-out period for Class Members from December 15, 2020, to March 8, 2021, stating that any members who did not opt out would be bound by the outcome of the lawsuit, would receive the benefits of any settlement, and would not be able to exclude themselves from the Class in the future.[33]

**4. Settlement Administration**

JND, a nationally recognized administrator, managed the notice and distribution plan, consistent with the court-approved November 5, 2020, plan. It mailed 6,624,714 Post Card Notices from June 2 to June 24, 2025, using updated addresses from health plans, skip-trace databases, and the U.S. Postal Service. Undeliverable notices were re-mailed to forwarding addresses.[34] It emailed 1,994,468 notices from June 2, 2025, to June 28, 2025, with three follow-up campaigns.[35] Digital ads on LinkedIn, Facebook, Instagram, programmatic advertising (through OMTrade Desk); SHRM.org (the largest trade-association site), Google Display Network (GDN, the leading digital network), and Demand Gen (an AI-powered advertising method) generated 1,885,534 digital impressions from June 2 to July 13, 2025.[36] A press release reached 139.7 million, with 13.5 million via regional outlets.[37] The website, www.SutterHealthPremiumLawsuit.com, provided case details and claim forms.[38] JND's toll-free line received 25,345 calls, and it received 6,169 emails.[39] 206,546 claims were filed by the claim-filing deadline of September 12, 2025.[40] Administration costs are approximately $10 million.[41]

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[33] Order – ECF No. 955; Settlement Agreement, Ex. A to Kim Decl. – ECF No. 1761-2 at 15–16 (§ II.D).

[34] Kim Decl. – ECF No. 1761-2 at 2–3 (¶ 9); Keough Decl. – ECF No. 1761-3 at 1–3 (¶¶ 2, 5, 9); Order – ECF No. 901.

[35] Keough Decl. – ECF No. 1761-3 at 3–4 (¶¶ 12, 14).

[36] *Id.* at 4–5 (¶¶ 16–20); Digital Ads, Ex. D to *id.* at 24–45.

[37] Keough Decl. – ECF No. 1761-3 at 7 (¶¶ 30–31).

[38] *Id.* at 7–8 (¶¶ 32–33, 35).

[39] *Id.* at 8 (¶¶ 37–38).

[40] *Id.* (¶ 40).

[41] *Id.* (¶ 47) ($4 million for notice and $6 million for claims administration).

**5. Objections**

Two objections were filed. On August, 26, 2025, William Legler objected to calculating fees on the gross fund.[42] Hao Tze Wang's objection, alleging inadequate notice and discrimination, was withdrawn (after a September 10, 2025, hearing, per Fed. R. Civ. P. 23(e)(5)(B)), with a $900 payment (predicated on his claim that he paid $15,000 in premiums during the class period) and (2) provision of the public opt-out list.[43]

**6. Efforts of Class Representatives**

Class Representatives, some involved since 2012, contributed significantly through discovery, depositions, and trial preparation.[44]

**7. Additional Costs**

Since preliminary approval, the plaintiffs and class counsel incurred additional costs for data expert analysis in connection with assisting certain large Class Members (such as CalPERS). The revised costs total $28,185,752.[45]

**ANALYSIS**

**1. Jurisdiction**

The court has jurisdiction under the Class Action Fairness Act (CAFA). 28 U.S.C. § 1332(d)(2).

**2. Certification of the Settlement Class**

The court previously certified the class under Rule 23(a) and (b)(3).[46] The class remains appropriate, with no changed circumstances. Numerosity is satisfied with over three million

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[42] Obj. – ECF No. 1757.

[43] Minute Entry – ECF No. 1759; Order – ECF No. 1760.

[44] *See* Pls.' Decls. – ECF Nos. 1754-10–15.

[45] Kim Decl. – ECF No. 1761-2 at 4 (¶ 17); Kim. Suppl. Decl. – ECF No. 1762; Reimbursement Costs, Ex. D to *id.* – ECF No. 1761-2.

[46] Orders – ECF Nos. 823, 1750.

members. *Nelson v. Avon Prods., Inc.*, No. 14-cv-02276-BLF, 2015 WL 1778326, at *5 (N.D. Cal. Apr. 17, 2015). Commonality exists in questions about Sutter's contracting practices. Typicality is met, as the plaintiffs' claims arise from the same conduct. Adequacy is satisfied: there are no conflicts and counsel is qualified. Fed. R. Civ. P. 23(a); *Staton v. Boeing Co.*, 327 F.3d 938, 953 (9th Cir. 2003); *In re Hyundai and Kia Fuel Econ. Litig.*, 926 F.3d 539, 566 (9th Cir. 2019). A class action is superior to other available methods for fairly and efficiently adjudicating the controversy. Fed. R. Civ. P. 23(b)(3); *Brown v. Hain Celestial Grp., Inc.*, No. 11-cv-03082-LB, 2014 WL 6483216, at *15–20 (N.D. Cal. Nov. 18, 2014).

**3. Approval of Settlement**

A court may approve a proposed class-action settlement only "after a hearing and only on finding that it is fair, reasonable, and adequate after considering whether":

> (A) the class representatives and class counsel have adequately represented the class;
> (B) the proposal was negotiated at arm's length;
> (C) the relief provided for the class is adequate, taking into account:
> > (i) the costs, risks, and delay of trial and appeal;
> > (ii) the effectiveness of any proposed method of distributing relief to the class, including the method of processing class-member claims;
> > (iii) the terms of any proposed award of attorney's fees, including timing of payment; and
> > (iv) any agreement required to be identified under Rule 23(e)(3); and
> (D) the proposal treats class members equitably relative to each other.

Fed. R. Civ. P. 23(e)(2). These factors "are substantially similar to those articulated" in *Hanlon v. v. Chrysler Corp.*, 150 F. 3d 1011, 1027 (9th Cir. 1998), *overruled on other grounds by Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338 (2011). *Student A v. Berkeley Unified Sch. Dist.*, No. 17-cv-02510-JST, 2021 WL 6332353, at *2 n.2 (N.D. Cal. July 8, 2021). In *Hanlon*, the Ninth Circuit identified factors relevant to assessing a settlement proposal: (1) the strength of the plaintiff's case; (2) the risk, expense, complexity, and likely duration of further litigation; (3) the risk of maintaining class-action status throughout trial; (4) the amount offered in settlement; (5) the extent of discovery completed and the stage of the proceeding; (6) the experience and views of counsel;

(7) the presence of a government participant; and (8) the reaction of class members to the proposed settlement. 150 F.3d at 1026.

The settlement is fair, reasonable, and adequate.

First, representation is adequate. Class counsel and the representatives litigated vigorously over thirteen years, navigating motions, discovery, trial, and appeals.

Second, mediation with Mr. Lindstrom, together with experienced and knowledgeable counsel, ensured a non-collusive process. Fed. R. Civ. P. 23(e)(2)(B) advisory committee's note (2018) ("[T]he involvement of a neutral . . . in negotiations may bear on whether they were conducted in a manner that would protect and further the class interests."); *Villegas v. J.P. Morgan Chase & Co.*, No. CV 09-00261 SBA (EMC), 2012 WL 5878390, at *6 (N.D. Cal. Nov. 21, 2012) (private mediation "tends to support the conclusion that the settlement process was not collusive").

Third, the relief is adequate, providing class members with a recovery of over fifty-five percent of single damages, exceeding typical settlements. *See, e.g.*, *Rodriguez v. W. Publ'g Corp.*, 563 F.3d 948, 963 (9th Cir. 2009) (approximately thirty percent of the estimated damages before trebling was fair, adequate, and reasonable); *Roe v. SFBSC Mgmt., LLC*, No. 14-cv-03616-LB, 2022 WL 17330847, at *12 (N.D. Cal. Nov. 29, 2022) ("[T]welve percent of the best-case scenario is within the range courts approve."); *Reynolds v. Direct Flow Med., Inc.*, No. 17-cv-00204-KAW, 2019 WL 4168959, at *3 (N.D. Cal. Sept. 3, 2019) (approving settlement representing thirteen percent of the plaintiffs' estimated damages); *Edwards v. Nat'l Milk Producers Fed'n*, No. 11-cv-04766-JSW, 2017 WL 3616638, at *3 (N.D. Cal. June 26, 2017) (settlement of approximately thirty percent of the estimated single damages); *In re Lithium Ion Batteries Antitrust Litig.*, No. 4:13-md-02420-YGR (DMR), 2017 WL 1086331, at 4* (N.D. Cal. Mar. 20, 2017) (settlement of "11.2% of the single damages attributable to Sony sales"); *In re Cathode Ray Tube (CRT) Antitrust Litig.*, No. 14-cv-2058 JST, 2017 WL 565003, at *4, *6 (N.D. Cal. Feb. 13, 2017) (preliminary approval of twenty-four percent of single damages). The settlement is in line with the monetary settlement in the related state-court cases (UEBT and the California AG's affirmative lawsuit), where the direct-

purchaser class obtained approximately fifty-seven percent of single damages.[47] The risks of trial, appeal delays, and costs support approval.

Fourth, the settlement is equitable. Pro rata and prompt distribution ensures fairness. *See In re: Cathode Ray Tube (CRT) Antitrust Litig.*, No. 14-cv-2058 JST, 2017 WL 2481782, at *5 (N.D. Cal. June 8, 2017) (approving settlement distribution plan that "fairly treats class members by awarding a pro rata share to the class members based on the extent of their injuries").

Finally, the *Hanlon* factors overall support approval: strong results, high litigation risk, completed discovery, experienced counsel, and minimal objections (one withdrawn). *Ching v. Siemens Indus.*, No. 11-cv-04838-MEJ, 2014 WL 2926210, at *6 (N.D. Cal. June 27, 2014) (a court "may appropriately infer that a class action settlement is fair, adequate, and reasonable when few class members object to it" (cleaned up)); *cf. Staton*, 327 F.3d at 959 (the court should consider "reaction of the class members to the proposed settlement").

In sum, the settlement is fair, adequate, and reasonable. *Officers for Justice v. Civil Serv. Comm'n of the City and Cty. of S.F.*, 688 F.2d 615, 625 (9th Cir. 1982).

**4. Attorney's Fees and Costs**

Class Counsel's $75.4 million fee request (thirty-three percent of the settlement fund) and $28,185,752 in costs are approved.[48]

"In a certified class action, the court may award reasonable attorney's fees and nontaxable costs that are authorized by law or by the parties' agreement." Fed. R. Civ. P. 23(h). The court must ensure that the award is reasonable. *In re Bluetooth Headset Prods. Liab. Litig.*, 654 F.3d 935, 941 (9th Cir. 2011). The court is not bound by the parties' settlement agreement as to the amount of fees. *Id.* at 941–43. The court must review fee awards with special rigor:

> Because in common fund cases the relationship between plaintiffs and their attorneys turns adversarial at the fee-setting stage, courts have stressed that when awarding attorneys' fees from a common fund, the district court must assume the role of

[47] Mot. – ECF No. 1761-1 at 19 (citing settlement in state cases).

[48] Mot. – ECF No. 1754 at 29–30; Mot. – ECF No. 1761-1 at 15; Kim. Suppl. Decl. – ECF No. 1762.

> fiduciary for the class plaintiffs. Accordingly, fee applications must be closely scrutinized. Rubber-stamp approval, even in the absence of objections, is improper.

*Vizcaino v. Microsoft Corp.*, 290 F.3d 1043, 1052 (9th Cir. 2002) (cleaned up). When counsel recovers a common fund that confers a "substantial benefit" on a class, counsel is "entitled to recover their attorney's fees from the fund." *Fischel v. Equitable Life Assurance Soc'y of U.S.*, 307 F.3d 997, 1006 (9th Cir. 2002). In common-fund cases, courts may calculate a fee award under either the "lodestar" or "percentage of the fund" method. *Id.*; *Hanlon*, 150 F.3d at 1029.

The "percentage of the fund" method is typically used. The Ninth Circuit's benchmark is twenty-five percent of the settlement, but courts diverge based on factors that include the results obtained, risks undertaken by counsel, the complexity of the issues, the length of the professional relationship, the market rate, and similar awards. *Morales v. Stevco, Inc.*, No. CIV-F-09-0704-AWI-JLT, 2013 WL 1222058, at *2 (E.D. Cal. Mar. 25, 2013); *Morris v. Lifescan, Inc.*, 54 F. App'x 663, 664 (9th Cir. 2003) (thirty-three-percent fee award); *In re Pac. Enters. Sec. Litig.*, 47 F.3d 373, 379 (9th Cir. 1995) (same).

If the court applies the percentage method, it calculates the lodestar as a cross-check to assess the reasonableness of the fees. *See, e.g.*, *Weeks v. Kellogg Co.*, No. CV-09-8102-MMM-RZx, 2013 WL 6531177, at *25 (C.D. Cal. Nov. 23, 2013); *see also Serrano v. Priest*, 20 Cal. 3d 25, 48–49 (1977); *Fed-Mart Corp. v. Pell Enters.*, 111 Cal. App. 3d 215, 226–27 (1980). The lodestar is the number of hours reasonably expended multiplied by a reasonable hourly rate. *Lealao v. Beneficial Cal., Inc.*, 82 Cal. App. 4th 19, 26 (2000). The court has discretion to apply a multiplier to take into account other factors, "including the quality of the representation, the novelty and complexity of the issues, the results obtained, and the contingent risk presented." *Id.*; *accord Laffitte v. Robert Half Int'l Inc.*, 1 Cal. 5th 480, 503–06 (2016) (California standard).

The fees are appropriate as a percentage of the common fund, supported by a lodestar cross-check, the complexity and results, and the lack of objections to the settlement amount.[49] *See, e.g.*, *Bellinghausen v. Tractor Supply Co.*, 306 F.R.D. 245, 259–65 (N.D. Cal. 2015) (approving

[49] *See* Mot. – ECF No. 1754 at 24–28; Pearl Decl. – ECF No. 1754-16 at 10–30 (¶¶ 15–26); Kim Decl. – ECF No. 1754-1 at 2–5 (¶¶ 5–22), 7 (¶ 32); Report, Ex. E to Kim Decl. – ECF No. 1754-1 at 46.

benchmark twenty-five percent of the common fund); *Burden v. SelectQuote Ins. Servs.*, No. C 10-5966-LB, 2013 WL 3988771, at *4–5 (N.D. Cal. Aug. 2, 2013) (thirty-three percent, given extensive litigation, successful results, and contingency risk); *Villalpando v. Exel Direct Inc.*, Nos. 12-cv-04137-JCS, 13-cv-03091-JCS, 2016 WL 7740854, at *2 (N.D. Cal. Dec. 12, 2016) (same). Class counsel collects cases supporting the conclusion that the inherent complexity of antitrust cases is a factor that courts consider in awarding a one-third fee award.[50] The lodestar exceeds the fees sought, and counsel did not seek enhanced rates, which supports the reasonableness of the percentage fee request.[51] *Taylor v. Shutterfly, Inc.*, No. 5:18-CV-00266-BLF, 2021 WL 5810294, at *9 (N.D. Cal. Dec. 7, 2021) (counsel sought less in fees than they reasonably incurred). The objection to the gross-fee calculation is overruled because precedent supports gross-fund calculations. *In re Anthem, Inc. Data Breach Litig.*, No. 15-MD-02617-LHK, 2018 WL 3960068, at *8–9 (N.D. Cal. Aug. 17, 2018); *In re Online DVD-Rental Antitrust Litig.*, 779 F.3d 934, 953 (9th Cir. 2015); *Powers v. Eichen*, 229 F.3d 1249, 1258 (9th Cir. 2000); *Hermosillo v. Davey Tree Surgery Co.*, No. 18-CV-00393-LHK, 2021 WL 2826697, at *5 (N.D. Cal. July 7, 2021).

The expenses are reasonable and compensable, involving experts and other categories routinely charged to paying clients. Fed. R. Civ. P. 23(h) (compensable expenses include "nontaxable costs that are authorized by law or by the parties' agreement"); *Harris v. Marhoefer*, 24 F.3d 16, 20 (9th Cir. 1994) (can recover reasonable expenses that would be billed to paying clients in non-contingency matters); *Van Vranken v. Atl. Richfield Co.*, 901 F. Supp. 294, 299 (N.D. Cal. 1995) (approving reasonable expenses in class action settlement).[52]

[50] Mot. – ECF No. 1754 at 23–24 (citing *In re Flonase Antitrust Litig.*, 291 F.R.D. 93, 104 (E.D. Pa. 2013) and collecting other cases).

[51] Report, Ex. E to Kim Decl. – ECF No. 1754-1 at 46 (attorney's fees of $81,368,771.00 at historical rates).

[52] Mot. – ECF No. 1761-1 at 34 at 23–24 & n.5 (collecting cases).

**5. Service Awards**

The court approves the service awards, which reflect the representatives' significant time and effort during this protracted litigation. *See, e.g.*, *Bernstein v. Virgin Am., Inc.*, No. 15-cv-02277-JST, 2023 WL 7284158, at *3–4 (N.D. Cal. Nov. 3, 2023) (service awards of $25,000 and $12,000); *Rabin v. PricewaterhouseCoopers LLP*, No. 16-cv-02276-JST, 2021 WL 837626, at *10 (N.D. Cal. Feb. 4, 2021) ($20,000); *In re Wells Fargo & Co. S'holder Derivative Litig.*, 445 F. Supp. 3d 508, 534 (N.D. Cal. 2020), *aff'd*, 845 F. App'x 563 (9th Cir. 2021) ($25,000); *Perez v. Rash Curtis & Assocs.*, No. 4:16-cv-03396-YGR, 2020 WL 1904533, at *22 (N.D. Cal. Apr. 17, 2020) ($25,000 where the plaintiff held regular meetings with class counsel for more than three years, sat for a lengthy deposition, traveled multiple times from Sacramento to Oakland to appear at trial, testified live at trial, and worked with class counsel to pursue collection efforts); *Vietnam Veterans of Am. v. Cent. Intel. Agency*, No. 09-cv-00037-CW, 2018 WL 4827397, at *1 (N.D. Cal. Oct. 4, 2018) ($20,000); *In re Nat'l Collegiate Athletic Ass'n Athletic Grant-in-Aid Cap Antitrust Litig.*, No. 4:14-md-2541 CW, 2017 WL 6040065, at *11 (N.D. Cal. Dec. 6, 2017), *aff'd*, 768 F. App'x 651 (9th Cir. 2019) ($20,000).

**6. Class Representative, Class Counsel, and Claims Administrator**

The court confirms its appointment of the class representative, class counsel, and JND as administrator and approves $10 million in administrative costs.[53] Fed. R. Civ. P. 23(a), (g)(1).

**7. Class Notice**

The notice plan, executed by JND under the court-approved notice plan, satisfied Rule 23(c)(2) and due process, providing the best notice practicable with information via mail, email, digital mail, and a website. It adequately advised class members of their rights and provided all required information, including (1) a summary of the lawsuit and claims asserted, (2) a clear

[53] Order – ECF No. 901 at 2–3; Settlement Agreement, Ex. A to Kim Decl. – ECF No. 1761-2 at 12 (§ I.A.17).

definition of the class, (3) a description of the material terms of the settlement, (4) a disclosure of the release of the claims, (5) an explanation of class members' opt-out rights, a date by which they must opt out, and information about how to do so, (6) the date, time, and location of the final fairness hearing, and (7) the identity of class counsel and the provisions for attorney's fees, costs, and class-representative service awards.

**8. Compliance with CAFA**

The defendants complied with CAFA notice requirements under 28 U.S.C. § 1715(b), with the fairness hearing held over ninety days after service.[54]

## CONCLUSION

The court approves the class-action settlement, including the fees and costs, and will separately enter the plaintiffs' proposed order and proposed form of judgment.

**IT IS SO ORDERED.**

Dated: November 6, 2025

LAUREL BEELER
United States Magistrate Judge

[54] Settlement Agreement, Ex. A to Kim Decl. – ECF No. 1761-2 at 14 (§ II.B.3).

# Exhibit 71

Message

**From**: Kyle L. Monroe [kmonroe@the-alliance.org]
**Sent**: 7/18/2021 9:01:59 PM
**To**: Debora Kunferman [DKunferman@The-Alliance.org]
**Subject**: Fwd: Centivo and Aurora

FYI

KLM

---

**From:** Melina Kambitsi, Ph.D. <mkambitsi@the-alliance.org>
**Sent:** Friday, July 16, 2021 4:40:44 PM
**To:** Cheryl DeMars <CDeMars@The-Alliance.org>; Kyle L. Monroe <kmonroe@the-alliance.org>; Paul Meyer <PMeyer@The-Alliance.org>
**Cc:** Jennifer Austin <Jaustin@the-alliance.org>
**Subject:** Centivo and Aurora

The new Centivo product will place Aurora in the lowest tier indicating that the all plans language is no longer an issue with Aurora. I also heard that the regulators are having serious discussions with Aurora because of their remaining contracts with the all plan language. Have a great weekend. Melina

Get Outlook for iOS

# Exhibit 72

Message

**From**: andrea.lathers@bcbswi.com [andrea.lathers@bcbswi.com]
**Sent**: 6/29/2020 11:52:06 AM
**To**: amy.patrick@anthem.com
**CC**: Barry.Eldridge@bcbsmo.com
**Subject**: RE: ML Differential for ASC vs Outpt

[redacted]

**From:** Patrick, Amy M. <amy.patrick@anthem.com>
**Sent:** Monday, June 29, 2020 9:11 AM
**To:** Lathers, Andrea <andrea.lathers@bcbswi.com>
**Cc:** Eldridge, Barry <Barry.Eldridge@bcbsmo.com>
**Subject:** RE: ML Differential for ASC vs Outpt

Hi Andrea,

WI plans will not have a different cost for ASCs in 2021. It was decided that we would not be able to implement this due to the anti-steerage language with the Aurora contract. Also, there was a lack of independently owned ASCs. (The cost share differential for ASCs could only apply to independently owned/free standing)

Let me know if you have any questions.

Thanks,

Amy

**Anthem, Inc.**

**Amy Patrick,** *Product Management Director*
O: (224) 456-0798| M: (847) 858-6095
amy.patrick@anthem.com

**From:** Lathers, Andrea <andrea.lathers@bcbswi.com>
**Sent:** Monday, June 29, 2020 8:46 AM
**To:** Patrick, Amy M. <amy.patrick@anthem.com>
**Cc:** Eldridge, Barry <Barry.Eldridge@bcbsmo.com>
**Subject:** ML Differential for ASC vs Outpt

[redacted]

Thanks,
Andrea



*Andrea Lathers, Dir. Network Management*
*Anthem Blue Cross and Blue Shield*
*N17W24340 Riverwood Dr.*
*Waukesha, WI 53188*
*(o) 262-523-3637 (m) 262-442-9709*



# Exhibit 73

Message

**From:** John.Foley@bcbswi.com [John.Foley@bcbswi.com]
**Sent:** 3/3/2014 2:36:15 PM
**To:** Sandi.Camp@anthem.com
**Subject:** Re: Texas Account Request - WI

Steerage

Sent from my iPhone

> On Mar 3, 2014, at 12:34 PM, "Camp, Sandi" <Sandi.Camp@anthem.com> wrote:
>
> IL wanted to confirm if the restriction was due to steerage or precert penalties?
>
> Sandi Camp | Director, National Network Management
> Anthem BCBS |Phone: 513.445.0438 | Cell: 216.374.4969
>
> -----Original Message-----
> From: Foley, John J
> Sent: Friday, February 28, 2014 4:47 PM
> To: Camp, Sandi
> Subject: RE: Texas Account Request - WI
>
> Cannot do this in GB because Aurora contract restricts this activity.
>
> -----Original Message-----
> From: Camp, Sandi
> Sent: Friday, February 28, 2014 2:42 PM
> To: Foley, John J
> Subject: FW: Texas Account Request - WI
>
> Have another one for you. BCBSTX is looking to do member penalty based on facilities costs. Would you allow them to implement as noted below?
>
>
> Sandi Camp | Director, National Network Management Anthem BCBS |Phone: 513.445.0438 | Cell: 216.374.4969
>
>
> -----Original Message-----
> From: JENNESSJ@BCBSIL.COM [mailto:JENNESSJ@BCBSIL.COM]
> Sent: Thursday, February 27, 2014 6:28 PM
> To: Miller, Terry
> Subject: Re: Texas Account Request - WI
>
> They are meeting with the group next week.
>
> Thank you
> --------------------------
> Jim Jenness
> DVP, Bluecard Program Executive
> Health Care Service Corporation
> Tel:  312-653-7502
> jennessj@bcbsil.com
>
>
>
> ----- Original Message -----
> From: "Miller, Terry" [Terry.Miller@anthem.com]
> Sent: 02/27/2014 07:46 PM GMT
> To: James Jenness
> Cc: "Camp, Sandi" <Sandi.Camp@anthem.com>
> Subject: Re: Texas Account Request - WI
>
>
>
> Jim:  We need to engage the local market in this discussion. What kind of timing do you have for response?
>
> Terry
>
> Sent from my iPhone



>
>> On Feb 27, 2014, at 2:21 PM, "JENNESSJ@BCBSIL.COM" <JENNESSJ@BCBSIL.COM> wrote:
>>
>>

>> Thank you
>> --------------------------
>> Jim Jenness
>> DVP, Bluecard Program Executive
>> Health Care Service Corporation
>> Tel:  312-653-7502
>> jennessj@bcbsil.com
>>
>> HCSC Company Disclaimer
>>
>> The information contained in this communication is confidential,
>> private, proprietary, or otherwise privileged and is intended only for
>> the use of the addressee.  Unauthorized use, disclosure, distribution
>> or copying is strictly prohibited and may be unlawful.  If you have
>> received this communication in error, please notify the sender
>> immediately at
>> (312)653-6000 in Illinois; (800) 437-5000 in Montana;
>> (800)835-8699 in New Mexico; (918)560-3500 in Oklahoma; or
>> (972)766-6900 in Texas.
>
> CONFIDENTIALITY NOTICE: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information or otherwise be protected by law. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.
>
>
>



# Exhibit 78

Milliman

71 S. Wacker Drive
31st Floor
Chicago, IL 60606
USA
Tel +1 312 726 0677
Fax +1 312 499 5685

milliman.com

April 2, 2021

Daniel Bailey
VP, Payer Contracting and Finance
ProHealth Care

*[Sent via email: daniel.bailey@phci.org]*

**Re: Hospital Pricing Transparency Rule Data – United HealthCare Commercial Rate Takeaways - DRAFT**

Dear Dan:

This letter summarizes initial findings regarding United HealthCare's commercial contracting in the Milwaukee Area. We have attached an Excel exhibit to assist you in further exploration of reimbursement rates.

Our analysis includes data from the Ascension and Aurora health systems. We have also included the ProHealth system's data to facilitate comparisons. Data for other facilities operating in Milwaukee and Waukesha county is not yet available.

## Inpatient Reimbursement

Based on hospital price transparency data by diagnosis-related group (DRG), United HealthCare generally reimburses Ascension facilities more than ProHealthCare facilities, and reimburses Aurora facilities even more than Ascension facilities. Most United plans include Ascension facilities, including some single facility narrow networks.

There is significant variation in payment relativity by DRG. For example, reimbursement relativities for Ascension vary from 67% to over 600% for most facilities, averaging approximately 115% of ProHealth reimbursements. There is more variation for Aurora relative to ProHealth, and average reimbursements for United HealthCare commercial business average approximately 160% of ProHealth reimbursements.

## Outpatient Reimbursement

Based on the data provided, we understand that ProHealth contracts with United HealthCare for outpatient services on a Current Procedure Terminology (CPT) basis. Aurora also contracts with united HealthCare on this basis, and similar patterns appear to hold. Based on ProHealth's top 100 outpatient services, Aurora is reimbursed at approximately 230% of ProHealth reimbursement on average. As with inpatient data, there is significant variation by service.

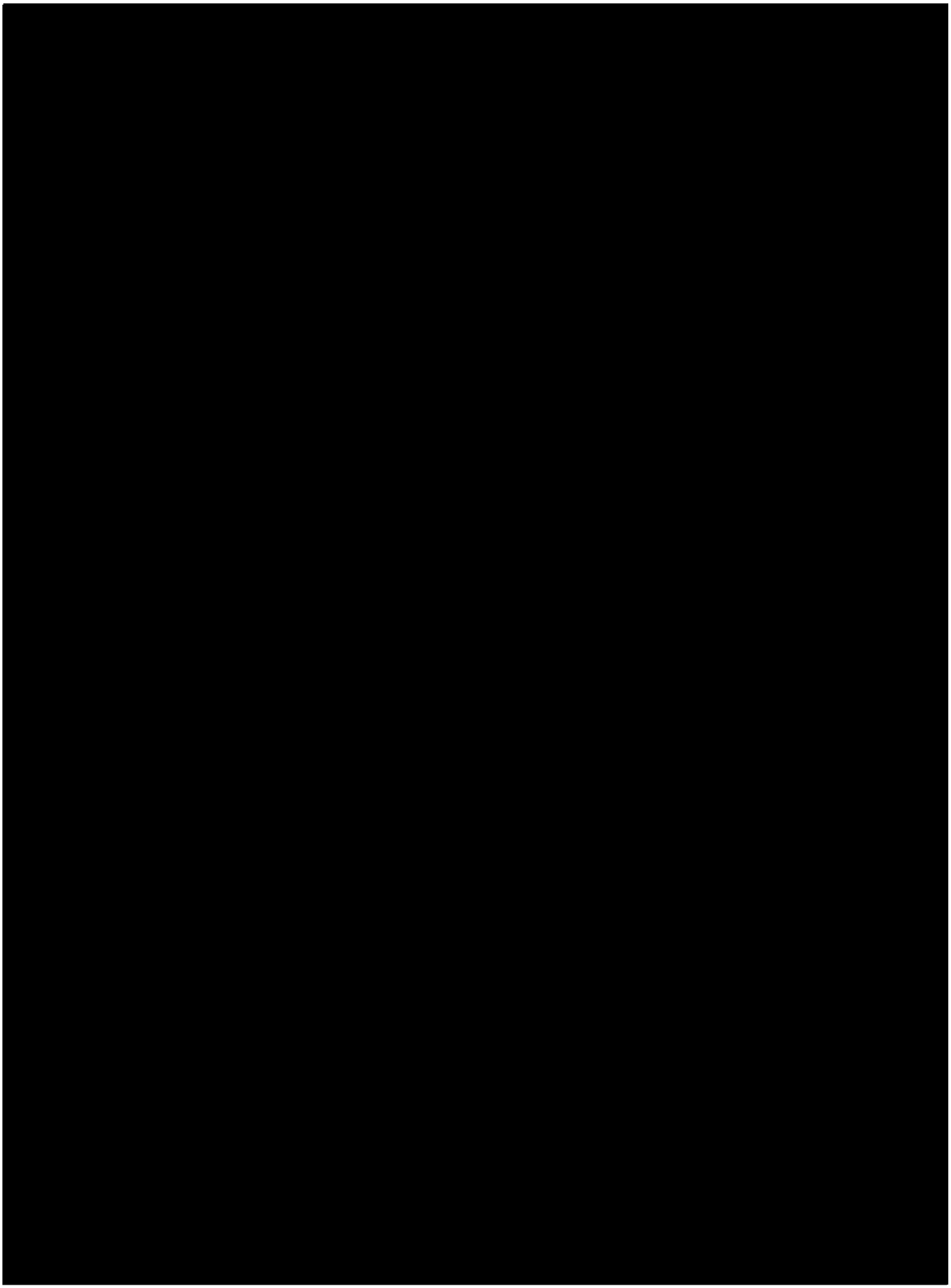
We also reviewed listed revenue codes, and Ascension did not have rates for certain revenue codes covered by ProHealth than Aurora.

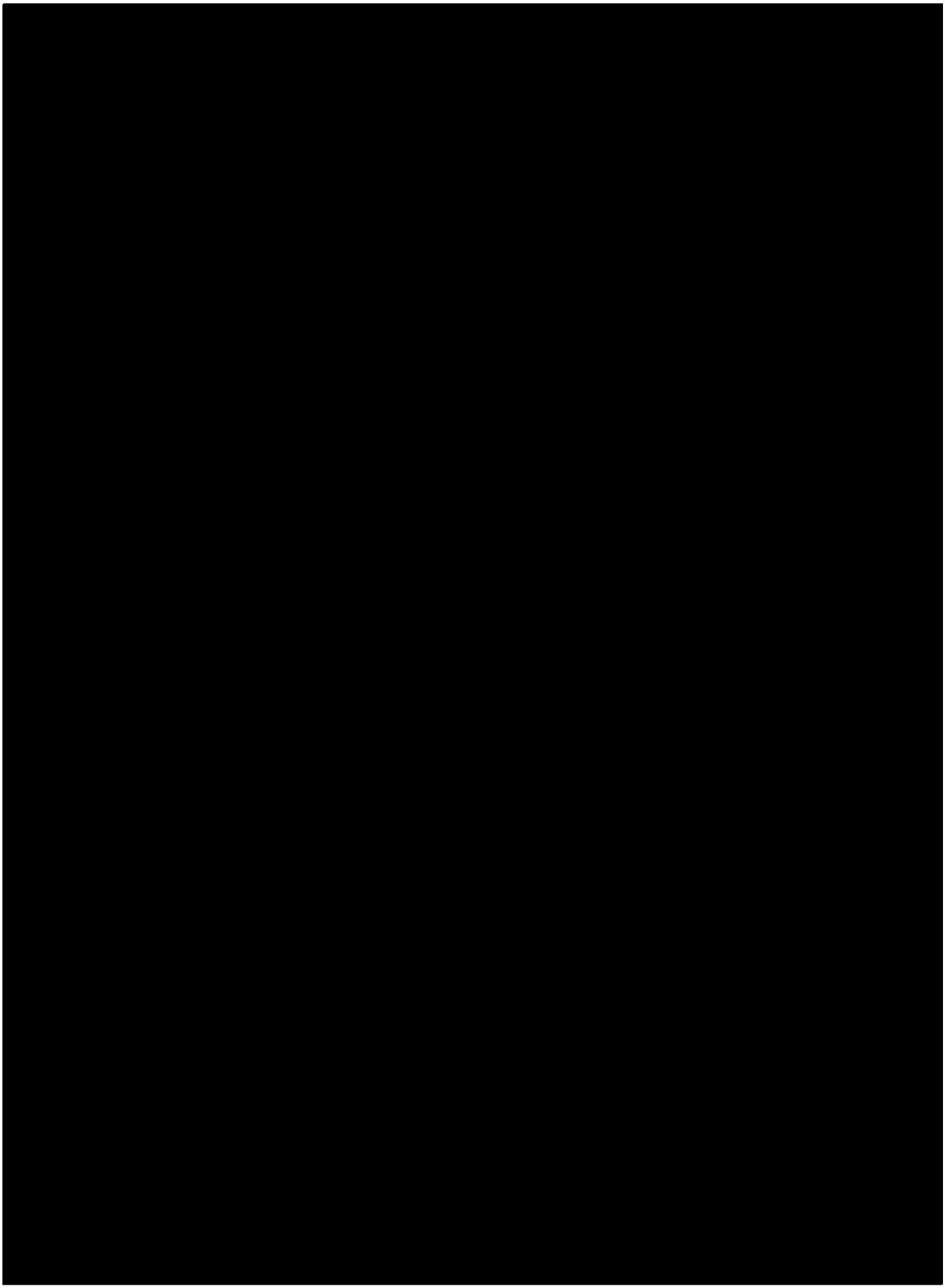
## United Contracted Rates Exploration

We prepared the attached Excel file, 'Bailey04 - PHC Price Transparency Competitor Comparison Workbook - UHC Commercial Rates.xlsx', to assist ProHealth with understanding United HealthCare's contracted rates with regional competitors. This Excel workbook contains five tabs:

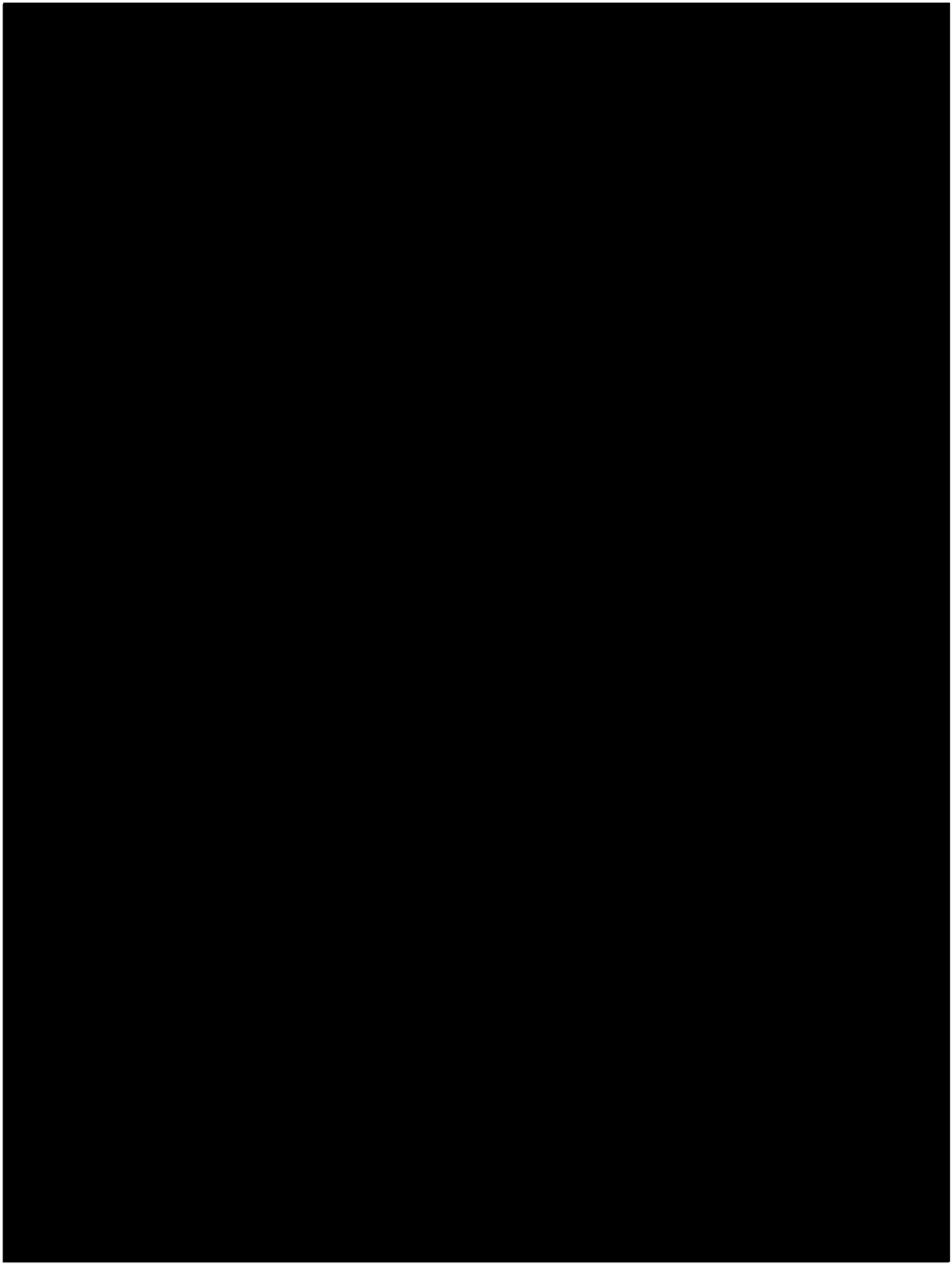
- **Top100 DRGs and CPTs**

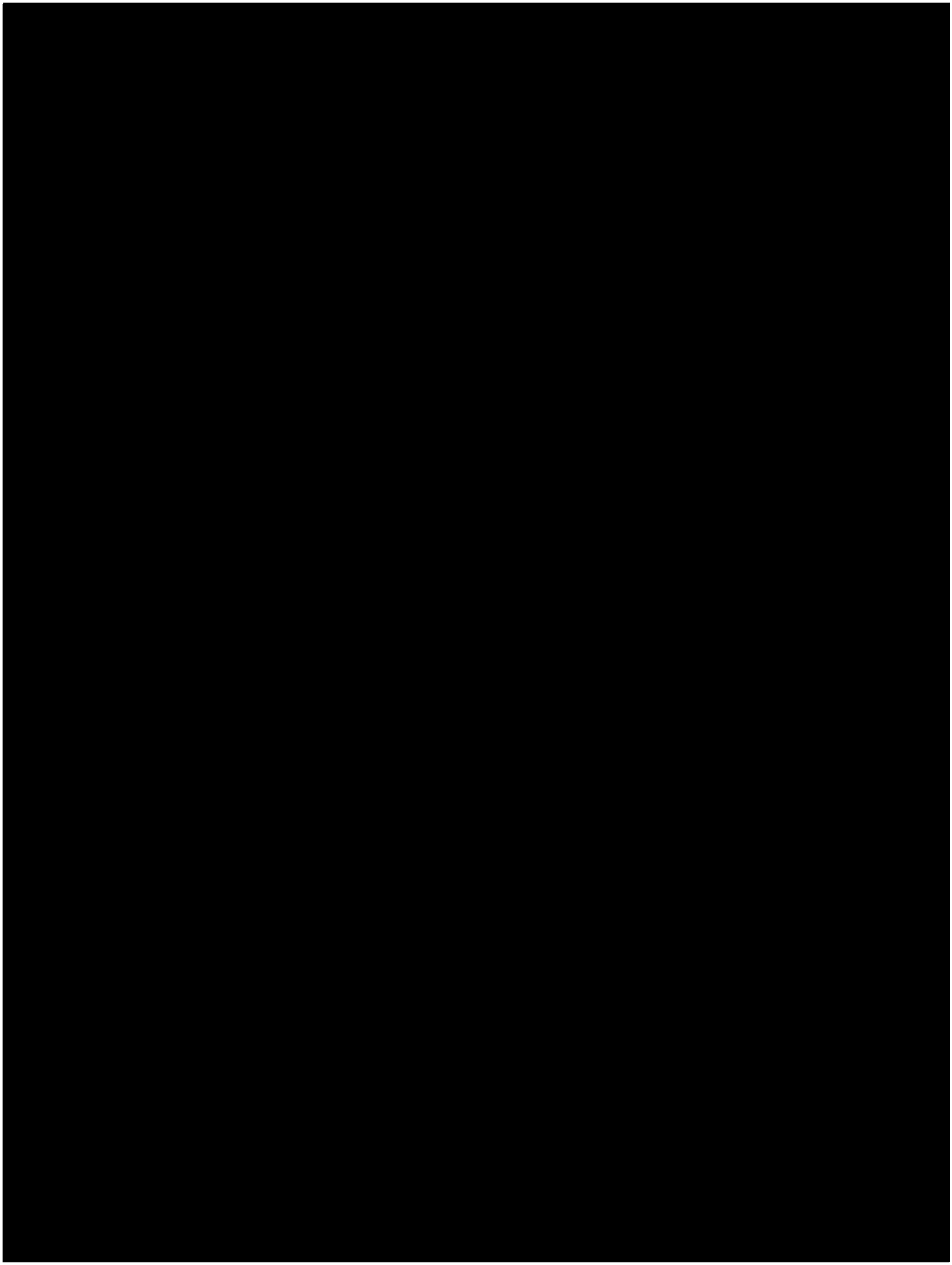
  This tab summarizes reimbursement rates for Ascension and Aurora health systems relative to average ProHealth reimbursements in Price Transparency data.

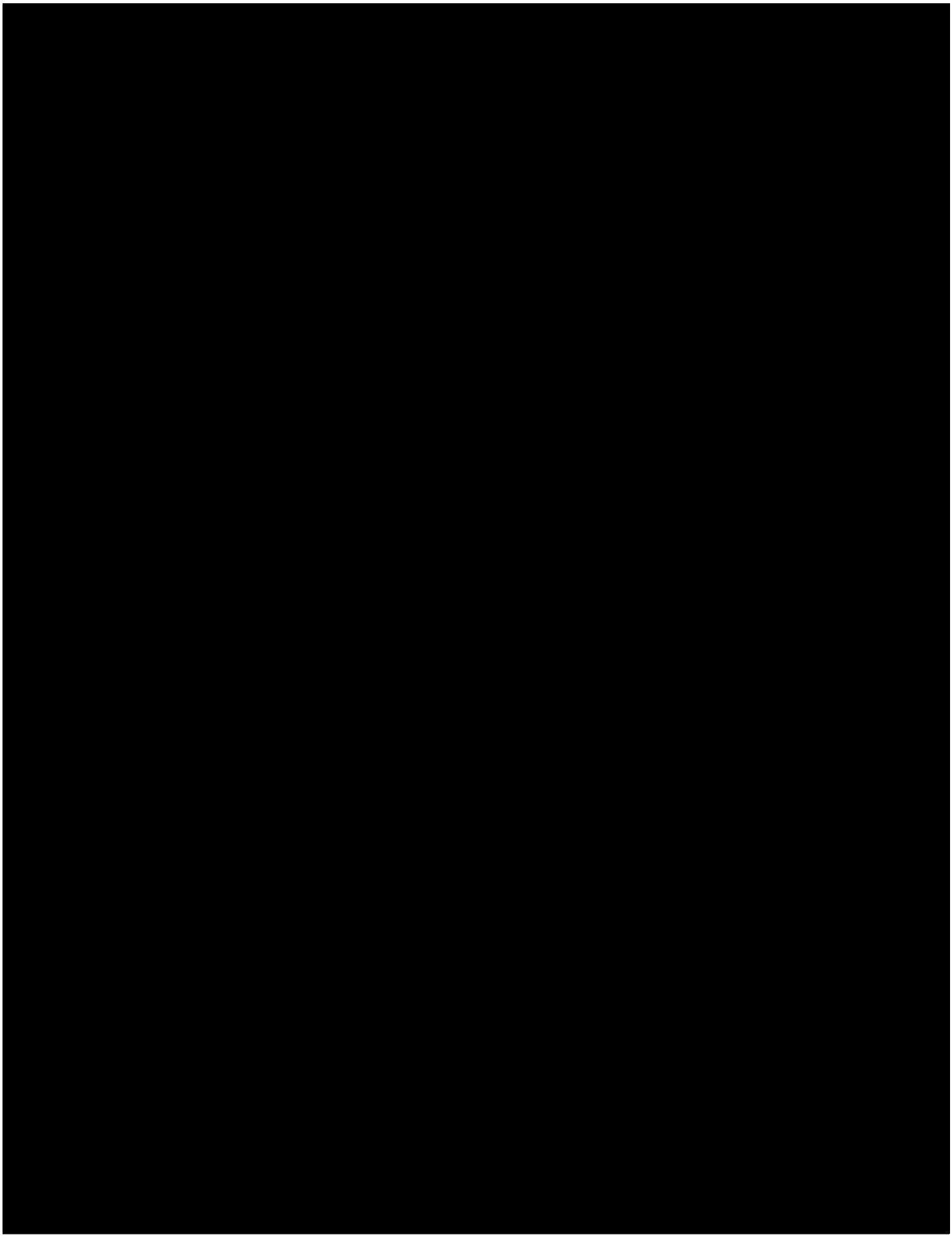


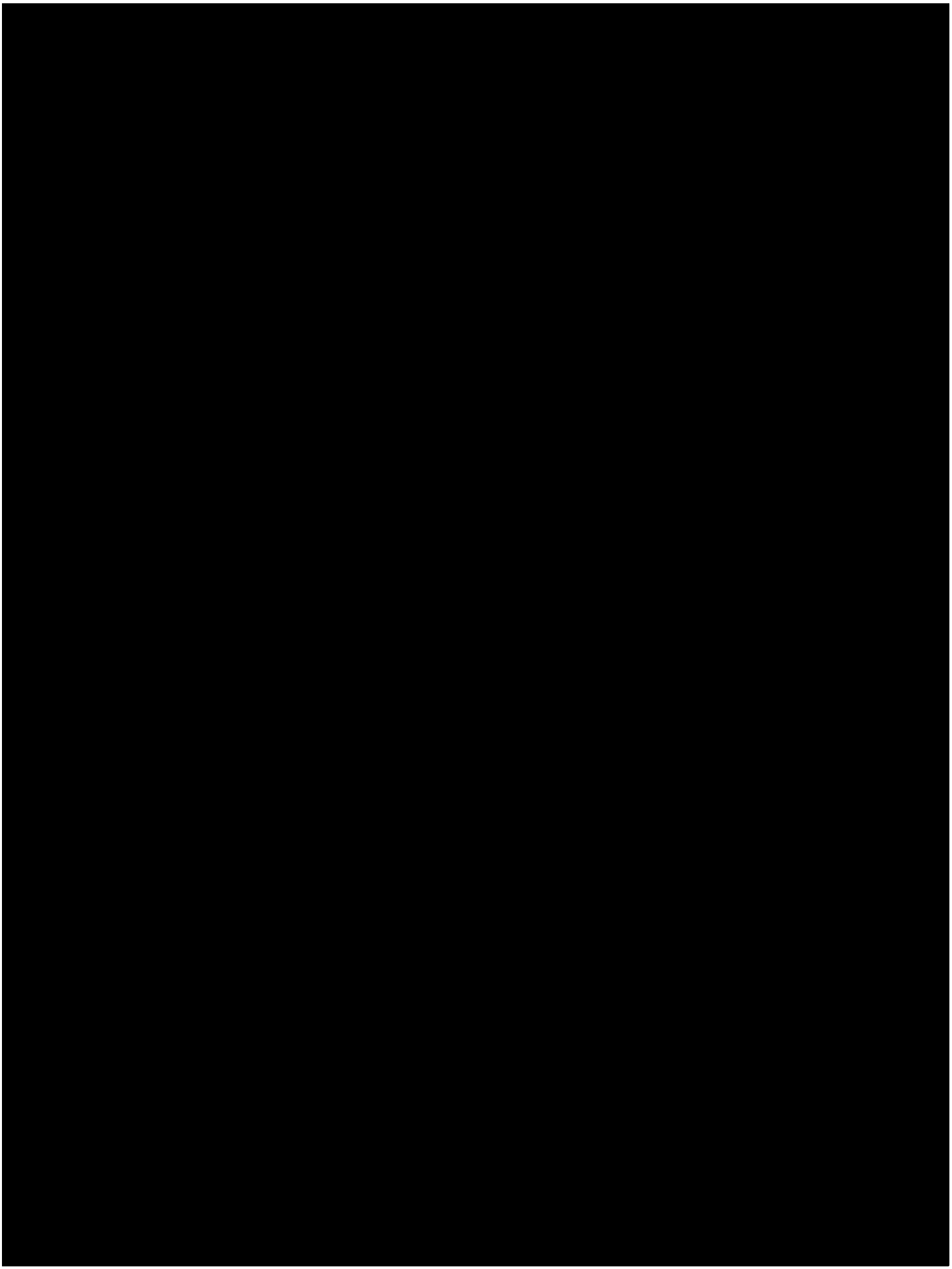


# Exhibit 79









**From:** Lenz, Larry <Larry.Lenz@aah.org>
**Sent:** Tuesday, July 25, 2023 8:19 AM
**To:** Oliva, Heather <Heather.Oliva@wpsic.com>; Stahlkopf, Daniel <Daniel.Stahlkopf@aah.org>
**Cc:** Spiegel, Katie <Katie.Spiegel@wpsic.com>
**Subject:** RE: Follow-up to WPS Employer Navigation


Heather, I thought the gist of your whole initiative was to move to a single network and fee schedule. Are you now suggesting changing direction and splitting off another network? Is this a one off for a single employer or would this become a standard plan design?

**Larry Lenz**
Vice President, Managed Health
Payor Contracting
O 414-647-3120

ADVOCATEHEALTH

---

**From:** Oliva, Heather <Heather.Oliva@wpsic.com>
**Sent:** Monday, July 17, 2023 1:44 PM
**To:** Lenz, Larry <Larry.Lenz@aah.org>; Stahlkopf, Daniel <Daniel.Stahlkopf@aah.org>
**Cc:** Spiegel, Katie <Katie.Spiegel@wpsic.com>
**Subject:** [EXTERNAL] Follow-up to WPS Employer Navigation
**Importance:** High



Good Afternoon-

A few weeks back, I mentioned that WPS has an ASO client that wants to implement a tiered plan for its members. At the time it was still in discussion as an option for the group, but we're now in active planning for a 1/1/2024 effective date.

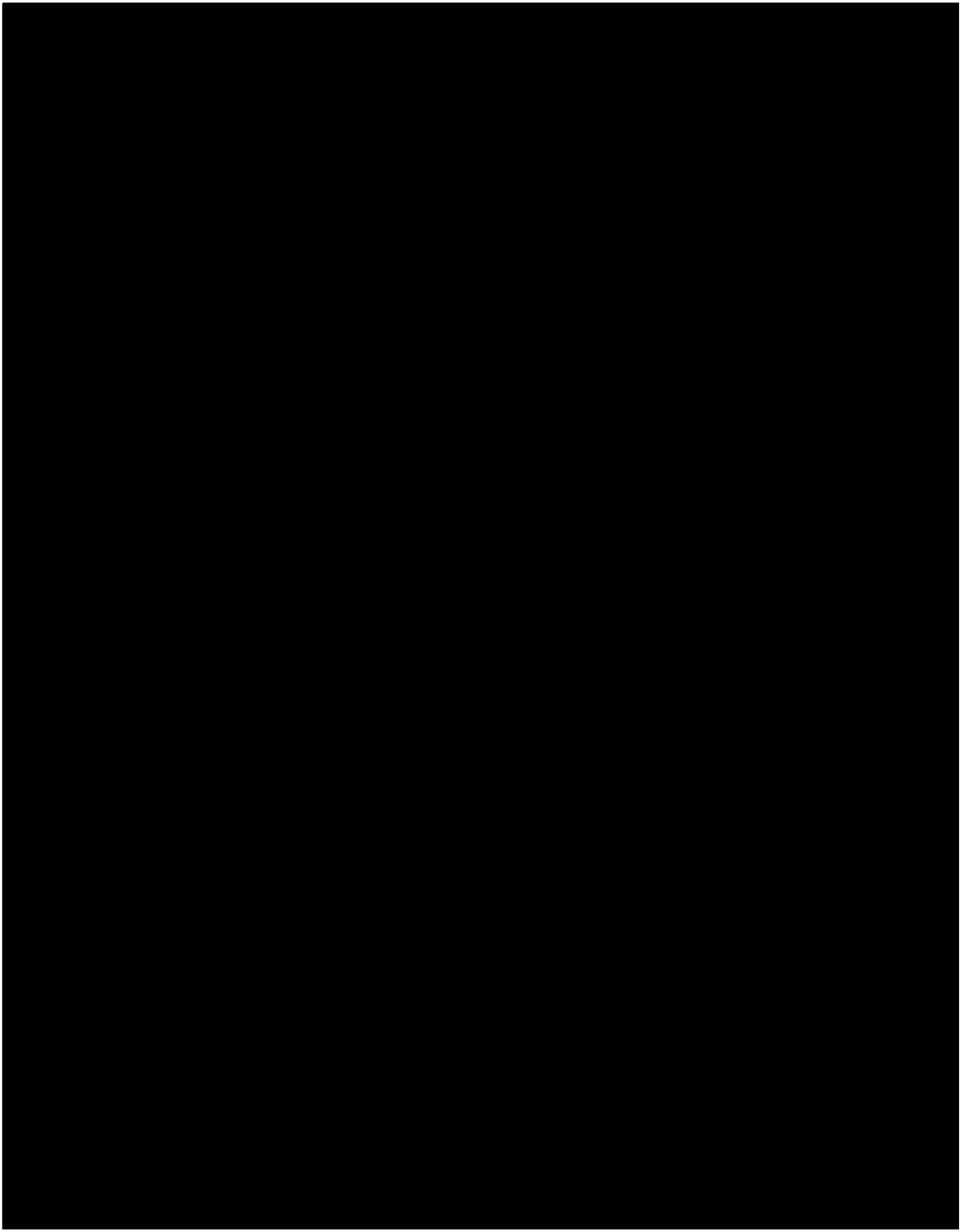
The employer has roughly 800 total lives, split roughly 65/35 between Dane County and Milwaukee with plans to add jobs in Milwaukee next year.

The group is in our Alliance/Statewide integrated network, and would use an Alliance tiered network for Dane county. For the Milwaukee population, we'd like to put Aurora in Tier 1, at the highest benefit level, the rest of Statewide at Tier 2, out of network at Tier 3. The benefit differential will be 10% between each of the Tiers- think 90/80/70.

Aurora was willing to extend a 5% differential to WPS for our on-Exchange product. Given the steerage built into the plan, the reduced patient contribution and collection costs for care at Aurora, and the interest we're seeing with other employers, would you be willing to do the same here?

We are meeting with the group next week on this, and while I know it's a short timeline, I'd like to be able to let them know if we can make this work. Call or email with any questions.

Thank you,
Heather



# Exhibit 81

STATE OF WISCONSIN CIRCUIT COURT BRANCH 2 MILWAUKEE COUNTY



AURORA HEALTH CARE, INC.,

Plaintiff,

v.

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION,

Defendant.

Case No. 05-CV-11279

Case Type: Other Contract, Intentional Tort

Case Code: 30303, 30106

**WPS'S ANSWER TO AURORA'S AMENDED COMPLAINT, AMENDED COUNTERCLAIMS, AND REPLY TO COUNTER-COUNTERCLAIMS**

**ANSWER TO AMENDED COMPLAINT**

Defendant Wisconsin Physicians Service Insurance Corporation ("WPS"), by its undersigned attorneys, Godfrey & Kahn, S.C. and Seyfarth Shaw, LLP, answers the Amended Complaint in the above-captioned action, paragraph-by-paragraph, as follows:

1. Answering paragraph 1, admits that plaintiff Aurora Health Care, Inc. ("Aurora") is a Wisconsin corporation with its offices and principal place of business located at 3000 West Montana, Milwaukee, Wisconsin 53215; admits that Aurora is a health care system comprised of physicians, hospitals and other health care providers and facilities; and denies knowledge or information sufficient to form a belief as to the truth of the remaining allegations in paragraph 1.

2. Answering paragraph 2, admits that WPS is a Wisconsin corporation with its principal place of business located at 1717 West Broadway, Madison, Wisconsin 53713; admits that WPS is a health insurance company that sells individual and group health insurance products to employers, associations, and individuals; admits that WPS provides administrative services to

certain self-insured employers, associations, and other entities; and denies the remaining allegations in paragraph 2.

3. Answering paragraph 3, admits that WPS offers several different insurance products to its customers; admits that the products have many characteristics that distinguish one from another, including, but not limited to, some of the "distinguishing factors" listed in paragraph 3; affirmatively alleges that each separate product is defined by agreements with customers and other written documents; and denies the remaining allegations in paragraph 3.

4. Answering paragraph 4, admits that on December 11, 2001, Aurora and WPS entered into a Preferred Provider Agreement (the "Agreement") effective July 1, 2001, and that a true and correct copy of the Agreement is attached to the Complaint as Exhibit A; affirmatively alleges that the Agreement is a written document that speaks for itself; admits the allegations in paragraph 4 to the extent that they are consistent with the Agreement; denies the allegations in paragraph 4 to the extent that they are inconsistent with the Agreement; and denies the remaining allegations in paragraph 4.

5. Answering paragraph 5, admits that the terms "Plan" and "WPS" are defined in the Agreement; affirmatively alleges that the Agreement, including, but not limited to, those definitions, speaks for itself; admits the allegations in paragraph 5 to the extent that they are consistent with the Agreement; denies the allegations in paragraph 5 to the extent that they are inconsistent with the Agreement; and denies the remaining allegations in paragraph 5.

6. Denies.

7. Answering paragraph 7, admits that WPS Health Plan, Inc. ("WPS Health Plan") does not include Aurora providers in its network; affirmatively alleges that WPS Health Plan is a Wisconsin corporation that is a health maintenance organization ("HMO"), not a preferred

provider plan, that WPS Health Plan began doing business as WPS Prevea Health Plan ("Prevea"), and that WPS is not contractually obligated to include Aurora's health care providers in the Prevea network; and denies the remaining allegations in paragraph 7.

8. Answering paragraph 8, admits that Aurora representatives have stated to WPS representatives that Aurora believes WPS has breached the Agreement; affirmatively alleges that WPS has not breached the Agreement; and denies the remaining allegations in paragraph 8.

9. Answering paragraph 9, admits that Aurora representatives and WPS representatives have met to discuss their differences about the Agreement; affirmatively alleges that WPS has not breached the Agreement; and denies the remaining allegations in paragraph 9.

10. Answering paragraph 10, admits that Donald J. Nestor of Aurora forwarded a letter dated June 24, 2005 to Josephine Musser of WPS; affirmatively alleges that the letter is a written document that speaks for itself; admits the allegations in paragraph 10 to the extent that they are consistent with the document; denies the allegations in paragraph 10 to the extent that they are inconsistent with the document; and denies the remaining allegations in paragraph 10.

11. Answering paragraph 11, admits that Donald J. Nestor of Aurora forwarded a letter dated July 18, 2005 to William T. Bathke of WPS and that a true and correct copy of the letter is attached to the Complaint as Exhibit B; affirmatively alleges that the letter is a written document that speaks for itself; admits the allegations in paragraph 11 to the extent that they are consistent with the document; denies the allegations in paragraph 11 to the extent that they are inconsistent with the document; and denies the remaining allegations in paragraph 11.

12. Answering paragraph 12, admits that on October 17, 2005, WPS and Aurora attempted, unsuccessfully, to mediate their dispute and that the Hon. Michael J. Barron (retired)

served as the mediator; affirmatively alleges that WPS, not Aurora, suggested that the parties attempt to mediate their differences; and denies the remaining allegations in paragraph 12.

13. Denies.

14. Denies.

15. Denies.

WPS denies each and every other allegation that it has not expressly admitted.

**AFFIRMATIVE DEFENSES**

As and for its affirmative defenses, WPS states as follows:

1. Aurora's claims are barred by the doctrine of unclean hands.

2. Aurora's claims are barred by the doctrine of laches.

3. Based on its conduct with respect to the Agreement, Aurora has waived its claims.

4. Based on its conduct with respect to the Agreement, Aurora is estopped from asserting its claims.

5. Based on information and belief, Aurora has failed to mitigate its alleged damages, if any.

6. If Aurora's interpretation of the Agreement were correct, then the Agreement would be illegal and unenforceable under Wisconsin law.

7. If Aurora's interpretation of the Agreement were correct, then the Agreement would be void pursuant to Wis. Stat. § 133.14.

8. If Aurora has suffered any damages as alleged in the Amended Complaint, then those damages are based on Aurora's conduct or on the conduct of third parties over whom WPS had and has no control.

**AMENDED COUNTERCLAIMS**

As and for its amended counterclaims against Aurora, WPS states as follows:

**Claim 1: Declaratory Judgment (Wis. Stat. § 806.04)**

1. WPS is a nonprofit, nonstock Wisconsin service insurance corporation organized under Wis. Stat. chapter 613, with its principal place of business located at 1717 West Broadway, Madison, Wisconsin 53713. WPS is a health insurance corporation and benefits administrator licensed by the state of Wisconsin.

2. Aurora is a Wisconsin corporation with its principal place of business located at 3000 West Montana, Milwaukee, Wisconsin 53215. Aurora is a vertically integrated health care system comprising primary care physicians, specialist physicians, clinics, hospitals, and other health care providers and facilities across the eastern half of Wisconsin. Aurora is the largest health care provider in Wisconsin.

3. Effective July 1, 2001, WPS and Aurora entered into a Preferred Provider Agreement (the "Agreement"). A true and correct copy of the Agreement is appended to Aurora's Complaint as Exhibit A.

4. Pursuant to the Agreement, "AURORA shall, during the term of this Agreement: 1. Permit designation by WPS to current and prospective Covered Members that all AURORA providers are Participating Providers and are Preferred Providers." Agreement, p. 2.

5. Pursuant to the Agreement, "WPS shall, during the term of this Agreement: 1. Identify all AURORA Participating Providers as Participating Preferred Providers in all WPS Plans within Aurora's defined service area of eastern Wisconsin." Agreement, p. 3.

6. Aurora is a designated Preferred Provider participating in the WPS Statewide Network. Each time WPS offers one of its health plans to an employer or individual applicant, Aurora health care providers are identified as Preferred Providers participating in the WPS Statewide Network, and the WPS Statewide Network is offered as an option to the employer or individual applicant.

7. Since 2002, WPS has had leasing or rental arrangements with third-party health care networks, including Patient Choice, and with third-party networks accessed by employer associations, including Sheboygan Employer's Alliance to Reduce the Cost of Healthcare, Inc. ("SEARCH"),[1] and Health Care Coalition Holy Family Exclusive Network ("HCC"). None of these third-party networks are WPS plans. WPS did not create them; it does not control the composition of the network; and the network's health care providers do not contract with WPS. Accordingly, WPS is not obligated under the Agreement to identify Aurora health care providers as Preferred Providers to the participants using those networks.

8. WPS provides a group health insurance plan for certain Milwaukee County employees who are covered under a group health insurance policy issued by WPS, as the insuring underwriter, to Milwaukee County, as the group policy-owner. During a period of open enrollment, each Milwaukee County employee eligible for group health insurance through WPS had the opportunity to choose among eight health care networks from which to receive their health care services from Preferred Providers, including the WPS Statewide Network, in which Aurora is a designated Preferred Provider. At the time of the open enrollment, there were no financial or monetary disincentives for Milwaukee County employees to select the WPS Statewide Network.

9. WPS Health Plan is a Wisconsin stock insurance corporation and a subsidiary of WPS that is specifically licensed in Wisconsin as a health maintenance organization ("HMO"). In June, 2005, WPS Health Plan purchased certain assets from PHP Insurance Plan, Inc., another Wisconsin HMO, and began doing business as WPS Prevea Health Plan. WPS Health Plan and Prevea did not exist when WPS and Aurora entered into the Agreement. Furthermore, WPS

[1] SEARCH accesses two networks. One includes Aurora health care providers, and one does not.

Health Plan is an HMO, not a preferred provider organization ("PPO"), and the Agreement, by its terms, conditions, and provisions, only applies to PPOs.

10. When WPS offers the Patient Choice network to a prospective customer, it also offers the WPS Statewide Network. If the customer chooses Patient Choice, however, then Aurora health care providers will not be included in the customer's health care provider network. Aurora claims that violates the Agreement. WPS disagrees. Patient Choice is a rented third-party network, not a WPS plan. Furthermore, the WPS Statewide Network is an option offered at the same time as third-party networks like Patient Choice are offered. The customer, not WPS, chooses which network option to purchase. Finally, Patient Choice offered Aurora the opportunity to participate in the Patient Choice network, but Aurora chose not to participate.

11. When WPS offers the SEARCH networks to a prospective customer, it also offers the WPS Statewide Network. If the customer chooses the SEARCH network that does not include Aurora, however, then Aurora health care providers will not be included in the customer's health care provider network. Aurora claims that violates the Agreement. WPS disagrees. SEARCH is an employer association that accesses third-party networks, it is not a WPS plan. Furthermore, the WPS Statewide Network is a network option offered by WPS at the same time as the SEARCH third-party networks. The customer, not WPS, chooses which network option to purchase from WPS. Finally, SEARCH has two separate networks, and Aurora health care providers are included in one of them.

12. When WPS offers the HCC network to a prospective customer, it also offers the WPS Statewide Network. If the customer chooses the HCC network, however, then Aurora providers will not be included in the customer's health care provider network. Aurora claims that violates the Agreement. WPS disagrees. HCC is an employer association that accesses a

third-party network and other health care providers, it is not a WPS plan. Furthermore, the WPS Statewide Network is a network option offered by WPS at the same time as the HCC third-party networks. The customer, not WPS, chooses which network option to purchase from WPS.

13. WPS offered to eligible Milwaukee County employees eight health care provider networks. Some employees chose network options that do not include Aurora health care providers. Aurora claims that violates the Agreement. WPS disagrees. During the open enrollment period for Milwaukee County employees, the WPS Statewide Network was an alternative network available to all participating employees. Furthermore, there was no financial or monetary disincentives for the employees to choose the WPS Statewide Network, which includes Aurora health care providers as participating Preferred Providers. The employees, not WPS, chose which network option to accept. Finally, Patient Choice offered Aurora the opportunity to participate in the Patient Choice network, which also was a network option for eligible Milwaukee County employees, but Aurora chose not to participate.

14. Aurora health care providers are not included in Prevea. Aurora claims that violates the Agreement. WPS disagrees. WPS Health Plan, which does business as Prevea, is an HMO organized under Wis. Stat. chapter 611. The Agreement, entitled "Preferred Provider Agreement," applies to WPS PPO plans, not to HMOs. "Preferred Provider Plan" and "Health Maintenance Organization" are mutually exclusive defined terms in Wis. Stat. § 609.01. Furthermore, the terms, conditions, and provisions of the Agreement and the relevant extrinsic evidence concerning the Agreement support WPS's position that the Agreement was not intended to include HMOs. At the time that Aurora and WPS entered into the Agreement, for example, WPS did not offer any HMO products. Finally, WPS Health Plan is a separate insurance company, licensed under a separate chapter of the Wisconsin Statutes, and WPS

Health Plan and Prevea did not even exist at the time that Aurora and WPS entered into the Agreement.

15. A real and substantial controversy exists between WPS and Aurora concerning the interpretation and implementation of the Agreement. That controversy is ripe for judicial determination.

16. Therefore, WPS is entitled to a declaration of its rights and responsibilities under the Agreement, pursuant to Wis. Stat. § 806.04.

**Summary of Antitrust Allegations**

17. WPS brings the following claims for damages, repayment, and to enjoin the defendant – the largest health care provider in Eastern Wisconsin – from maintaining or enforcing policies and contracts that restrain competition in the provision of health care services and health insurance throughout Eastern Wisconsin.

18. Aurora is attempting to condition health insurer access to Aurora's network of health care providers in Aurora-necessary markets – markets in which Aurora has market power and a dominant market position – on the health insurer's agreement to include Aurora's network in markets where Aurora does not enjoy the same degree of market power. Specifically, Aurora has used its dominant market position in certain markets to insist that insurers that want to offer Aurora's system in *any* insurance product must offer the Aurora system as a top-tier provider network in *every* insurance product that the insurer offers. Given the structure of the health insurance and health care industries in Wisconsin, Aurora's insistence functionally requires insurers to offer Aurora's health care providers in markets in which Aurora lacks market power as a condition of receiving access to Aurora's health care providers in markets where inclusion of Aurora is necessary in order to sell commercial health insurance policies to employers and other groups.

19. On information and belief, all or virtually all major health insurers have acceded to Aurora's demands. On information and belief, other health insurers have acquiesced, in part, because they have received assurances from Aurora representatives that their competitors were agreeing to similar terms and conditions and, in part, because Aurora has promised to enforce those terms and conditions against all health insurers. Aurora's lawsuit against WPS is part and parcel of Aurora's scheme.

20. Aurora's contracts and other conduct violate Wisconsin's antitrust laws in numerous ways.

21. First, Aurora's contracts with health insurers (and its anticompetitive interpretation of the Agreement) constitute tying arrangements that are per se illegal under Wis. Stat. § 133.03(1).

22. Second, Aurora's contracts with health insurers (and its anticompetitive interpretation of the Agreement) each constitute an unreasonable restraint of trade in violation of Wis. Stat. § 133.03(1).

23. Third, Aurora's coercive and interdependent contracting arrangements with other health insurers and Aurora's related conduct have reduced competition in the provision of health care services in Eastern Wisconsin by constraining both the types of products offered and price competition among those insurers with respect to those products.

24. Fourth, Aurora's conduct violates Wisconsin's statutory prohibitions against monopolization and attempted monopolization under Wis. Stat. § 133.03(2). Given Aurora's size and market power in many parts of Eastern Wisconsin, and given the realities of the health insurance and health care industries, Aurora acts as a monopolist in a number of Wisconsin markets. Accordingly, its exclusionary conduct constitutes illegal monopolization under

Wisconsin antitrust law. Moreover, there are additional areas in which there is a dangerous probability that Aurora will acquire monopoly power by virtue of its exclusionary practices. Because Aurora specifically intends to acquire monopoly power in those markets, it is attempting to monopolize in violation of Wis. Stat. § 133.03(2) as well.

**Concerted Action**

25. Various other entities, not named as parties in Aurora's Complaint or in these counterclaims, have contracted, combined, or conspired with Aurora in certain of the violations alleged in this Complaint and have performed acts and made statements in furtherance thereof.

**Trade and Commerce**

26. Aurora provides health care services within the state of Wisconsin. On information and belief, essentially all of Aurora's commercial activity takes place within the state of Wisconsin, and the vast majority of the patients receiving health care services from Aurora physicians and in Aurora health care facilities are Wisconsin residents.

27. WPS is engaged in the provision of health insurance products and administrative services within the state of Wisconsin. WPS sells all of its products and administrative services exclusively within the state of Wisconsin, primarily to Wisconsin employers and groups employing primarily Wisconsin residents, and to Wisconsin residents directly.

28. The illegal activities alleged in this counterclaim restrain trade and commerce in Wisconsin, and are, therefore, subject to the Wisconsin antitrust laws.

**Relevant Markets**

29. Aurora has committed a number of per se violations of the Wisconsin antitrust laws. WPS is not required to prove a relevant market as to per se violations, because they are so inherently pernicious that no detailed inquiry into competitive effect is necessary.

30. Aurora's conduct has also unreasonably restrained trade in a number of different markets throughout Eastern Wisconsin.

31. Aurora's conduct has unreasonably restrained trade in large, relevant product and geographic markets (*e.g.*, "health care services in Eastern Wisconsin" or "sales of commercial health insurance in Eastern Wisconsin"). Aurora also has unreasonably restrained trade in smaller relevant markets.

32. For example, the sale of commercial health insurance to small employers and groups is a separate relevant service market, as is the provision of health care services to health insurers serving the small employer/group market. The same is true for large employer and group sales. On the small employer side, commercial health insurers, brokers who assist employers and groups in purchasing health insurance products, and state insurance commissioners all view the market for the sale of commercial health insurance to small employers and groups as distinct from the large employer and group market. Commercial health insurers market and sell to small employers and groups specifically, often using dedicated small-employer sales staff. Many insurance brokers specialize in working with small employers and groups. And many state insurance commissioners, including Wisconsin's, have regulations applying exclusively to the sale of commercial health insurance to small employers. *See* Wis. Stat. § 635. In Wisconsin, small employers are statutorily entitled to certain limitations and restrictions governing the premium rates that small employers are charged for group health insurance, and insurers selling group health insurance to small employers must guarantee issuance of group health insurance to every small employer that applies for such insurance from that health insurer.

33. Moreover, the economics of small-employer and large-employer health insurance and health care service sales are different. Most small employers and groups are relatively more price-sensitive, and they are less sensitive to health care provider access issues that dominate the large-employer health insurance market. With few exceptions, the small employer typically is driven primarily by the financial bottom line when it comes to buying group health insurance. This often translates to a desire to purchase health insurance products that exclude high-cost health care providers like Aurora.

34. By contrast, health insurance decisions made by large employers and groups are often driven by provider access issues. Large employers have geographically dispersed workforces; their employees demand access to the physicians, clinics, and hospitals convenient to them. In much of Eastern Wisconsin, this translates to a hard and fast requirement: To sell group health insurance products to large employers and groups, health insurers must offer access to the Aurora provider network. Aurora is simply too big and too dominant in too many places to make a health insurance plan without Aurora health care providers palatable to large employers and groups. The sale of group health insurance to large employers and groups and the associated sale of health care services to health insurers serving large employers and groups are separate relevant product markets for antitrust purposes.

35. There also are smaller relevant geographic markets within Eastern Wisconsin. Health care is ultimately a patient-centered business, and those patients seek professional relationships with physicians and facilities located close to the places in which patients live and work. Like other parts of the country, health care markets and health insurance markets in Wisconsin tend to be intensely local. This makes sense. Few employers would purchase group health insurance outside their metropolitan areas, even if local health insurers raised their prices

(in response to provider price increases, for example). More importantly, few patients would travel to distant communities for health care if local health care providers raised their prices. Aurora's conduct has had anticompetitive consequences in Eastern Wisconsin as a whole, but it also has restrained trade in smaller geographic markets within Eastern Wisconsin.

**Relevant Product and Service Markets**

36. The provision of health care services to commercial insurers is a relevant service market.

37. The provision of health care services to commercial insurers serving large employers and groups is a relevant service market.

38. The provision of health care services to commercial insurers serving small employers and groups is a relevant service market.

39. The sale of commercial health insurance products to employers and groups is a relevant product market.

40. The sale of commercial health insurance products to large employers and groups is a relevant product market.

41. The sale of commercial health insurance products to small employers and groups is a relevant product market.

42. The sale of "administrative services only" or "ASO" services to large employers and groups is a relevant service market.

43. Each of the above product and service markets is present in each of the approximate geographic areas set forth below.

**Relevant Geographic Markets**

44. On information and belief, Eastern Wisconsin is a relevant geographic market.

45. On information and belief, the Milwaukee/Waukesha/West Allis, Wisconsin Metropolitan Statistical Area ("MSA") ("Milwaukee Area MSA") is a relevant geographic market.

46. On information and belief, the Green Bay, Wisconsin MSA is a relevant geographic market.

47. On information and belief, the Appleton, Wisconsin MSA is a relevant geographic market.

48. On information and belief, the Manitowoc, Wisconsin Micropolitan Statistical Area ("MicroSA") is a relevant geographic market.

49. On information and belief, the Sheboygan, Wisconsin MSA is a relevant geographic market.

50. On information and belief, Walworth County, Wisconsin is a relevant geographic market.

51. On information and belief, the Racine, Wisconsin MSA is a relevant geographic market.

**Aurora's Strategy**

52. Aurora is the largest provider of health care services in Eastern Wisconsin. It owns a critical mass of hospitals, clinics, and pharmacies throughout the region, and it directly employs or contracts with thousands of primary care and specialist physicians who treat patients in Aurora facilities and funnel patients into other Aurora facilities for additional treatment. Aurora's vertical integration has the effect of erecting barriers to entry for competing health care providers at each of the various levels of the health care system.

53. Aurora has and exercises substantial market power in many discrete regions within Eastern Wisconsin by virtue of its size, the location of its facilities, and its employment of

primary care and specialist physicians. In some of these regions, Aurora is effectively "the only game in town." In the few areas where Aurora is not yet the dominant provider of health care services, Aurora is taking exclusionary steps to become the dominant provider.

54. Aurora did not have its market power thrust upon it by accident. Instead, Aurora's growth has been part of a longstanding, deliberate, and intentional plan to dominate the provision of health care in Eastern Wisconsin so that it can control price and exclude rivals. In pursuit of its market dominance strategy, Aurora has embarked upon an acquisition program, focusing its acquisition efforts upon physician practices, clinics, and hospitals that it regards as necessary to its plan. The conduct challenged in this counterclaim is part of the same strategy. In addition, Aurora often uses the overt threat of expansion as a lever to obtain agreement from otherwise reluctant acquisition targets.

55. Aurora consistently exercises its leverage to extract high prices from health insurance companies (and ultimately from employers and consumers who pay higher premiums). The prices that Aurora charges are a function of its market power throughout the region, and those prices are higher than they would be if the markets in which Aurora operates were competitive. Aurora's exercise of market power has the effect of increasing overall price levels for health care services within Eastern Wisconsin.

**The GAO Diagnosis**

56. The federal government recently highlighted the high cost of health care services in the Milwaukee area. In 2004, the Government Accountability Office ("GAO") conducted a study of the Milwaukee area's health care costs relative to other metropolitan areas. The results of that study and a more comprehensive follow-up study are telling.

57. According to the GAO, Milwaukee area residents pay well above the national average for their health care services, "and preliminary analyses point to providers' leverage in

negotiating prices with insurers as one of the contributing factors." Out of 239 MSAs studied, the Milwaukee Area MSA had the fifth-highest hospital inpatient prices (at least 56% higher than the study average). And the Milwaukee Area MSA's physician prices were at least 22% higher than the average of the 319 MSAs studied for that market, ranking 16th-highest.

58. Moreover, these dramatic figures understate just how dysfunctional the Milwaukee area's health care markets are. In the inpatient hospital pricing study, the Milwaukee Area MSA was the only MSA its size in the top *fifty* – among the 50 MSAs topping the list, no other city was within 300,000 residents of Milwaukee's population. (San Antonio, Texas, was the most expensive inpatient MSA in the country that is larger than the Milwaukee Area MSA, coming in at number 56. Where the Milwaukee Area MSA's inpatient costs were over 56% above the survey average, San Antonio's were only 13% higher.)

59. The same is true for physician pricing. Milwaukee came in 16th-highest out of 319 MSAs. It is the largest city in the top 125 cities, at least 600,000 residents larger than every city until New Orleans, LA. New Orleans ranked 128th, and its physician prices were only 2.6% above the study average, compared with Milwaukee's 21.7% above the study average.

60. In other words, Milwaukee has by far the most expensive health care markets in the country for cities its size or larger. This is important, because larger cities should generally support a larger health care infrastructure with a greater number of health care providers engaging in more robust competition. According to the GAO, this is not so in Milwaukee. Although other providers may enjoy some lesser degree of market power by virtue of the market structure, they have not, to WPS's knowledge, abused that market power in exclusionary fashion. Aurora, however, has more market power than any of its rivals. More importantly, Aurora has abused that market power through its conduct.

**Aurora's Control Over Commercial Health Insurers**

61. Because of Aurora's market power, commercial health insurers like WPS are effectively required to purchase network health care services from Aurora in order to participate in a variety of different health insurance markets within Wisconsin. For example, health insurance products that do not include the Aurora system are not commercially viable for large employer and group accounts in many of the population centers within Eastern Wisconsin, including metropolitan Milwaukee. In other regions (*e.g.*, Walworth County), the Aurora network is a necessary component of any health insurance product sold to employers or other groups of *any* size. The need to offer Aurora's health care providers to certain classes of employers in certain regions is a function of two interrelated phenomena. First, many large employers have geographically dispersed workforces that include groups of employees for whom Aurora facilities and physicians are the only practicable alternatives. Second, in several parts of Wisconsin, Aurora owns the only significant health care delivery infrastructure in the area.

62. Notwithstanding the necessity of offering Aurora to certain classes of customers within Eastern Wisconsin, there are a number of other regions and customer bases within Eastern Wisconsin for which the Aurora network is not a necessary component of a health insurance product. In particular, smaller employers who are more cost-sensitive are often interested in purchasing group health insurance that does not contain Aurora. Moreover, there are several regions in which Aurora has not yet achieved dominance. Because "non-Aurora" products are typically significantly less expensive than "Aurora" products, there is substantial demand for non-Aurora alternatives among many smaller health insurance purchasers. There is similar demand for non-Aurora alternatives among all classes of purchasers in areas in which Aurora is not yet dominant. Aurora seeks to force sales to these customers as well.

63. In some sense, Aurora's ambitions are a matter of public record. Aurora's aspirations for dominance as it raises prices and acquires additional physician practices and health care facilities are well-known. Accordingly, Aurora has simultaneously embarked on a public relations campaign designed to obfuscate its intentions and to limit the public outcry occasioned by its appetite for market dominance.

**The All Plans Contracts**

64. On information and belief, Aurora decided several years ago that it needed to entrench itself further as the dominant health care provider in Eastern Wisconsin. It also decided to expand its dominance into the few remaining markets in Eastern Wisconsin where it was not yet the dominant health care provider.

65. To accomplish this goal, Aurora began to implement a two-pronged contracting strategy with the commercial health insurers that form the backbone of its revenue engine. First, Aurora used its market dominance in several key markets to force insurers into new contracts with disproportionately long terms and one-sided exit provisions. On information and belief, all or most of these contracts carried a fifteen-year term with what Aurora contends are essentially automatic renewals-in-perpetuity. Second, Aurora included in these contracts language under which it contends that the insurer is required to offer the Aurora system as a first-tier provider in all insurance products and ASO products offered by that insurer ("all plans requirement"). On information and belief, health insurers representing well over 80% of the covered lives in metropolitan Milwaukee have executed such contracts with Aurora. The contracts in question have already injured competition in a variety of Wisconsin markets, and they threaten to injure competition further if Aurora is allowed to continue seeking enforcement of the offensive provisions.

**WPS Fights Back**

66. Because health insurance products that do not offer access to the Aurora network are commercially worthless in several critically important Wisconsin health insurance markets and the ASO services market, WPS reluctantly executed the Agreement effective July 1, 2001, with the understanding that the Agreement did not constrain WPS's ability to offer non-WPS plans, non-WPS networks, and non-PPO plans that did not include Aurora, even though the Agreement constrained WPS's ability to compete in other ways. If Aurora had not possessed market power sufficient to condition WPS's access to those markets upon WPS's acceptance of the Agreement's anticompetitive terms and conditions, WPS would not have signed the Agreement even assuming that the Agreement did not constrain WPS's ability to offer non-WPS plans, non-WPS networks, and non-PPO plans without Aurora. As one Aurora representative informed WPS, "you need us more than we need you." If WPS had known that Aurora would take the extreme and indefensible anticompetitive interpretation that the Agreement constrains WPS's ability to compete as described in Aurora's Complaint in this case, WPS would not have executed the Agreement.

67. Notwithstanding the position Aurora takes in this litigation and elsewhere with other health insurers, WPS has consistently refused to accede to Aurora's unconscionable and anticompetitive interpretation of the Agreement's all plans requirement. Instead, WPS has consistently asserted that the specific language of the Agreement does *not* require WPS to include Aurora in non-WPS plans, non-WPS networks, and non-PPO health insurance products that WPS offers.

68. WPS continues to offer a number of different non-WPS plans, non-WPS networks, and non-PPO plans that do not include Aurora in the provider mix. For example, WPS offers an HMO product in the Appleton MSA and in the Green Bay MSA that does not include

Aurora. It also participates in the Sheboygan and Manitowoc markets through employer associations offering non-WPS third-party rented networks.

69. On information and belief, more recent long-term Aurora contracts with other health insurers contain revised language designed to eliminate the arguments WPS has advanced for a competitively neutral interpretation of the all plans requirement. Moreover, on information and belief, every other major health insurer with which Aurora has contracted, including United Health Group, Inc., WellPoint Health Networks, Inc., Humana, Inc., Aetna, Inc., and others, has been forced to accede to Aurora's anticompetitive interpretation of the all plans requirement, regardless of the specific text of that requirement in their respective contracts.

70. Also on information and belief, the other major insurers have agreed to Aurora's anticompetitive contractual terms and conditions only after receiving assurances from Aurora that competing health insurers would also agree to the same restrictions. Aurora also assured insurers that it would enforce its interpretation of the all plans requirement against any insurer that attempted to circumvent the anticompetitive effects of its contract with Aurora by offering lower cost health insurance products or any products that did not include the Aurora system in its first tier.

71. The Aurora policies and contracts in question unreasonably restrain trade and illegally reduce competition in a variety of ways, thereby allowing Aurora to further entrench and expand its already significant market power in health care markets within Eastern Wisconsin. In essence, Aurora's conduct is intended to, and has the effect of, limiting or eliminating price competition for the provision of health care services in Aurora's operating territory.

72. Aurora's anticompetitive conduct injures all classes of Aurora's downstream customers, including WPS and other health insurers, and the small and large employers, groups and individuals that purchase health insurance and ASO products from those insurers, and the patients who ultimately consume Aurora's health care services.

73. Accordingly, WPS brings these counterclaims and asserts these affirmative defenses to enjoin Aurora from maintaining or enforcing Aurora policies and contracts that illegally restrain competition in the provision of health care services, health insurance products, and ASO products in various Wisconsin markets. As is its statutory right, WPS also seeks full repayment of all amounts paid to Aurora under the Agreement, and it seeks treble damages for the injuries it has suffered as a result of Aurora's anticompetitive acts.

**Injury to Competition**

74. In order to understand the extent to which acceding to Aurora's interpretation of the Agreement would injure competition, consumers, and WPS, it is first necessary to describe the pricing of health care services in greater detail.

**Chargemasters and Discounts**

75. Each provider of health care services prices its various services by reference to an itemized list of default charges for each of the services that provider offers in each of its locations. This document is typically known as the "chargemaster."

76. On information and belief, each large provider of health care has a single chargemaster. The provider sets the prices on its chargemaster as it sees fit.

77. The chargemaster forms the basis for each provider's negotiated pricing with health insurers. In practical terms, a health insurer negotiates a discount off the chargemaster with each individual provider. As a nominal matter, the insurer typically negotiates a "reimbursement rate" it must pay to the provider. These reimbursement rates are typically lower

than the chargemaster list pricing. For example, simplified somewhat, the Agreement at issue in this litigation specifies that for covered expenses WPS is to reimburse Aurora for health care services rendered at a rate of 85% of Aurora's chargemaster pricing. If Aurora's chargemaster specifies $100 for a particular procedure, WPS is contractually obligated to reimburse Aurora for $85 for that procedure. Each health insurer's specific reimbursement rates are typically a closely-guarded secret and are subject to confidentiality restrictions set forth in the applicable contract between the parties.

78. Nominal negotiated discounts are significant as a relative matter, in that each health insurer theoretically can measure the desirability of its reimbursement rates against the reimbursement rates received by other health insurers, assuming it can learn something about its competitors' deals with that same provider. But the nominal negotiated discount is irrelevant as an absolute matter for at least two reasons:

- First, the provider retains control over its chargemaster, so the absolute price level is always within the provider's control. For example, if WPS's 15% discount hurts Aurora too much, Aurora can simply raise prices on its chargemaster, in the absence of effective competition. Competition in the relevant markets alleged in this counterclaim is insufficient to mitigate Aurora's pricing power to any significant degree.

- Second, the overall cost to a health insurer of a particular patient's claim for health care services is also dependent upon the number of procedures ordered by the provider. Accordingly, a health care provider can supplement its per-case revenue and profit by ordering additional procedures not called for by the patient's primary diagnosis.

**Aurora's Interpretation of the Agreement Injures Competition, Consumers, and WPS**

79. Aurora's conduct, including but not limited to its anticompetitive interpretation of the Agreement (and its similar contracts with other health insurers) injures competition, consumers and WPS in at least two ways:

- First, because Aurora is a high-price health care provider relative to other providers located within the various markets in which WPS offers its products, adding Aurora to any non-Aurora health insurance product would necessarily force WPS to raise its prices for health insurance. Specifically, WPS will be forced to increase its pricing of that product to reflect the weighted average associated with the anticipated number of Aurora cases. Employers and patients suffer from these higher prices. WPS is injured as well because fewer employers will purchase higher-priced health insurance products from WPS.

- Second, WPS obtains larger discounts from the other health care providers that compete against Aurora for its non-Aurora health insurance products. Those providers are willing to provide larger discounts to WPS because Aurora is not a preferred provider for that non-Aurora health insurance product. If WPS were forced to include Aurora in every non-Aurora health insurance product WPS offers, many other competing providers would limit or eliminate the discounts they offer WPS in connection with those products. WPS would be forced to charge higher premiums to its customers.

80. Finally, Aurora's abuse of its market power has effectively eliminated price competition from the health insurance markets in Eastern Wisconsin and other parts of Wisconsin. Most health insurers must now include Aurora in all of their health insurance products, which has the same effects on them as it would have on WPS – increased health care prices due to Aurora's high costs and unnecessary additional procedures and the reduced discounts received from other providers. This produces a market in which all health insurers must offer substantially the same health insurance product – an Aurora dominated product – substantially limiting employers' and individual consumers' health care choices and increasing the costs of the few remaining health care financing options. Moreover, to the extent there is currently any choice or price competition, they exist at already inflated price levels due to Aurora's monopolization efforts and their other conduct in restraint of trade.

**Competitive Effects**

81. Each of the claims for relief alleged below have had and will continue to have anticompetitive effects in the relevant markets, including but not limited to:

a. reducing competition in the provision and increasing the price of health care services to employees of small employers and groups;

b. reducing competition for sales and increasing the price of health insurance to small employers and groups;

c. reducing competition in the provision and increasing the price of health care services for *all* employees and individual consumers in Eastern Wisconsin generally, and in other smaller relevant markets within the larger geographic market; and

d. raising barriers to entry for competing network health care providers.

**Antitrust Claims for Relief**

**Claim 2: Tying - Large Employers to Small Employers (Wis. Stat. § 133.03(1))**

82. WPS incorporates by reference the allegations in paragraphs 1 - 81 above.

83. Aurora's anticompetitive interpretation of the all plans requirement conditions WPS's purchase of health care services for inclusion in WPS's large-employer health insurance products and ASO products sold in the Milwaukee Area MSA upon WPS's simultaneous purchase of Aurora's health care services for inclusion in WPS's small-employer and individual health insurance products sold throughout Eastern Wisconsin.

84. Aurora has market power in the provision of health care services for inclusion in large-employer insurance products and ASO products sold in the Milwaukee Area MSA.

85. The provision of health care services for inclusion in small employer and group health insurance products constitutes a separate relevant product market in which WPS does not want to be forced to buy health care services from Aurora throughout Eastern Wisconsin.

86. Accordingly, Aurora has conditioned the purchase of a product or service over which it has market power upon the purchase of a different, undesired product or service. This tying arrangement is per se illegal under Wis. Stat. § 133.03(1).

**Claim 3: Tying – Milwaukee to Other Geographic Markets (Wis. Stat. § 133.03(1))**

87. WPS incorporates by reference the allegations in paragraphs 1 - 86 above.

88. Aurora's anticompetitive interpretation of the all plans requirement conditions WPS's purchase of health care services for inclusion in health insurance products and ASO products offered in the Milwaukee Area MSA upon WPS's simultaneous purchase of health care services for inclusion in health insurance and ASO products offered in other relevant geographic markets, including the Appleton MSA, the Green Bay MSA, the Manitowoc MicroSA, the Sheboygan MSA and the Racine MSA.

89. Aurora has market power in the provision of health care services for inclusion in health insurance products and ASO products offered in the Milwaukee Area MSA.

90. The provision of health care services in each non-Milwaukee relevant geographic market referenced above constitutes a separate relevant market in which WPS does not want to be forced to buy health care services from Aurora.

91. Accordingly, Aurora has conditioned the purchase of a product or service over which it has market power upon the purchase of a different, undesired product or service. This tying arrangement is per se illegal under Wis. Stat. § 133.03(1).

**Claim 4: Tying – Generally**

92. WPS incorporates by reference the allegations in paragraphs 1 - 91 above.

93. Aurora has market power in the provision of health care services in a variety of relevant geographic markets within Eastern Wisconsin.

94. Through its anticompetitive interpretation of its all plans requirement in its contracts with health insurers, Aurora is conditioning the sale of health care services in markets in which it has market power upon insurers' simultaneous purchase of health care services in markets in which Aurora does not have market power.

95. These tying arrangements are per se illegal under Wis. Stat. § 133.03(1).

**Claim 5: Horizontal Restraint of Trade (Wis. Stat. § 133.03(1))**

96. WPS incorporates by reference the allegations in paragraphs 1 - 95 above.

97. On information and belief, Aurora's serial long-term "all plans requirement" contracts with insurers and the coerced and enforced interdependence among the other health insurers in acceding to Aurora's anticompetitive interpretation of the all plans requirement constitute a per se violation of Wis. Stat. § 133.03(1). In this conspiracy, Aurora is the primary beneficiary of the coerced and enforced interdependence among the other health insurers and the anticompetitive reduction in price competition and consumer choice caused by these coercive contracts.

**Claim 6: Unreasonable Restraints of Trade (Wis. Stat. § 133.03(1))**

98. WPS incorporates by reference the allegations in paragraphs 1 - 97 above.

99. Aurora's anticompetitive interpretation of the all plans requirement in the Agreement, and the Aurora contracts with other health insurers in which there is an all plans requirement all constitute agreements which unreasonably restrain trade in the provision of health care services in Eastern Wisconsin and in each separate relevant geographic market identified in paragraphs 44 - 50 of this Answer and Counterclaim. In addition, Aurora's anticompetitive interpretation of the all plans requirement in the Agreement, and the Aurora contracts with other health insurers in which there is an all plans requirement all constitute agreements which unreasonably restrain trade in the provision of commercial health insurance products to small and large employers and groups in Eastern Wisconsin and in each separate relevant geographic market identified in paragraphs 44 - 50 of this Answer and Counterclaim.

**Claim 7: Monopolization (Wis. Stat. § 133.03(2))**

100. WPS incorporates by reference the allegations in paragraphs 1 - 99 above.

101. Aurora has monopoly power in the provision of network health care services in a number of relevant geographic markets within Eastern Wisconsin, including but not limited to: Milwaukee Area MSA, Walworth County, Sheboygan MSA, and Manitowoc MicroSA. Aurora enjoys monopoly power in these markets by virtue of the unique dynamics of the health care and health insurance industries.

102. Other competitors do not significantly constrain Aurora's pricing power.

103. Aurora's imposition upon health insurers of effectively perpetual contracts containing the all plans requirement constitutes exclusionary conduct undertaken with the purpose and effect of maintaining Aurora's existing monopoly power and acquiring additional monopoly power within Eastern Wisconsin and the smaller relevant geographic markets contained therein.

104. Aurora's conduct therefore violates Wis. Stat. § 133.03(2).

**Claim 8: Attempted Monopolization (Wis. Stat. § 133.03(2))**

105. WPS incorporates by reference the allegations in paragraphs 1 - 104 above.

106. As discussed in paragraph 53 above, Aurora has engaged in a deliberate strategy of expansion and domination, with considerable success. Aurora specifically intends to monopolize the markets for the provision of health care services in each of the relevant geographic markets described in paragraphs 44 - 50 above.

107. In every market in which Aurora participates, it has quickly obtained significant market share, and almost immediately thereafter, significant market power. To the extent Aurora does not already have monopoly power in any of the geographic markets described in paragraphs 44 – 50 above, there is a dangerous probability that Aurora will acquire that power by virtue of the exclusionary practices described in this Counterclaim.

108. Aurora's conduct therefore violates the Wisconsin antitrust law's prohibition against attempted monopolization. Wis. Stat. § 133.03(2).

**Damages and Right to Seek Injunctive Relief**

109. WPS has been injured both directly and indirectly by reason of Aurora's illegal contracts and conduct. Wis. Stat. § 133.18.

110. Under Wisconsin law, any person may seek injunctive relief to prevent or restrain a violation of the Wisconsin antitrust laws. Wis. Stat. § 133.16.

## AURORA'S ADDITIONAL DEFENSES

As and for its response to Aurora's additional defenses, WPS states as follows:

110.-122. The allegations of paragraph 110 through 122 of Aurora's Amended Complaint and Amended Reply to Counterclaims and Counter-Counterclaims set forth defenses to which no response is required by WPS.

## REPLY TO COUNTER-COUNTERCLAIMS

As and for its response to Aurora's counter-counterclaims, WPS states as follows:

123. WPS incorporates by reference its allegations in paragraphs 1 through 110 of its Amended Counterclaim, its responses to paragraphs 110 through 122 above, and its responses to paragraphs 1 through 15 of the Amended Complaint above.

124. Answering paragraph 124, admits that Aurora has provided healthcare services to individuals insured by WPS; and denies the remaining allegations in paragraph 124.

125. Answering paragraph 125, admits that WPS knows that Aurora has provided healthcare services to individuals insured by WPS; and denies the remaining allegations in paragraph 125.

126. Denies.

127. Denies.

128. Denies.

129. WPS incorporates by reference its allegations in paragraphs 1 through 110 of its Amended Counterclaim, its responses to paragraphs 110 through 128 above, and its responses to paragraphs 1 through 15 of the Amended Complaint above.

130. Admits.

131. Answering paragraph 131, admits that Aurora provided healthcare services to individuals insured by WPS; and denies the remaining allegations in paragraph 131.

132. Denies.

133. Denies.

**PRAYER FOR RELIEF**

**WHEREFORE**, WPS respectfully requests that the Court enter judgment as follows:

A. Dismissing Aurora's Amended Complaint with prejudice;

B. Declaring that WPS has not violated the Agreement with respect to Patient Choice, SEARCH, HCC, Milwaukee County and its group health insurance, or WPS Health Plan;

C. Declaring that WPS has not, in any other way, violated the Agreement;

D. Declaring that the conduct alleged in Claims 2, 3, 4, and 5 of the Counterclaims constitute per se violations of Wisconsin's antitrust laws, Wis. Stat. § 133.03(1);

E. Declaring that the conduct alleged in Claim 6 of the Counterclaims constitutes a contract, combination or conspiracy in unreasonable restraint of trade in violation of Wisconsin's antitrust laws, Wis. Stat. § 133.03(1);

F. Declaring that the conduct alleged in Claims 7 and 8 of the Counterclaims constitute violations of Wisconsin's antitrust laws, Wis. Stat. § 133.03(2);

G. Enjoining Aurora from requiring that WPS and other health insurers agree to offer Aurora's network in every product offered by those insurers. Wis. Stat. § 133.16;

H. Declaring the Agreement void, and awarding WPS repayment of all amounts previously paid to Aurora under the Agreement. Wis. Stat. § 133.14;

I. Awarding WPS threefold the damages that WPS proves at trial that it has sustained by reason of Aurora's conduct. This includes but is not limited to all damages WPS has suffered as a result of its overpayments to Aurora resulting from Aurora's illegal monopolization. The damages that WPS is awarded are to be reduced by the amount of previous payments recovered under Wis. Stat. § 133.14;

J. Awarding WPS its attorney's fees and costs recoverable in this action. *See* Wis. Stat. §§ 133.16 and 133.18;

K. Dismissing Aurora's counter-counterclaims with prejudice; and,

L. Awarding any other and further relief that the Court deems appropriate.

Dated this 10th day of July, 2006.

GODFREY & KAHN

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mw1166432_1

# Exhibit 82


LEXITAS™

[redacted]

Q. Do you recall whether Ascension had a requirement in its contracts with Anthem that Ascension must be included in the highest preferred tier in all networks that Anthem offered?

A. We did not have that terminology in our contract.

Q. What's your understanding of why Ascension did not have that terminology in the Anthem contracts?

MS. JOHNSON PALMER: Objection to form.

MR. MATTHEWS: You can answer.

A. Anthem won't let us put it in.

BY MS. WALLIN:

Q. Can you elaborate on what you mean by that.

A. We would have preferred that as

a position to say that we are always in a preferential spot within the networks and the offerings of a payer, but the payer has to agree to allow that in the contract.

Q. And so is it fair to say that Ascension didn't have the leverage needed to require Anthem to include that in the contract?

MS. JOHNSON PALMER: Objection to form.

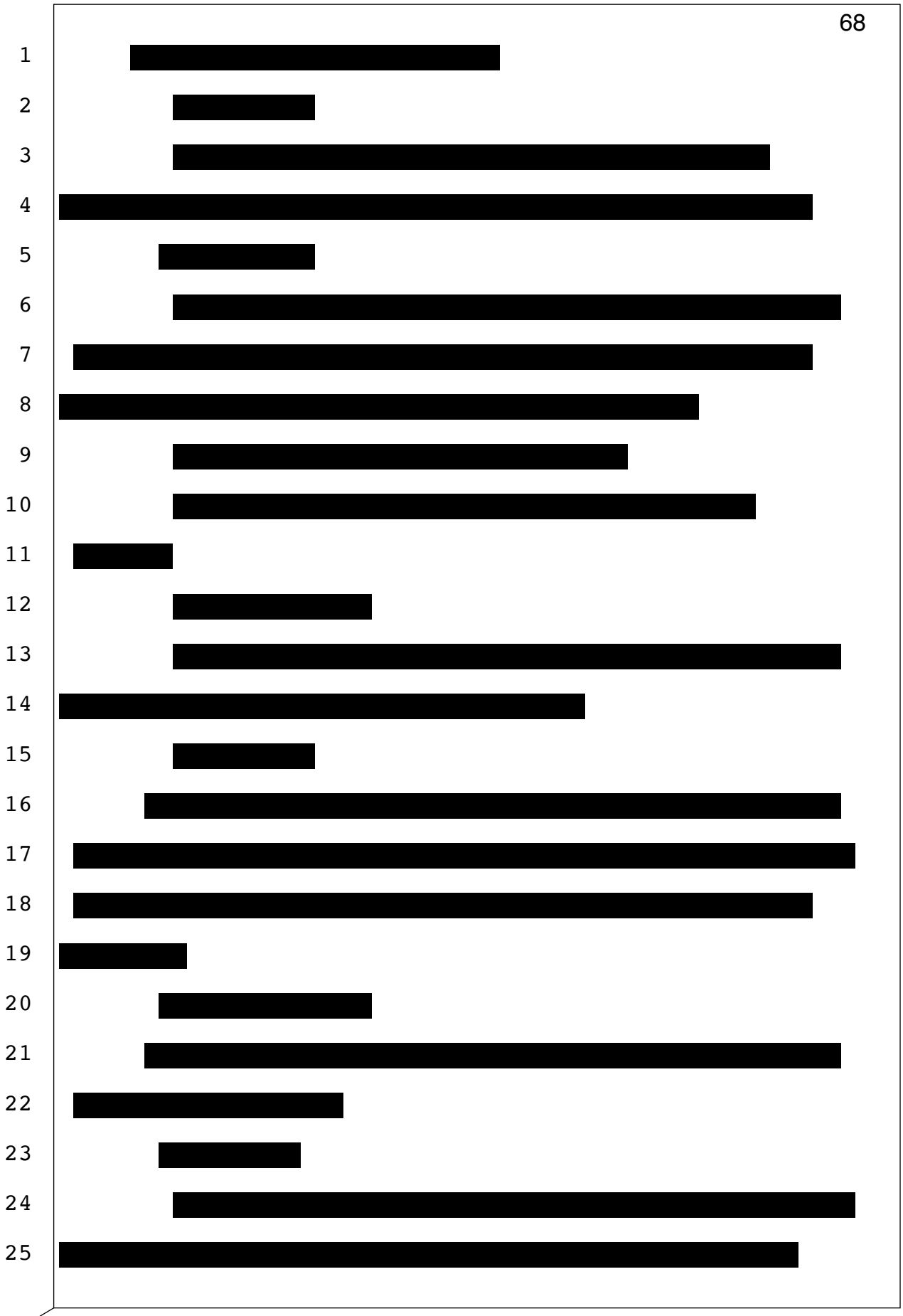
MR. MATTHEWS: You may answer.

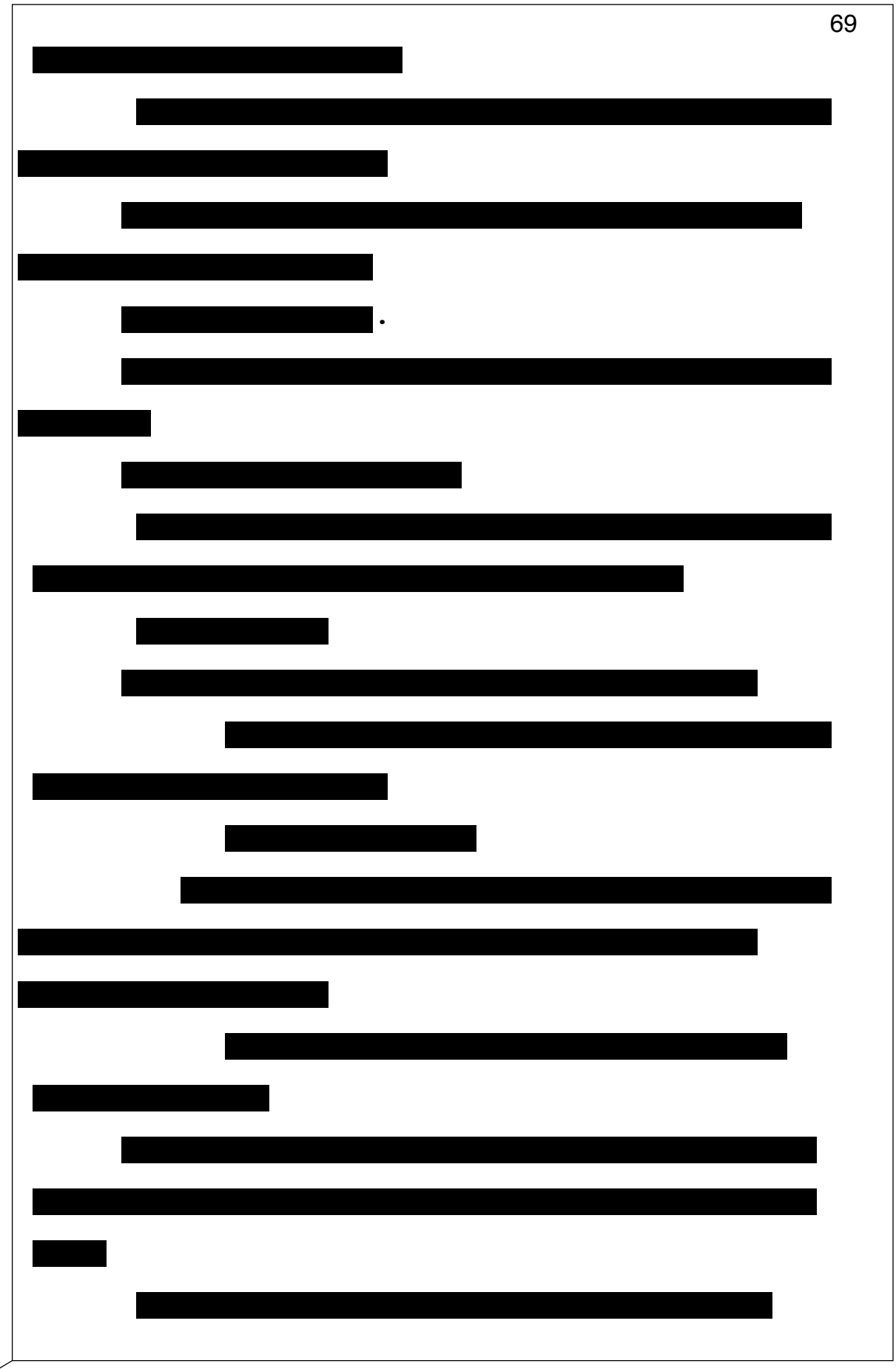
A. So to say Anthem or Ascension was not able to get that language in the agreements with Anthem. It would not open that position up and allow us to include it, and we accepted that.

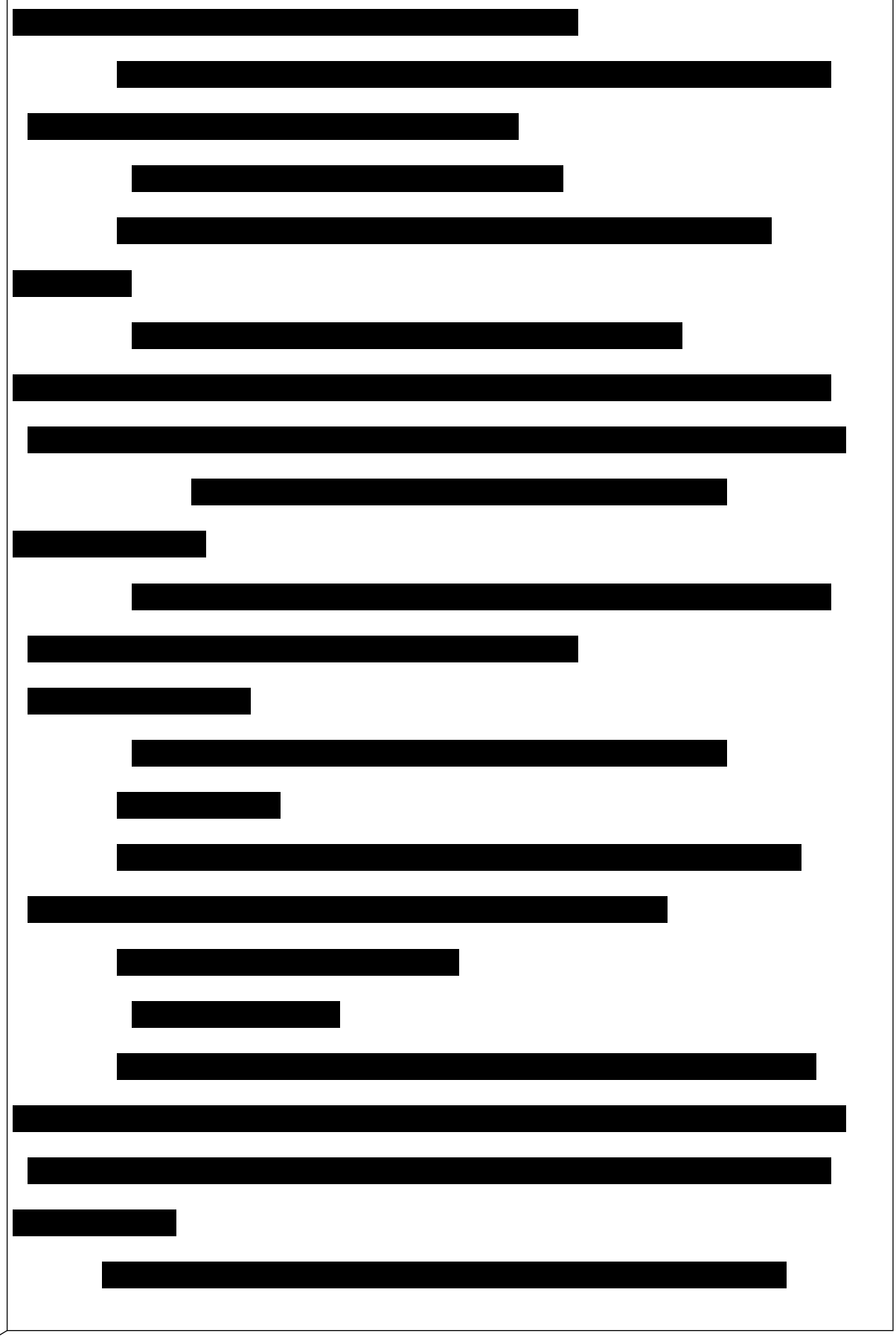
[redacted]

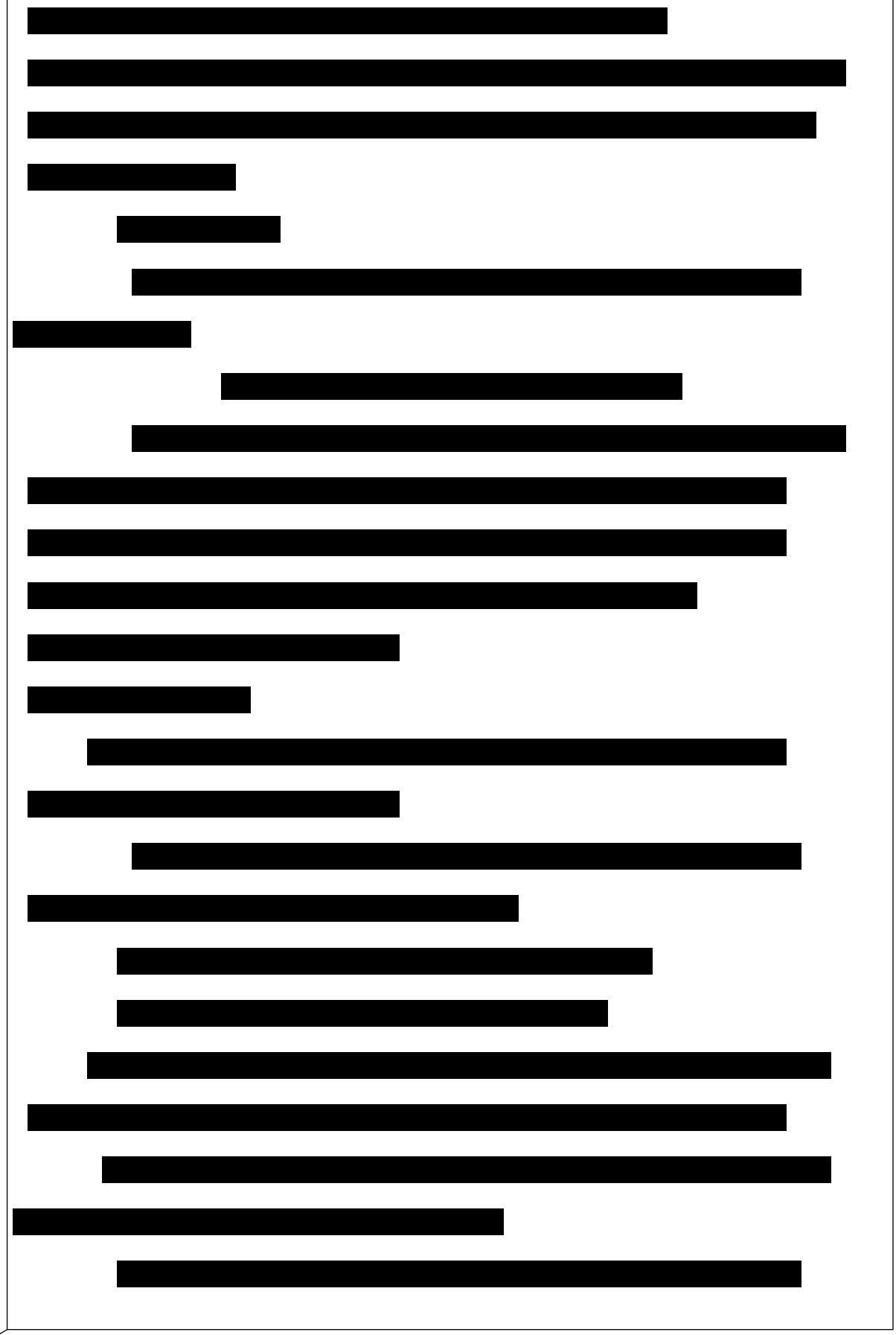
# Exhibit 83


LEXITAS™









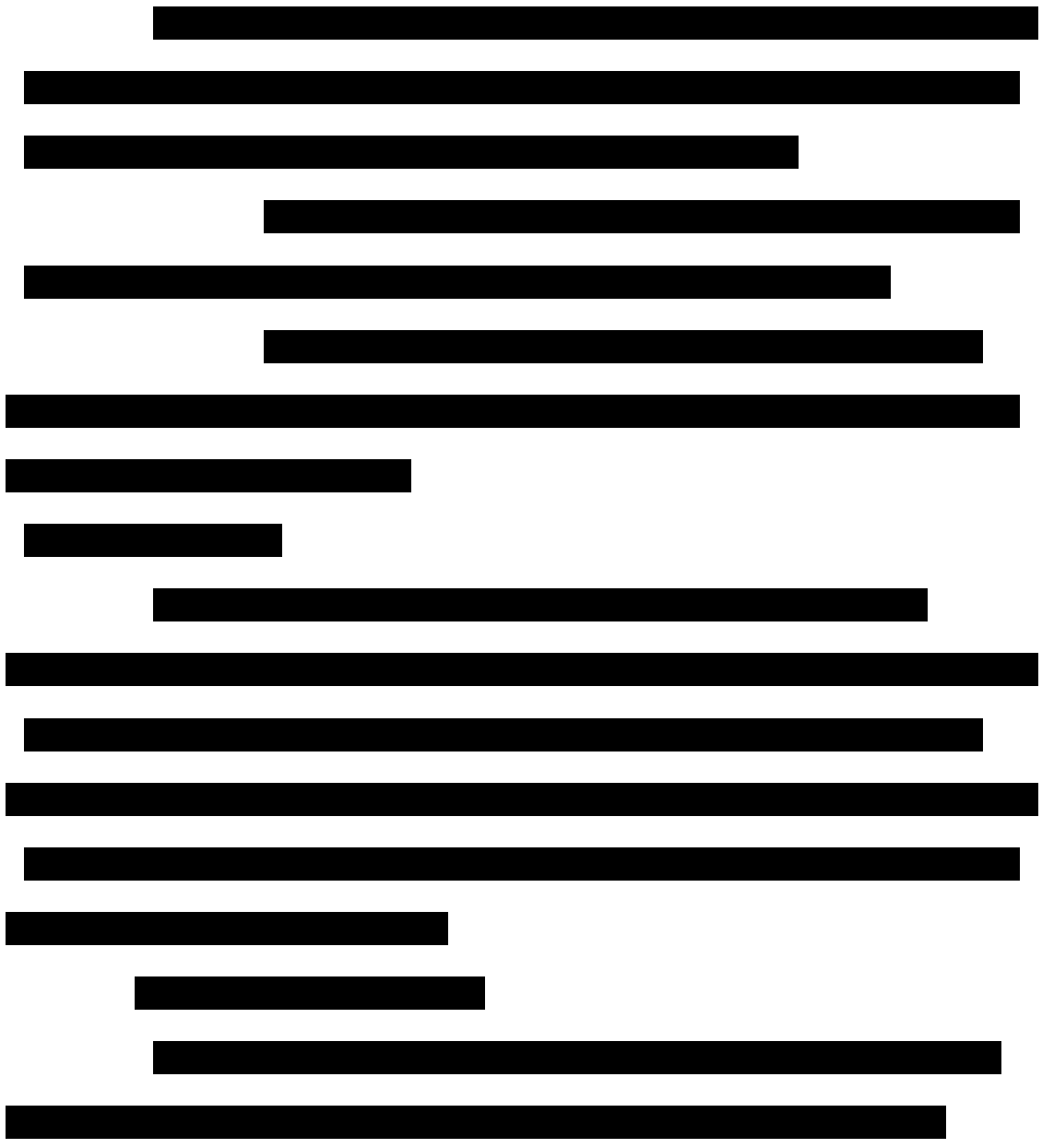
[redacted]

Q. To your understanding, has Bellin ever -- and I'm referring here to Bellin Health Partners and

prior to it Physician Partners Limited -- have they ever contracted with a commercial payer for only portions of the health system?

MS. ARENDS: Objection. Form.

A. There have been times where we could not include our entire network because the insurer would not allow it.



# Exhibit 84


LEXITAS™

Q. Okay. And have you heard of the term an "all-or-nothing clause"?

A. Yes.

Q. What does that mean to you?

A. That you're either in all products or no products.

Q. And, generally speaking, why do health systems deploy those clauses?

A. Well, if they feel they have the leverage, they'll do that because they want to participate in all products.

Q. What do you mean, "leverage"?

A. Well, once again, when we discussed earlier that the larger the health system, the -- the stronger their position is because there would be more disruption if they were not in the network.

Q. Got it.

Does ProHealth have this type of leverage?

A. No.

Q. Why not?

A. Well, we don't have the size. I mean, I don't think it fits our philosophy. We want to compete on a basis of cost and

quality, but once again, we have a very nice market share in our market, which is a very important market to all payers, but I just don't think we -- we hold that same level.

Q. What are some systems that -- or health systems that you think do have that kind of leverage?

A. I would --

MR. TSAI: Object to form.

THE WITNESS: I would imagine Aurora and Froedtert would be two.

[redacted]

[redacted]

Q. Okay. So you don't need things like an all-or-nothing or an anti-tiering or an anti-steering to gain access into those networks; right?

A. That's not been the strategy we've employed, and I'm not sure we -- we would get that.

Q. Can you explain what you mean?

A. I just -- in negotiations, you go off of a base contract. For us to incorporate language like that, I'm not sure that we could come to an agreement with a payer.

Q. Are you saying a payer wouldn't agree to that sort of language with you?

A. Probably not.

MR. TSAI: Objection to form. Vague as to time.

THE WITNESS: I'm sorry.

BY MS. KATZ:

Q. Why do you think a payer wouldn't agree to that?

A. I just don't --

MR. TSAI: Objection to form.

THE WITNESS: I don't believe our size would -- would allow us that leverage.

BY MS. KATZ:

Q. Does -- do those sort of anti-tiering/anti-steering mechanisms, do those limit payers' ability to be flexible in their network structures?

MR. TSAI: Objection to form. Calls for expert testimony.

THE WITNESS: I -- I would -- I would certainly think it complicates it.

BY MS. KATZ:

Q. How so?

A. If they have to be in the product, they had more clout to try to extract more value out of the contract.

[redacted]

# Exhibit 89


LEXITAS™

[redacted]

Q. Okay. Okay. The network process. Pardon me.

Do you have an understanding of why BlueCross creates these types of tiered products?

A. Yes. Our employer groups are always looking for affordable health care options, and we often look at our network offerings to ensure that we are meeting the needs of our employer groups and members.

[redacted]

[redacted]

Q. Okay. And do you know if BlueCross engages in steering relating to site of service, so incentives that might direct members to certain sites over other sites of service?

A. Yes.

Q. Okay. Does BlueCross engage in that?

A. Yes, we have site of service policies that incentivize members to go to the most affordable site of care where medically necessary.

[redacted]

[redacted]

Q. Okay. It says, "Lower costs and high-quality care can, in fact, go hand in hand."

Did I read that correctly?

A. Yes.

Q. Do you agree with that?

A. Yes, they can -- they can go hand in hand.

[redacted]

[redacted]

A. I'm not aware of any prohibitions in our network contracts with any health care provider in the State of Illinois that would prohibit us from developing a narrow network with a particular health care provider.

[redacted]

[redacted]

To your understanding, is there anything that would have prohibited BlueCross from developing a tiered network, any contractual terms with any providers that would have prohibited BlueCross from establishing a tiered network?

A. No.

[redacted]

[redacted]

Q. And so I think what I'm understanding is that before you -- when you answered, you were answering with respect to, you know, the broad -- some broader concept.

But now narrowing it to the commercial, does that -- does your answer change when I narrow it to commercial?

A. I'm not aware of --

MR. TSAI: Object as to form. Sorry.

A. I'm not aware of any prohibitions on establishing a narrow PPO network for a commercial business.

[redacted].

And given that, and I guess I could say in spite of that, in spite of the lack of that language in contracts, providers in this market have been able to achieve quality outcomes for patients?

Would you agree with that?

MR. TSAI: Object as to form.

A. Health care providers in the State of Illinois have been able to achieve quality outcomes for our members.

BY MR. ONAYEMI:

Q. Sure. Including Advocate?

A. Yes, Advocate achieves quality outcomes for our members.

Q. Without prohibitions on inclusion or

development of narrow networks that would exclude Advocate Aur -- Advocate?

A. There are no prohibitions on narrow PPO networks that would exclude Advocate from participation.

[redacted]

[redacted]

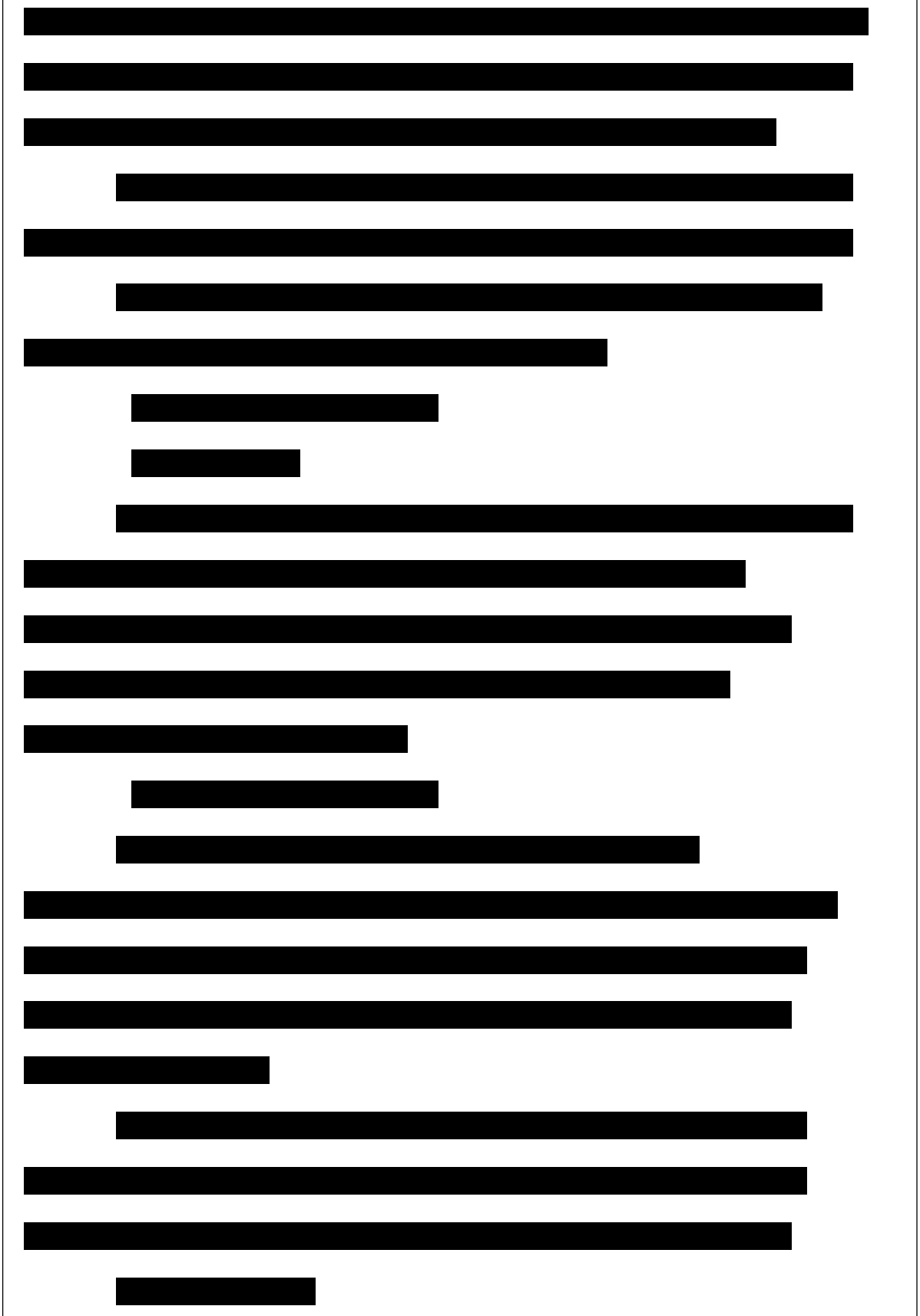
Q. Okay. Great.

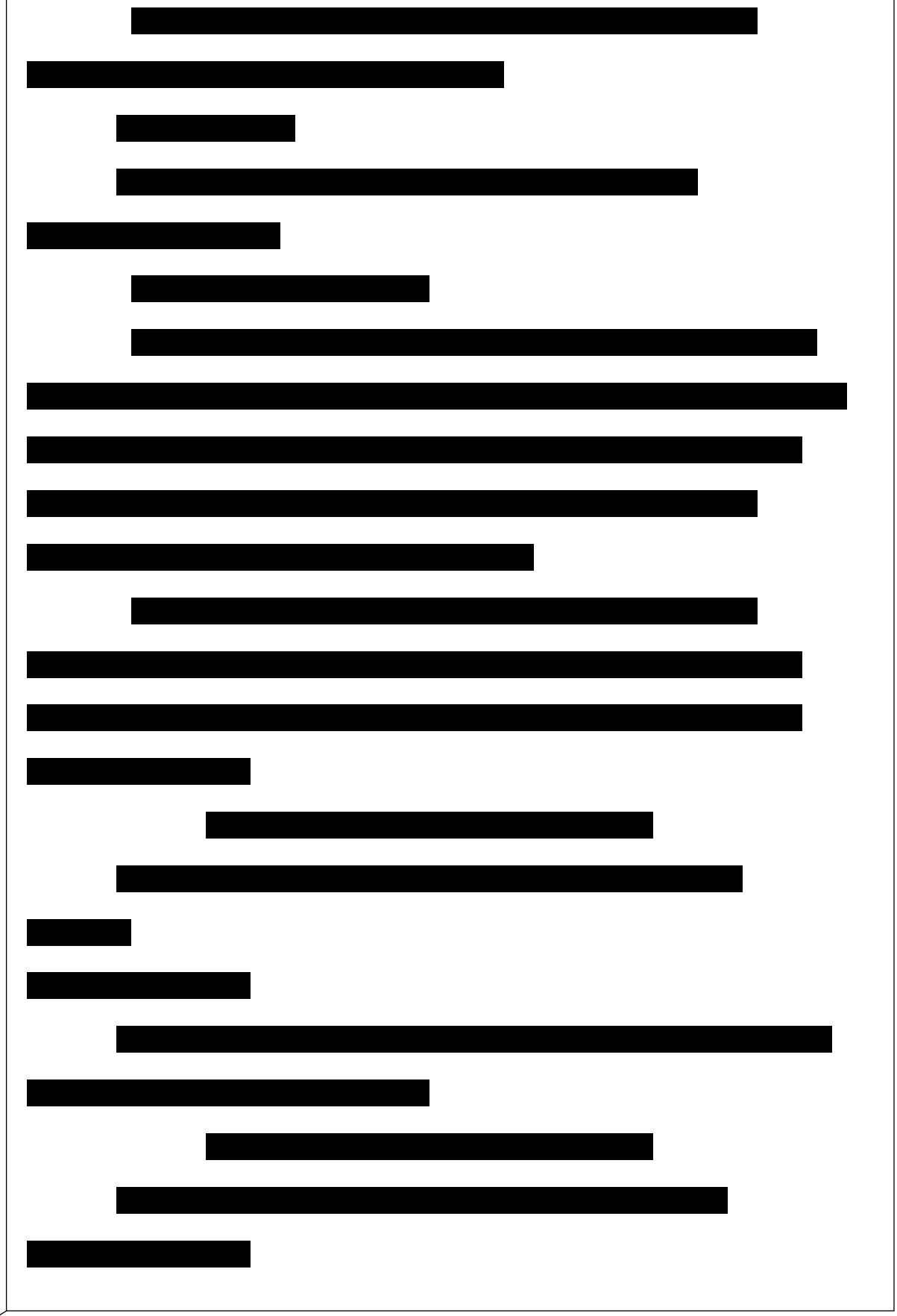
But is it fair to say that at the moment of this -- at the time of this writing, Mr. Anderson had notified Mr. Linsley of the fact that Advocate was in Tier 2 of the named product?

A. He is notifying Nathan Linsley that he

believes Advocate is participating in the Blue Choice PPO Options product as a Tier 2 provider.

[redacted]





**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF WISCONSIN**

| | |
|---|---|
| URIEL PHARMACY HEALTH AND WELFARE PLAN; URIEL PHARMACY, INC.; HOMETOWN PHARMACY; AND HOMETOWN PHARMACY HEALTH and WELFARE BENEFITS PLAN, on their own behalf and on behalf of all others similarly situated,<br><br>Plaintiffs,<br><br>v.<br><br>ADVOCATE AURORA HEALTH, INC. and AURORA HEALTH CARE, INC.,<br><br>Defendants. | Case No. 2:22-cv-610<br><br>**REDACTED PUBLIC VERSION** |

**PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR CLASS CERTIFICATION**

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## I. INTRODUCTION

Uriel Pharmacy Health and Welfare Plan, Uriel Pharmacy, Inc. (together, "Uriel"), Hometown Pharmacy, and Hometown Pharmacy Health and Welfare Benefits Plan (together, "Hometown", and collectively with Uriel, "Plaintiffs") respectfully move under Federal Rule of Civil Procedure 23 for certification of the following "Class:"

> All entities that purchased in-network Healthcare Services directly from Advocate Aurora Health, Inc. or Aurora Health Care, Inc. ("AAH") providers in Eastern Wisconsin at any time during the period from May 24, 2018 up to and including December 31, 2022 (the "Class Period"), to the extent such purchases were made pursuant to contracts between AAH and any of the following Network Vendors: Anthem/Blue Cross Blue Shield of Wisconsin, United Healthcare, Cigna Healthcare, Humana Inc., Wisconsin Physicians Services, Health Payment Systems, and/or Trilogy Health Solutions.[1] Excluded from the Class are AAH, and their officers, directors, management, employees, subsidiaries, or affiliates, judicial officers and their personnel, and all federal governmental entities.[2]

Defendant AAH operates the most hospitals and the most hospital beds of any health system in Eastern Wisconsin. It abused that market dominance, however, to engage in anticompetitive conduct and overcharge Class members (self-funded employer health plans and commercial insurers) for Healthcare Services. [redacted]

[1] "Healthcare Services" are inpatient and outpatient facility claims (for use of a facility) and claims for professional services (for treatment by a healthcare professional). "Eastern Wisconsin" comprises the following Health Service Areas: Appleton, Brookfield, Burlington, Chilton, Cudahy, Elkhorn, Fond Du Lac, Fort Atkinson, Green Bay, Hartford, Kenosha, Kewaunee, Manitowoc, Marinette, Menomonee Falls, Milwaukee, Neenah, Oconomowoc, Oconto Falls, Oshkosh, Plymouth, Port Washington, Racine, Shawano, Sheboygan, Sturgeon Bay, Two Rivers, Watertown, Waukesha, West Allis, and West Bend. Ex. 3, Dranove Rpt. ("DR1") ¶11 n.7 (defining Eastern Wisconsin). All Exs. are attached to the accompanying Wallin Declaration.

[2] The Class definition is narrower than the definition in the complaint (2d Am. Compl., ECF 46, ¶231) and includes an end date for the Class Period. Such revisions are permitted. *See Abbott v. Lockheed Martin Corp.*, 725 F.3d 803, 814 (7th Cir. 2013); *Gaertner v. Commemorative Brands, Inc.*, 2026 WL 248292, at *3 (S.D. Ill. Jan. 30, 2026) (certifying class where "[b]oth sides acknowledge that the proposed class definition differs from" the definition in the complaint).

[redacted] (Ex. 8, AAHEDWI00597913-27 at 916), [redacted]

AAH's wrongful conduct reduced competition and allowed it to charge supracompetitive prices for years—[redacted]. Ex. 10, Lenz 30(b)(6) Dep. (AAH) 21:2-27:21 (citing Ex. 85, AAHEDWI00630685-732 at 689). That the Challenged Conduct inflated AAH's prices is clear, and will be proven with common evidence, including multiple benchmarks, economic analyses, and documents and testimony from market participants, [redacted] Ex. 53, AAHEDWI00082436 at 438. AAH's unlawful conduct caused all or virtually all Class members ("Payors"[3]) to be overcharged. The evidence at trial will focus on AAH's antitrust violation and will be entirely or primarily common and Class-wide. Class certification should be granted.

## II. FACTUAL BACKGROUND

The key facts are summarized below. All are common to the Class and will be proven with Class-wide evidence. Additional Class-wide evidence supporting Plaintiffs' claims is set forth in

[3] "Payors" include (1) commercial health insurers that offer coverage for fully-insured plans, and (2) self-funded Plan Sponsors that pay claims on behalf of their members, typically employees and their families. "Plan Sponsors" are entities that establish and manage health insurance plans for groups, such as employers that offer health insurance plans to their employees and unions that offer plans to their members. Plaintiffs are Plan Sponsors and self-funded Payors for Healthcare Services. Ex. 3, DR1 ¶9 & n.1.

Plaintiffs' expert reports (Exs. 1-6), is incorporated by reference, and can be supplied to the Court.

### A. Competition in the Health Insurance Industry

Many businesses, local governments, and unions provide health insurance plans to their employees and members, acting as "Plan Sponsors." Some sponsor "fully insured" plans, whereby they pay premiums to a commercial insurance company, which then pays healthcare providers. *See* Ex. 3, DR1 ¶50. Others sponsor "self-funded" plans, whereby they pay providers and bear the insurance risk themselves. *Id.* Commercial insurance companies who pay bills for fully insured plans and self-funded employers who pay bills themselves are "Payors," because they pay healthcare providers for covered Healthcare Services. *Id.* ¶52.

The prices that Plaintiffs and Class members (Payors) pay for medical services are determined in negotiations between healthcare providers and Network Vendors,[4] which are entities that negotiate with providers and assemble "insurance networks"—networks of healthcare providers that have agreed to provide services at negotiated prices. *Id.* ¶¶9 n.1, 44. An "in-network provider" has agreed to provide services at prices negotiated with the Network Vendor. Ex. 1, Leitzinger Rpt. ("LR1") ¶¶13-14, 16. Plan Sponsors can select a Network Vendor's network with the Plan Sponsor's desired price and non-price characteristics. Ex. 3, DR1 ¶49.

Some networks are "broad" with many providers; others are "narrow" with fewer. *Id.* ¶44. Network breadth reflects a tradeoff between access and cost: broader networks usually provide access to more providers across multiple categories—such as primary care physicians, specialists, and hospitals—while narrow networks offer fewer options but lower prices. *Id.* ¶45. Patients have

[4] Some entities function as both Network Vendors and Payors: a commercial health insurer, like Anthem, acts as a Network Vendor and a Payor when offering fully-insured plans. Entities may act as Network Vendors without acting as Payors: Anthem acts as a Network Vendor but not a Payor when contracting with providers to create an insurance network for self-funded Payors. Ex. 3, DR1 ¶9 & n.1

financial incentives to use in-network providers, so providers will get more patient volume if they are selected as an in-network provider. *Id*. ¶¶46, 62.

Price competition in healthcare occurs through a process known as "selective contracting," whereby healthcare providers compete on price for inclusion and placement within provider networks. *Id*. ¶¶17, 54, 68, 74. Selective contracting increases competition at three stages of competition within the healthcare insurance market. At **stage 1**, providers compete on price for network inclusion and placement (*i.e.*, which "tier" they will be on, which impacts the level of patient cost sharing).[5] At **stage 2**, Network Vendors compete to sell insurance networks to Plan Sponsors and their members, which seek networks offering (a) a wide enough variety of providers, (b) in every specialty, (c) close to where their members live and work, (d) at affordable costs. At **stage 3**, providers compete for patient volume, with patients choosing providers based on factors such as cost sharing (which depends on whether the provider is in-network and in what tier), convenience, location, and prior experience. *Id*. ¶¶55-56, 61-69.

A Network Vendor's willingness to agree to higher prices in stage 1 depends on whether excluding that provider would make the network less attractive to Plan Sponsors and their members in stage 2. *Id.* ¶¶64, 69. Conversely, a provider's willingness to offer lower prices to a Network Vendor in stage 1 depends on how much patient volume the provider would lose if it were not included in the Network Vendor's network or if it were steered away from. *Id.* ¶¶68, 78-82.

Because Network Vendors represent large numbers of prospective patients, they typically

[5] Courts have found that, because the prices Payors pay to healthcare providers are negotiated between Network Vendors and providers in stage 1, "antitrust analysis focuses on the first stage." *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 784 n.10 (9th Cir. 2015) (citation omitted). But as described herein, AAH's All Plans provision interfered with stages 2 and 3 as well, thus worsening the harm inflicted by the Challenged Conduct.

negotiate discounted prices from healthcare providers in exchange for the increased patient volume for being in-network. *Id.* ¶76; LR1 ¶13. Network Vendors also use narrow networks and "steering" or "tiering" to encourage providers to lower their prices. DR1 ¶77. With **narrow networks**, a provider can obtain more volume because the network includes fewer competing providers. *Id.* ¶¶62, 78-80. With **steering**, Network Vendors use financial incentives or informational tools to encourage patients to obtain care from specific providers at lower prices. *Id.* ¶¶47, 188 & nn.326, 327. One method of steering is through **tiered** networks, which rank providers by price and quality: providers ranked higher have lower patient cost sharing, incentivizing patients to choose them. *Id.* ¶48. As with narrow networks, providers are incentivized to offer lower prices in exchange for placement in a higher tier to obtain more patients. *Id.* ¶¶81-82. Even when Network Vendors do not implement such programs, the credible threat of doing so helps keep prices down. Ex. 4, Dranove Rebuttal ("DR2") ¶21. For example, a high-priced provider may lower its prices to prevent a Network Vendor from implementing a steering program that would disfavor it. DR1 ¶¶193-96.

### B. AAH's Imposition of the All Plans Provision Suppressed Price Competition

The All Plans provision [redacted], decreased price competition, and allowed AAH to impose inflated prices on Plaintiffs and the proposed Class. The All Plans provision is [redacted] even more onerous than, the restraints at issue in antitrust litigation involving Sutter Health, a health system in California. *See* Ex. 3, DR1 ¶198 & n.359. In that litigation, in which the State of California also pursued antitrust claims, classes were certified in state and federal cases, leading to eve-of-trial settlements of $575 million and $228.5 million, respectively, along with injunctive relief requiring the removal of the challenged restraints.[6]

[6] *See Sidibe v. Sutter Health*, 2020 WL 4368221 (N.D. Cal. July 30, 2020) (certifying damages class); *Sidibe v. Sutter Health*, 333 F.R.D. 463, 475 (N.D. Cal. 2019) (certifying injunctive-relief

[redacted]. Ex. 3, DR1 ¶¶34, 40, 169-74, Tables 2, 7-9. [redacted] Ex. 11, AAHEDWI00756315-58 at 318; Ex. 12, HURON_054337-47 at 341; Ex. 75, HURON_068476-82 at 78. [redacted] Ex. 13, AAHEDWI00450873-98 at 882; Ex. 48, Klein 30(b)(6) Dep. (AAH) 15:5-10 [redacted] Ex. 48, Klein 30(b)(6) Dep. (AAH) 39:10-19, 40:6-42:4. [redacted] *Id.* 41:7-42:4. [redacted] *Id.* 40:3-43:6, 52:23-53:8. [redacted] Ex. 3, DR1 ¶84. [redacted]

class); Ex. 26, Order Granting in Part Motion To Strike, Granting Class Certification, and Setting Case Management Conference, *UEBT v. Sutter Health*, No. CGC-14-538451 (Sup. Ct. Cal. Aug. 14, 2017) ("*UEBT v. Sutter* Class Order"); Ex. 55, Press Release, Cal. Dep't of Justice, *Attorney General Bonta Announces Final Approval of $575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices* (Aug. 27, 2021), at 2 ("Sutter will no longer have free rein to engage in anticompetitive practices that force patients to pay more for health services."); *Sidibe v. Sutter Health*, No. 12-CV-04854, ECF 1763 (N.D. Cal. Nov. 6, 2025) (granting final approval of $228.5 million settlement).

[redacted][7] [redacted] Ex. 15, AAHEDWI00658806-07 at 806.

The All Plans provision [redacted], suppressed competition among providers and Network Vendors, and increased prices and limited provider choices at each stage of market competition. *See* Ex. 3, DR1 ¶¶58, 184-86.

***Stripping Network Vendors of bargaining leverage (Stage 1).*** [redacted].[8] [redacted], AAH had no incentive to offer competitive rates, creating "upward rather than downward pricing pressure." *Id.* ¶203. The All Plans provision also suppressed competitive incentives among AAH's rivals by raising the AAH prices against which any price competition occurred and limiting or eliminating the competitive benefits of reducing prices (the "umbrella" effect). *Id.* ¶¶196, 203. One Network Vendor confirmed this impact of the restrictions, noting [redacted]

[7] Ex. 3, DR1 ¶85 (citing Ex. 14, AAHEDWI00621359-63 at 360; Ex. 15, AAHEDWI00658806-07 at 806; Ex. 13, AAHEDWI00450873-98 at 882; Ex. 48, Klein 30(b)(6) Dep. (AAH) 33:19-34:9; Ex. 57, AAHEDWI00630735-72 at 751-52, 754; Ex. 22, Lathers 30(b)(6) Dep. (Anthem-BCBS) 332:15-333:4; Ex. 86, Beck 30(b)(6) Dep. (UnitedHealthcare) 272:12-273:9); Ex. 3, DR1, Tables F.8, F.9.

[8] Ex. 3, DR1 ¶¶193-95 [redacted] (citing Ex. 22, Lathers 30(b)(6) Dep. (Anthem-BCBS) 50:16-53:21; Ex. 62, AAHEDWI01188952; Ex. 79, AURORA00011858-63 at 862; Ex. 24, Ott 30(b)(6) Dep. (WPS) 83:1-21; Ex. 19, AAHEDWI00007080-85 at 080; Ex. 87, Skogsbergh Dep. (AAH) 241:24-243:14, 286:9-16; Ex. 61, AAHEDWI00983339-64; Ex. 88, Anderson Dep. (AAH) 90:25-90:14, 139:5-23; Ex. 54, AAHEDWI00127810-18 at 810).

[redacted] this was not possible "in southeast Wisconsin because of [the All Plans] contractual provision." Ex. 22, Lathers 30(b)(6) Dep. (Anthem-BCBS) 50:16-53:21, 335:15-336:12.

***Foreclosing competition among networks (Stage 2).*** [redacted] Ex. 3, DR1 ¶¶197-99. [redacted] *Id.* ¶199. As Dr. Dranove explains, this component of the All Plans provision makes it even "more anticompetitive than" the restraints in the *Sutter Health* litigation (where he was also an expert): [redacted] *Id.* ¶198 (emphasis in original).

[redacted][9] [redacted]

[9] Ex. 3, DR1 ¶¶190-92 [redacted] (citing, *inter alia,* Ex. 87, Skogsbergh Dep. (AAH) 101:3-12; Ex. 48, Klein 30(b)(6) Dep. (AAH) 52:23-53:8; Ex. 62, AAHEDWI01188952 at 952; Ex. 71, Alliance_UrielPharm_00001585 at 585; Ex. 63, AAHEDWI01373683-84 at 683; Ex. 67, AAHEDWI02574179-21 at 184; Ex. 89, Turk 30(b)(6) Dep. (BCBS-IL) 26:2-10, 33:13-21, 89:19-90:2, 93:19-94:6; Ex. 88, Anderson Dep. (AAH) 98:11-24, 139:5-23).

[redacted][10] [redacted]

[redacted].[11] [redacted]

[redacted].[12]

### C. AAH Had Power to Charge Supracompetitive Prices

Common evidence will show that AAH had substantial market power vis-à-vis Network Vendors that compete for commercial plan sponsors in Eastern Wisconsin. DR1 §VI. [redacted]

[redacted] (Ex. 11, AAHEDWI00756315-58 at 318); [redacted]

[10] Ex. 3, DR1 ¶¶188-89. Anthem, a Network Vendor, determined a site of service policy would "violate the contract with Aurora." Ex. 16, BCBSWI AAH 00022781-82 at 781-82; Ex. 22, Lathers 30(b)(6) Dep. (Anthem-BCBS) 137:7-138:16 [redacted] (discussing Ex. 17, BCBSWI_AAH_00024689-91 at 690); *see also* Ex. 72, BCBSWI AAH 00024854-55 at 854; Ex. 73, BCBSWI AAH 00025759-60 at 759-60. [redacted] Ex. 18, AAHEDWI00299219-20 at 219; Ex. 19, AAHEDWI00007080-85 at 083. [redacted] Ex. 20, AAHEDWI00095705-07 at 707; Ex. 21, AAHEDWI00023436-42 at 436-47.

[11] Ex. 22, Lathers 30(b)(6) Dep. (Anthem-BCBS) 128:13-131:2 [redacted]; Ex. 23, UHG-Uriel-00000494-95 [redacted]; Ex. 24, Ott 30(b)(6) Dep. (Wisconsin Physician Services ("WPS")) 55:4-22, 60:11-16 [redacted]

[12] *E.g.*, Ex. 56, Klein Dep. (AAH) 49:13-50:7 [redacted] Ex. 21, AAHEDWI00023436-42 at 437, 436 [redacted].

[redacted] (Ex. 7, HURON_068646-49 at 648 [redacted]); [redacted] (Ex. 8, AAHEDWI00597913-27 at 916); [redacted] (Ex. 25, AAHEDWI00598196 at 196). [redacted] Ex. 9, Klein Dep. (AAH) 287:21-288:7.

[redacted] Ex. 3, DR1 ¶¶136-37, 176. **Anthem** testified it could not remove AAH from all its products and remain commercially viable because "employers wouldn't want to only offer insurance plans that don't include Aurora" and agreed that "Aurora is the most dominant system in southeastern Wisconsin" due to "the size and magnitude of the health system."[13] **Common Ground** "viewed [AAH] as a necessary provider" and identified AAH contract termination as its number one network risk.[14] [redacted][15] [redacted][16] **WPS** understood excluding AAH would be "detrimental" [redacted][17] [redacted]

[13] Ex. 22, Lathers 30(b)(6) Dep. (Anthem-BCBS) 323:4-324:20; 316:24–318:1.

[14] Ex. 27, Jackson 30(b)(6) Dep. (Common Ground) 77:18-78:1, 62:16-63:12.

[15] Ex. 28, Maxwell 30(b)(6) Dep. (Humana) 56:21-57:9, 57:22-58:2; Ex. 29, HUMANA019081 at slide 4 (AAH contract termination is the "biggest risk"); Ex. 31, HUMANA019080 at slide 4 (same).

[16] Ex. 32, UHG-Uriel-00000368 at slide 14; *see* Ex. 33, UHG-Uriel-00020038-46 at 038-40 (similar).

[17] Ex. 24, Ott 30(b)(6) Dep. (WPS) 200:13-201:8.

[redacted] Ex. 3, DR1 ¶¶139, 175 (citing, *inter alia*, Ex. 66, AAHEDWI02574124-62 at 125; Ex. 68, AAHEDWI02602381-422 at 385; Ex. 76, HURON_080281-351 at 304; Ex. 70, AAHEDWI02613840-61 at 854-56). [redacted] *Id.* ¶139 (citing Ex. 66, AAHEDWI02574124-162 at 125, 138; Ex. 74, Blomeyer Dep. (AAH) 136:4-141:10)). [redacted] *Id.* ¶137. Three other systems (Ascension, Bellin, ProHealth) testified that they were unable to impose restraints similar to All Plans because they lacked AAH's "leverage." *Id.* ¶147.[18]

Dr. Dranove conducted structural analyses evaluating AAH's importance to patients, Plan Sponsors, and Network Vendors, analyzing both "willingness to pay"—a well-established concept in health economics that evaluates how much worse off patients would be if they could no longer receive care from a given health system—and patient volumes. Ex. 3, DR1 §VI(E)-(F). Dr. Dranove found that AAH is by far the most powerful health system in Eastern Wisconsin and that its high share of patient volume indicates that Network Vendors would face significant challenges if they lacked all AAH providers in all their networks. *Id.*

[redacted] Ex. 3, DR1 ¶¶142-46.[19] [redacted]

[18] [redacted] Ex. 3, DR1 ¶138 (citing Exs. 49, 51, 90).

[19] [redacted] Ex. 30, AAHEDWI00573956-57 at 956; *see also* Ex. 34,

[redacted][20] [redacted] DR1 ¶149 (citing evidence).

**D. The Challenged Conduct Caused Higher Prices**

Class-wide evidence—including AAH's admissions—shows that the Challenged Conduct caused inflated prices, [redacted] (Ex. 40, AAHEDWI00435658-69 at 667 [redacted]), [redacted] (Ex. 41, AAHEDWI00025038-40 at 038-39 [redacted]), [redacted] (Ex. 53, AAHEDWI00082436-40 at 438 [redacted]), [redacted] (Ex. 42, AAHEDWI00868418-20 at 418 [redacted]),

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AAHEDWI00573958-64 at 959 (similar). **Anthem** repeatedly sought removal of the language. Ex. 22, Lathers 30(b)(6) Dep. (Anthem-BCBS) 351:10-352:4. Anthem viewed the provision as "problematic, punitive, or limit[ing] care choices for consumers," Ex. 35, BCBSWI AAH 00025938-39 at 938, [redacted] Ex. 36, AAHEDWI00158954-60 at 956. [redacted] Ex. 37, AAHEDWI00573949-50 at 949. [redacted] Ex. 38, AAHEDWI00008411-14 at 411-12. [redacted] Ex. 3, DR1 Table F.9; Ex. 39, AAHEDWI00152452-63 at 459; Ex. 40, AAHEDWI00435658-69 at 659. **WPS** alleged in a counterclaim against AAH in 2006 that the provision was an illegal restraint "imposed on all Network Vendors." Ex. 3, DR1 ¶146 (citing Ex. 81, WPS's Answer to Amended Compl., Amended Counterclaims, and Reply to Counter-Counterclaims, ¶¶18, 69, 71). WPS sought removal "multiple times over the years" but could not get the All Plans provision removed until 2023. Ex. 24, Ott 30(b)(6) Dep. (WPS) 191:20-192:8.

[20] Ex. 3, DR1 ¶¶147-48 [redacted] (citing, *inter alia*, Ex. 82, Squier Dep. (Ascension) 122:8-123:17; Ex. 83, Wedin 30(b)(6) Dep. (Bellin) 68:21-69:9, 75:25-76:13, 93:24-94:7; Ex. 84, Bacon 30(b)(6) Dep. (ProHealth) 240:1-241:11, 262:9-263:23; Ex. 22, Lathers 30(b)(6) Dep. (Anthem-BCBS) 343:14-344:6, 349:14-350:5; Ex. 24, Ott 30(b)(6) Dep. (WPS) 192:16-25).

[redacted] (Ex. 65, AAHEDWI02010094-96 at 95), and [redacted] (Ex. 43, AAHEDWI00083070-74 at 072 [redacted]).[21] [redacted] [22] [redacted] Ex. 3, DR1 ¶¶156-57; LR1 ¶23.[23] [redacted] Ex. 3, DR1 ¶151. [redacted] Ex. 44, AAHEDWI00450947-69 at 961. [redacted] [24] [redacted] Ex. 1, LR1 ¶20 & n.25 (citing Ex. 64, AAHEDWI01378772-03 at 772, 776), [redacted] Ex. 11, AAHEDWI00756315-58 at 318.

AAH was the highest priced system in Wisconsin for both inpatient and outpatient services.

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[21] *See* Ex. 3, DR1 ¶155; Ex. 1, LR1 ¶21 (citing evidence of AAH's high prices); Ex. 4, DR2 ¶74 & n.104 (citing, *inter alia*, Ex. 60, AAHEDWI00947831-41 at 838).

[22] Ex. 52, AAHEDWI00082402-04 at 404.

[23] *E.g.*, Ex. 45, CG_0063481 at 482 (AAH was "a more expensive provider"); Ex. 22, Lathers 30(b)(6) Dep. (Anthem-BCBS) 77:22-24 ("Aurora had a higher reimbursement rate in southeast Wisconsin compared to their peers."); Ex. 46, Spencer 30(b)(6) Dep. (Froedtert) 266:14-268:3 [redacted]; Ex. 47, UHG-Uriel-00006550, slide 2 [redacted] Ex. 80, Uriel-Sub0002739-50 at 745 [redacted].

[24] Ex. 3, DR1 ¶158 (citing Ex. 78, ProHealth_Uriel_0007534-36 at 534); Ex. 1, LR1 ¶20 (citing Ex. 77, MILLIMAN_00001-39 at 011; Ex. 78, ProHealth_Uriel_0007534-36 at 534).

Ex. 1, LR1 ¶25. For 2020-22, each of AAH's Wisconsin hospitals was in the highest-priced 10% of all hospitals nationwide, and AAH's hospital in Kenosha was the fourth highest-priced hospital in the country. Ex. 3, DR1 ¶¶152-54. In 2021, commercial healthcare prices in the Milwaukee and Racine metropolitan areas—AAH strongholds—were almost 50% higher than national median prices. Ex. 1, LR1 ¶24. Dr. Dranove confirmed that AAH's high prices are not attributable to alternative cost or demand factors. Ex. 3, DR1 ¶¶160-63.

Finally, as discussed further below, Plaintiffs' expert economist Dr. Leitzinger—as he did in the *Sutter* litigation—conducted econometric analysis, which showed in this case that the Challenged Conduct raised prices substantially, [redacted] and that all or virtually all Class members were overcharged. *Infra* §III.B.5.b; Ex. 1, LR1 ¶¶9, 40 & at Ex. 4.

## III. ARGUMENT

### A. Standard for Class Certification

Class actions play an important role in antitrust enforcement. *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343-44 (1979); *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 262-66 (1972). At class certification, "[t]he district court's task [is] to determine if the plaintiffs[] presented a scenario in which judicial efficiency would be served by allowing their claims to proceed en masse through the medium of a class action rather than through individual litigation." *Chi. Teachers Union, Local No. 1 v. Bd. of Educ. of Chi.*, 797 F.3d 426, 433 (7th Cir. 2015). Plaintiffs must demonstrate numerosity, typicality, commonality, and adequacy of representation under Rule 23(a) and, here, the Rule 23(b)(3) requirements of predominance and superiority. *Kleen Prods. LLC v. Int'l Paper Co.*, 831 F.3d 919, 922-23 (7th Cir. 2016). The Court's determination of whether Plaintiffs have met these prerequisites requires a "rigorous analysis" that may "entail some overlap with the merits of the plaintiff's underlying claim." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 351 (2011).

However, "Rule 23 grants courts no license to engage in free-ranging merits inquiries at the certification stage. Merits questions may be considered to the extent—but only to the extent—that they are relevant to determining whether the Rule 23 prerequisites for class certification are satisfied" and only by a preponderance of evidence.[25]

### B. Plaintiffs Satisfy the Requirements of Rule 23(a) and 23(b)(3)

#### 1. Rule 23(a)(1)'s Numerosity Requirement is Met

Proposed classes of "more than forty members generally satisf[y] the numerosity requirement." *Chavez v. Don Stoltzner Mason Contractor, Inc.*, 272 F.R.D. 450, 454 (N.D. Ill. 2011). There are at least 6,809 Class members. Ex. 1, LR1 ¶9(a) & at Ex. 3. Rule 23(a)(1) is met.

#### 2. Rule 23(a)(2)'s Commonality Requirement is Satisfied

Rule 23(a)(2) asks whether class members' claims "depend upon a common contention that is capable of classwide resolution." *Bell v. PNC Bank, Nat. Ass'n*, 800 F.3d 360, 374 (7th Cir. 2015). Commonality requires only "a single common question of law or fact." *Id.* In antitrust cases, "'antitrust liability alone constitutes a common question that will resolve an issue that is central to the validity of each class member's claim in one stroke.'" *Moehrl v. Nat'l Ass'n of Realtors*, 2023 WL 2683199, at *11 (N.D. Ill. Mar. 29, 2023) (citation omitted).

There are numerous common questions, including whether: (1) AAH engaged in the Challenged Conduct; (2) the Challenged Conduct was an unreasonable restraint of trade; (3) AAH had market power and used it to impose and maintain the Challenged Conduct; (4) the Challenged Conduct had anticompetitive effects that outweigh any cognizable procompetitive benefits; (5) antitrust impact (i.e., an overcharge) to the Class can be proven with common evidence; and (6)

[25] *Amgen Inc. v. Conn. Ret. Plans & Tr. Funds*, 568 U.S. 455, 466 (2013); *see also Messner*, 669 F.3d at 811 ("the court should not turn the class certification proceedings into a dress rehearsal for the trial on the merits").

aggregate Class-wide damages can be reliably measured. *See* Proposed Trial Plan (filed herewith).

### 3. Rule 23(a)(3)'s Typicality Requirement is Met

Rule 23(a)(3) is satisfied if "the claims or defenses of the representative parties are typical of the claims or defenses of the class." Under Rule 23(a)(3)'s "liberal[]" standard, typicality is satisfied "when the representative party's claim arises from the same course of conduct that gives rise to the claims of other class members and all of the claims are based on the same legal theory." *Saltzman v. Pella Corp.*, 257 F.R.D. 471, 479 (N.D. Ill. 2009), *aff'd*, 606 F.3d 391 (7th Cir. 2010). "In the antitrust context, typicality 'will be established by plaintiffs and all class members alleging the same antitrust violation by the defendants.'"[26] Plaintiffs and the Class all claim an overcharge injury from the same Challenged Conduct. Ex. 1, LR1 ¶¶9.c, 55, 64. Typicality is met.

### 4. Rule 23(a)(4)'s Adequacy Requirement is Met

Adequacy requires: "(i) the class representatives must not have claims in conflict with other class members, and (ii) the class representatives and proposed class counsel must be able to litigate the case vigorously and competently on behalf of named and absent class members alike." *In re Broiler Chicken Antitrust Litig.*, 2022 WL 1720468, at *3 (N.D. Ill. May 27, 2022). Those requirements are satisfied here. First, Plaintiffs' interests are fully aligned with those of the Class in proving that AAH violated the antitrust laws and thereby overcharged them for Healthcare Services. Here, "because *Hanover Shoe* sets the amount of the overcharge as plaintiffs' damages, all of the class members have the same financial incentive for purposes of the litigation—*i.e.* proving that they were overcharged and recovering damages based on that overcharge."[27]

[26] *Moehrl*, 2023 WL 2683199, at *12; *see In re Ready-Mixed Concrete Antitrust Litig.*, 261 F.R.D. 154, 168 (S.D. Ind. 2009) ("factual differences in date, size, manner, or conditions of purchase, the type of purchaser, or other concerns do not make named plaintiffs atypical") (citation omitted).

[27] *In re K-Dur Antitrust Litig.*, 686 F.3d 197, 223 (3d Cir. 2012) (citing *Hanover Shoe v. United Shoe Mach. Corp.*, 392 U.S. 481 (1968)). *See Ramirez v. Palisades Collection LLC*, 2007 WL

Plaintiffs have demonstrated that they will litigate vigorously on behalf of the proposed Class. In the more than four years of this litigation, they have conducted extensive work on behalf of the Class, including giving deposition testimony and producing documents. *See* Wallin Decl. ¶¶1, 4.

Second, Plaintiffs retained skilled counsel with experience prosecuting antitrust and class action litigation. Proposed Co-Lead Counsel Fairmark Partners, LLP (https://fairmarklaw.com/) and Berger Montague PC (https://bergermontague.com/) are experienced counsel in antitrust class actions and have diligently and zealously represented the interests of the Class. They have committed tens of thousands of hours and considerable resources, taking dozens of depositions, engaging in years of discovery, collecting and reviewing hundreds of thousands of documents, briefing dispositive and discovery motions, and engaging economic experts, among many other tasks. *Id*. ¶¶1-3. Adequacy is met.

**5. Rule 23(b)(3)'s Predominance Requirement is Met**

Predominance is "readily met" in cases alleging violation of the antitrust laws. *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 625 (1997); *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 815 (7th Cir. 2012). "Predominance is satisfied when 'common questions represent a significant aspect of a case and ... can be resolved for all members of a class in a single adjudication.'" *Kleen Prods.*, 831 F.3d at 925 (quoting *Messner*, 669 F.3d at 815). "[C]ourts routinely have found that common questions predominate where the case claims the existence of a widespread or uniform practice." *Ross v. Gossett*, 33 F.4th 433, 439 (7th Cir. 2022).

Rule 23(b)(3) "does *not* require a plaintiff seeking class certification to prove that each element of her claim is susceptible to classwide proof." *Amgen*, 568 U.S. at 469 (cleaned up;

4335293, at *6 (N.D. Ill. Dec. 5, 2007) (plaintiff adequate where "she and putative class members have suffered the same injury as a result of the same conduct"); *Alexander v. Q.T.S. Corp.*, 1999 WL 573358, at *8 (N.D. Ill. July 30, 1999) (same).

emphasis in original); *Kleen Prods.*, 831 F.3d at 922. The inquiry is whether common questions predominate as to the case *as a whole*, not as to individual elements. *Id*; *Tyson Foods, Inc. v. Bouaphakeo*, 577 U.S. 442, 453 (2016); *Butler v. Sears, Roebuck & Co.*, 727 F.3d 796, 801 (7th Cir. 2013). "Common issues predominate if they have a direct impact on every class member's effort to establish liability, and if that impact is more substantial than the impact of individualized issues in resolving the claims." *Doster Lighting, Inc. v. E-Conolight, LLC*, 2015 WL 3776491, at *8 (E.D. Wis. June 17, 2015). Individualized issues do not defeat predominance unless they "overwhelm common ones." *Halliburton Co. v. Erica P. John Fund, Inc.*, 573 U.S. 258, 276 (2014); *see Tyson Foods*, 577 U.S. at 453 (common issues may predominate "even though other important matters will have to be tried separately") (citation omitted).

Plaintiffs need not prove that the common "questions will be answered, on the merits, in favor of the class," *Amgen*, 568 U.S. at 459, but simply that the common questions are "*capable* of" class-wide resolution. *Messner*, 669 F.3d at 818 (citation omitted) (emphasis in original). *See also Bell*, 800 F.3d at 377 (plaintiffs not required to demonstrate that they "will ultimately prevail on the merits" of common questions); *Broiler Chicken*, 2022 WL 1720468, at *7 (whether the "evidence is sufficient to survive summary judgment or to demonstrate liability at trial is not at issue" at class certification).

Here, common questions are abundant and predominate over any individual questions.

**a. <u>Plaintiffs Will Prove AAH's Violation With Common Evidence</u>**

Plaintiffs allege that the Challenged Conduct violated Sections 1 and 2 of the Sherman Act. "To allege a valid claim under § 1 of The Sherman Act, a plaintiff must prove that (1) defendants had a contract, combination, or conspiracy; (2) the conspiracy impacted the market; and (3) it was injured." *Fond Du Lac Bumper Exch., Inc. v. Jui Li Enter. Co.*, 2016 WL 3579953, at *6 (E.D. Wis. June 24, 2016). Plaintiffs' Section 1 claim is subject to Rule of Reason analysis, whereby a

"plaintiff carries the burden of showing that an agreement or contract has an anticompetitive effect on a given market within a given geographic area" and "that the defendant has market power ... without which the defendant could not cause anticompetitive effects on market pricing."[28]

Plaintiffs' proof of AAH's antitrust violation is entirely common to the Class. *E.g.*, *supra* §II.B; Ex. 3, DR1 ¶¶83-85. [redacted] *Supra* §II.B; Ex. 3, DR1 ¶85; *cf. Sidibe*, 333 F.R.D. at 492 ("common questions will predominate with respect to the alleged antitrust violations"); *UEBT v. Sutter* Class Order at 14 (finding predominance where "[t]here is evidence that Network Vendors (and consequently, their self-funded payor members) were subject to the same or substantially similar restrictive contract provisions with Sutter, which consequently inhibited price competition in the marketplace.").

Likewise, whether AAH had substantial market power is a common question, to be addressed through common evidence. Plaintiffs' proof of AAH's market power is all common to the Class and includes both direct evidence of anticompetitive effects and indirect evidence of market definition and market share. *See Toys "R" Us, Inc. v. F.T.C.*, 221 F.3d 928, 937 (7th Cir. 2000) (both forms of evidence can be used to prove market power).

[28] *Agnew v. NCAA*, 683 F.3d 328, 335 (7th Cir. 2012). Section 2 similarly requires "(1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power[.]" *U.S. v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). Attempted monopolization under Section 2 requires "(1) specific intent to achieve monopoly power in a relevant market; (2) predatory or anticompetitive conduct directed to accomplishing this purpose; and (3) a dangerous probability that the attempt at monopolization will succeed." ECF 31, Decision and Order at 10 (citing *Mercatus Grp., LLC v. Lake Forest Hosp.*, 641 F.3d 834, 854 (7th Cir. 2011)). "Monopoly power" is "synonymous in most respects" and "sometimes used interchangeably" with market power, though "'monopoly power' generally denotes some higher threshold of market power[.]" *DSM Desotech Inc. v. 3D Sys. Corp.*, 2009 WL 174989, at *7 (N.D. Ill. Jan. 26, 2009). Monopoly power can be proven with the same evidence as market power. *See In re Dairy Farmers of Am., Inc. Cheese Antitrust Litig.*, 767 F. Supp. 2d 880, 902 (N.D. Ill. 2011).

Plaintiffs' direct evidence includes Class-wide expert analysis showing that AAH charged prices [redacted] higher than it would have absent the Challenged Conduct, and that the All Plans provision harmed competition. Ex. 1, LR1 §§V, VI; Ex. 3, DR1 ¶¶152-63, 184-99; Ex. 4, DR2 §VI. [redacted] Ex. 3, DR1 ¶89, §VI(A)-(C) (citing evidence); *supra* §§II.B-C; *Fortner Enters., Inc. v. U.S. Steel Corp.*, 394 U.S. 495, 504 (1969) (direct evidence includes the power to "impose other burdensome terms ... with respect to any appreciable number of buyers within the market"); *Toys "R" Us*, 221 F.3d at 937 (same). Dr. Dranove's market analyses confirm AAH's importance to patients, Plan Sponsors, and Network Vendors, proof of AAH's market power. Ex. 3, DR1 §VI(E)-(F).

Plaintiffs also will prove AAH's market power indirectly, with Class-wide evidence. This market evidence is, by definition, market-wide, and thus common across the Class. *See* Ex. 3, DR1 §§V, VI; Ex. 4, DR2 §IV; *supra* §II.C (citing evidence). Dr. Dranove, a preeminent healthcare economist, found that "the healthcare services that AAH offers to Network Vendors in Eastern Wisconsin is a well-defined antitrust market for this matter. This market includes as market participants AAH and other providers of competing healthcare services in Eastern Wisconsin." Ex. 3, DR1 ¶100 & §V.C-D. That this is a well-defined antitrust relevant market is undisputed and supported by overwhelming evidence, all common to the Class, including Dr. Dranove's application of the Hypothetical Monopolist Test from the U.S. Department of Justice and Federal Trade Commission's "Merger Guidelines," and business documents and testimony from AAH and other market participants. *Id.* ¶¶101-29.[29] Dr. Dranove also opines, again based

[29] Application of the Hypothetical Monopolist Test is a well-recognized way to define a relevant antitrust market. *See, e.g.*, *Corzo v. Brown Univ.*, 2026 WL 91424, at *10-11 (N.D. Ill. Jan. 12, 2026) (denying defendants' relevant market summary judgment motion).

on entirely Class-wide evidence and methodology, that "this market encompasses narrower well-defined antitrust markets (submarkets): inpatient GAC [general acute care] services offered to Network Vendors in Eastern Wisconsin; outpatient services offered to Network Vendors in Eastern Wisconsin; and physician specialty services offered to Network Vendors in Eastern Wisconsin." Ex. 3, DR1 ¶100.

As Dr. Dranove opined, AAH had sufficiently large shares of patient volume, above 30%, in these well-defined relevant antitrust markets to give it substantial market power, DR1 ¶¶166-74, and other evidence supports it, such as (a) [redacted] (*id.* ¶¶134-46, 175-76[30]; *supra* §II.C), (b) [redacted] (Ex. 3, DR1 ¶¶147-49), and (c) [redacted] (*id.* ¶¶150-63), and significant barriers exist to providers' entry and expansion in the Healthcare Services market in Eastern Wisconsin (*id.* ¶¶177-83). *See also, e.g.*, Ex. 4, DR2 §IV; *Toys "R" Us*, 221 F.3d at 937 (defendant had market power with a 20% share because "[i]t was remarkably successful" in imposing contractual restraints on "the 10 major toy manufacturers" comprising 40% of the toy market).

Common evidence in the form of Class-wide expert analysis and evidence "can be used to define the relevant product market[s]"[31] and to prove AAH's market power. Even if AAH could

[30] Dr. Dranove showed empirically that willingness to pay for AAH, "measured by evaluating how much worse off patients would be if they could no longer receive care from a given health system" was much higher than AAH's competitors. *Id.* ¶164; *see also id.* ¶¶165-76.

[31] *In re Turkey Antitrust Litig.*, 2025 WL 264021, at *26-27 (N.D. Ill. Jan. 22, 2025); *In re Automatic Card Shufflers Litig.*, 2026 WL 892509, at *21 (N.D. Ill. Mar. 31, 2026) ("[Q]uestions of market definition ... are classwide issues.").

show it lacked market power, this would not defeat predominance because its evidence is also common. *See Amgen*, 568 U.S. at 470 (alleged "failure of proof as to an element" of plaintiffs' claim is a "fatal similarity" supporting certification). The same is true of AAH's purported procompetitive justifications for the All Plans provision, [redacted].[32]

Plaintiffs also have overwhelming Class-wide evidence of anticompetitive effects: (a) Dr. Leitzinger's analysis of overcharges caused by the All Plans provision, (b) Dr. Dranove's opinion and explanation of how the All Plans provision undermines price competition, (c) Dr. Romano's opinion that [redacted] and (d) extensive record evidence consistent with these findings. Ex. 1, LR1 §V, ¶¶19-25; Ex. 3, DR1 §§III(D), VI(D)-(E), VII; Ex. 5, Romano Rpt. ¶17[33]; *supra* §II.

Courts have repeatedly found in cases such as this that common issues predominate as to violation, holding that the question of antitrust violation "relates solely to Defendants' conduct, and as such proof for these issues will not vary among class members."[34]

**b. Class-Wide Impact Can Be Proven With Common Evidence**

Plaintiffs' common evidence also can prove Class-wide impact in the form of overcharge

[32] *E.g.*, Ex. 85, AAHEDWI00630685-732 at 697 [redacted]

[33] Dr. Romano also opined that "'All Plans' contract provisions are not necessary to achieve or maintain clinical integration that benefits patients and communities." Ex. 5, Romano Rpt. ¶17.

[34] *In re Potash Antitrust Litig.*, 159 F.R.D. 682, 694 (D. Minn. 1995); *see also Messner*, 669 F.3d at 815-16 ("common questions clearly predominate in regard to whether [defendant] violated federal antitrust law"); *Kleen Prods., LLC v. Int'l Paper*, 306 F.R.D. 585, 593-94 (N.D. Ill. 2015), *aff'd*, 831 F.3d 919 (similar); *Fond Du Lac*, 2016 WL 3579953, at *6 (similar); *Panache Broad. of Pa., Inc. v. Richardson Elecs., Ltd.*, 1999 WL 342392, at *5 (N.D. Ill. May 14, 1999), *mod. on other grounds*, 2001 WL 290408 (N.D. Ill. Mar. 22, 2001) (Where the "bulk of Plaintiffs' allegations pertained to conduct under [certain] agreements" and the alleged "conduct arose out of the ... agreements" then "questions regarding Defendants' conduct are common.").

injury, a prototypical form of antitrust injury.[35] A plaintiff suffers antitrust injury from even a single overcharge.[36] Plaintiffs "do not need to prove that every ... purchase by a class member during the class period was affected by the conspiracy. A class member has a claim if *any* purchase during the class period was affected by the conspiracy." Class-wide impact does *not* require that each and every class member has been injured; classes often include class members who turn out to be uninjured.[37]

Plaintiffs' burden at class certification is "not to prove the element of antitrust impact." *Messner*, 669 F.3d at 818 (internal quotation and citation omitted). Rather, Plaintiffs need to "demonstrate that the element of antitrust impact ***is capable of proof at trial through evidence that is common to the class rather than individual to its members***." *Id.* (citations omitted) (emphasis added); *see Turkey*, 2025 WL 264021, at *2 ("'all that is necessary to show predominance'" is for plaintiffs to demonstrate "that it is possible to use common evidence that, if believed, would show that all or nearly all class members suffered antitrust injury") (quoting *Messner*, 669 F.3d at 818). Plaintiffs readily meet this standard with their overwhelming record and expert evidence, all common to the Class, that AAH engaged in unlawful conduct that caused prices to be substantially inflated—[redacted]—and that all or virtually all Class members paid higher prices as a result. In addition, unlike other antitrust cases,

[35] *See Hanover Shoe*, 392 U.S. at 494.

[36] *See, e.g.*, *id.*; *Zenith Radio Corp. v. Hazeltine Research*, *Inc.*, 395 U.S. 100, 114 n.9 (1969) ("Zenith's burden of proving the fact of damage under s 4 of the Clayton Act is satisfied by its proof of some damage flowing from the unlawful conspiracy; inquiry beyond this minimum point goes only to the amount and not the fact of damage.").

[37] *E.g.*, *Kleen Prods.*, 831 F.3d at 927; *Suchanek v. Sturm Foods, Inc.*, 764 F.3d 750, 757 (7th Cir. 2014); *Kohen v. Pac. Inv. Mgmt. Co.*, 571 F.3d 672, 677 (7th Cir. 2009); *Pella Corp. v. Saltzman*, 606 F.3d 391, 394 (7th Cir. 2010) (affirming class certification despite potential uninjured class members); *Olean Wholesale Grocery Coop. v. Bumble Bee Foods LLC*, 31 F.4th 651, 668-69 (9th Cir. 2022) (en banc) (court need not decide on class certification whether the class includes a *de minimis* number of uninjured class members); *Automatic Card Shufflers*, 2026 WL 892509, at *22 (similar) (citing *Kohen* 571 F.3d at 677; *Messner,* 669 F.3d at 823-24).

[redacted] (Ex. 1, LR1 ¶¶49-50, 52), eliminating the individual variation that defendants often argue can defeat predominance.

**i. Plaintiffs' Common Evidence Includes Evidence of High Prices and the Nature of the Market**

Plaintiffs' common record and economic evidence shows that AAH's prices were inflated because of the All Plans provision, and that the Class was overcharged. Dr. Dranove opined that the Challenged Conduct reduced competition and caused prices to be higher. Ex. 3, DR1 §§III.D, IV, VII. Both Dr. Dranove and Dr. Leitzinger analyzed record evidence and third-party analyses showing that AAH's rates were significantly inflated market-wide. *Infra* §II.D; Ex. 1, LR1 §§V.A, VI; Ex. 2, Leitzinger Rebuttal ("LR2"), §VIII; Ex. 3, DR1 §§ VI.D, VII.

Dr. Dranove and Dr. Leitzinger also found that the nature of the Challenged Conduct and the nature of the market showed that the inflated prices would be widespread and unavoidable. Ex. 1, LR1 §VIII; Ex. 2, LR2 §VIII; Ex. 3, DR1 §§VI.D, VII. [redacted] Ex. 3, DR1 ¶¶83-85. [redacted] Ex. 1, LR1 ¶¶49-50, 52. [redacted] *Id.* ¶¶49-54. [redacted] *Id.* ¶¶50, 55 & at Table 2. Accordingly, there was little or no room for Class members to avoid overcharges. *Id.* ¶¶49-55.

This sort of structural market analysis is widely recognized evidence of class-wide impact. *See*, *e.g.*, *Kleen Prods.*, 831 F.3d at 927 (the structure of the market is a common issue that can

support a finding of class-wide impact).[38] Indeed, an analysis that "prices generally move together over time," such that if defendants were able to "artificially inflate prices, this ... would have resulted in all or nearly all class members paying a higher price," is itself "sufficient to show that antitrust impact can be proven on a class-wide basis." *Fond Du Lac*, 2016 WL 3579953, at *8.

**ii. Plaintiffs' Robust, Class-Wide Quantitative Evidence**

Dr. Leitzinger also reliably employed a robust two-step regression analysis that further demonstrates Class-wide injury. Ex. 1, LR1, §VIII.C; Ex. 2, LR2, §VIII. Courts have found that such an analysis is "broadly accepted" and supports a finding that common issues predominate with respect to antitrust injury.[39] This common quantitative evidence is capable of proving "first, that class members paid artificially inflated prices and, second, that 'this price inflation occurred to substantially all class members.'"[40] Predominance is met because the question is fundamentally Class-wide: a jury either finds common impact or not. *Olean*, 31 F.4th at 681 ("If the jury found [plaintiffs' model] reliable, then [plaintiffs] would have succeeded in showing antitrust impact on a class-wide basis, an element of their antitrust claim."); *Black v. Occidental Petrol. Corp.*, 69 F.4th 1161, 1184 (10th Cir. 2023) ("[A] failure of proof on the element of antitrust impact would end the litigation for all.").

Regression analysis is a "commonly accepted mechanism" for proving class-wide impact. *Fond Du Lac*, 2016 WL 3579953, at *9; *see Kleen Prods.*, 306 F.R.D. at 602 (regression analysis

[38] *See also In re High Fructose Corn Syrup Antitrust Litig.*, 295 F.3d 651, 656 (7th Cir. 2002) (crediting expert opinion that market structure was conducive to cartelization and common impact); *In re Blood Reagents Antitrust Litig.*, 2015 WL 6123211, at *31 (E.D. Pa. Oct. 19, 2015) ("Many courts have accepted market-structure analyses in finding predominance with respect to antitrust impact."); *In re CRT Antitrust Litig.*, 308 F.R.D. 606, 627 (N.D. Cal. 2015) (similar).

[39] *E.g.*, *In re Broiler Chicken Growers Antitrust Litig. (No. II)*, 2024 WL 2117359, at *29 (E.D. Okla. May 8, 2024) ("*Broiler Chicken (No. II)*"); *Turkey*, 2025 WL 264021, at *17 (similar); *In re Restasis Antitrust Litig.*, 335 F.R.D. 1, 15 (E.D.N.Y. 2020) (similar); *Castro v. Sanofi Pasteur Inc.*, 134 F. Supp. 3d 820, 847-48 (D.N.J. 2015) (similar).

[40] *Restasis*, 335 F.R.D. at 15 (citation omitted).

"is common in antitrust cases, where the plaintiffs use it to show that an alleged 'conspiracy' has a statistically significant impact on the dependent variable—usually price.") (citing Daniel L. Rubinfeld, *Reference Guide on Multiple Regression,* in REFERENCE MANUAL ON STATISTICAL EVIDENCE 305-07 (3d ed. 2011)).[41] A regression can reliably control for variables that might have affected prices, isolate the effect of the Challenged Conduct, and determine whether and to what extent prices were inflated due to the Challenged Conduct. Ex. 1, LR1 ¶26; *see, e.g.*, *Fond Du Lac*, 2016 WL 3579953, at *9 (noting regression analysis is capable of "eliminat[ing] factors other than anti-competitive conduct that could have affected the price [at issue] in order to discover whether there was a correlation between the alleged anti-competitive conduct and price ... and then [use that] model to measure the estimated overcharge that all or nearly all class members paid."). "[T]he Seventh Circuit has recognized that courts afford wide 'latitude to experts employing regression analysis, a proven statistical methodology used in a wide variety of contexts.'"[42]

**a) Step 1: The Challenged Conduct Inflated Prices**

Dr. Leitzinger employed a standard "yardstick" regression analysis to measure the effect of the Challenged Conduct on prices paid by the Class by comparing those prices (the "treatment group") to prices not affected by the Challenged Conduct (the "control group"). Ex. 1, LR1 ¶28. Like regressions generally, yardstick analyses are widely accepted.[43] After controlling for other market supply and demand factors that could affect pricing, the yardstick comparison allows for the estimation of the prices the Class would have been paid absent the Challenged Conduct. *Id.*

Dr. Leitzinger's primary model compares [redacted]

[41] *See also Paper Sys. Inc. v. Mitsubishi Corp.*, 193 F.R.D. 601, 615 (E.D. Wis. 2000).

[42] *Turkey*, 2025 WL 264021, at *19 (quoting *Manpower, Inc. v. Ins. Co. of Pa.*, 732 F.3d 796, 808 (7th Cir. 2013)) (cleaned up)). *See Broiler Chicken*, 2022 WL 1720468, at *10 ("Regression analysis is a widely accepted method").

[43] The "'yardstick approach is a well-established methodology' in antitrust actions." *Moehrl*, 2023 WL 2683199, at *8 (citation omitted); *17 (yardstick challenge does not defeat certification).

[redacted] The model found that the Challenged Conduct inflated prices [redacted] over the Class Period for AAH's Healthcare Services. Ex. 1, LR1 ¶40 & at Ex. 4. His overcharge finding is statistically significant at the 99% level—the highest level of statistical confidence—and his model has an adjusted r-squared of 0.93, meaning that it is so well-specified that it explains 93% of the variation in prices [redacted] *Id.* ¶¶40, 61. [redacted] *Id.* ¶¶41-42. [redacted] *Id.* Finally, Dr. Leitzinger performed a second yardstick regression analysis that compared the rates of AAH and Ascension, [redacted] *Id.* ¶¶43-44. Using this second benchmark, Dr. Leitzinger found a [redacted] overcharge, which is directionally consistent with the primary model and (as expected) [redacted] *Id.* ¶45. AAH's disagreement with the variables Dr. Leitzinger used in his regression (which yielded results confirmed by record evidence) lack merit (Ex. 2, LR2 §V) but regardless provide no basis to deny class certification.[44]

[44] *E.g.*, *Bazemore v. Friday*, 478 U.S. 385, 400 (1986) ("Normally, failure to include variables will affect the analysis' probativeness, not its admissibility.") (Brennan, J., concurring in part); *Manpower*, 732 F.3d at 808 (similar); *Fond Du Lac Bumper Exch., Inc. v. Jui Li Enter. Co.*, 2016 WL 756568, at *3 (E.D. Wis. Feb. 26, 2016) ("economist need not account for every possible variable in order for a regression analysis to be admissible"); *Turkey*, 2025 WL 264021, at *17 (similar); *Broiler Chicken*, 2022 WL 1720468, at *10 (similar).

### b) Step 2: There was Class-wide price inflation

Dr. Leitzinger employed a widely used statistical methodology called "in sample prediction" to test whether there was widespread impact, which found empirical evidence that ***98 percent*** of Class members paid a price in excess of the predicted but-for price on at least one (typically more) transaction. Ex. 1, LR1 ¶60. This methodology "is the type of market-wide economic analysis [that] has been accepted by many courts to show predominance as to antitrust impact." *Turkey*, 2025 WL 264021, at *9 (citation omitted).[45] Dr. Leitzinger's robust findings confirm Class-wide impact even when the model incorporates various potential adjustments to Dr. Leitzinger's methodology that were baselessly suggested by AAH's expert. *See* LR2 §§II, V, VIII; Memo. In Supp. of Pls.' Mot. To Exclude Opinions Offered By Mr. Jonathan Orszag.

Documentary evidence about market structure and the uniformity of AAH's conduct is additional compelling proof of Class-wide impact. [redacted] (Ex. 1, LR1 ¶¶49-50, 52), [redacted][46] [redacted]

[45] *Broiler Chicken*, 2022 WL 1720468, at *10, *13 (common impact where "97.1% of customers paid an actual price that exceeded the but-for price at least once"); *Olean*, 31 F.4th at 676-82; *Broiler Chicken (No. II)*, 2024 WL 2117359, at *30; *Le v. Zuffa, LLC*, 2023 WL 5085064 (D. Nev. Aug. 9, 2023); *In re Pkg. Seafood Prods. Antitrust Litig.*, 332 F.R.D. 308, 328 (S.D. Cal. 2019); *In re Capacitors Antitrust Litig.*, 2018 WL 5980139, at *7-9 (N.D. Cal. Nov. 14, 2018).

[46] Indeed, courts have held that "regression analysis can be an appropriate tool to demonstrate class-wide impact even when the market involved diversity in products, marketing, and prices" and "even when prices are individually negotiated" by each class member—even where the class members included "nearly every entity in the United States that serves chicken." *Broiler Chicken*, 2022 WL 1720468, at *12, *15; *see Turkey*, 2025 WL 264021, at *9-10, *14-15.

### c. Aggregate Damages Are Provable Through Common Evidence

The predominance requirement is satisfied where aggregate Class damages can be reliably measured using Class-wide evidence and methodology. *Kleen Prods.*, 831 F.3d at 928-29. Reasonable damages estimates are sufficient "where the theory of harm is that the entire market price of a product was inflated as a result." *Kleen Prods.*, 306 F.R.D. at 605, *aff'd*, 831 F.3d 919.[47]

Dr. Leitzinger's damages calculations satisfy Rule 23(b)(3). He calculated aggregate damages by applying the [redacted] overcharge from his primary regression model to the Class member payments during the Class Period. Ex. 1, LR1 ¶¶46-48. Courts routinely find common issues predominate based on similar calculations. *E.g.*, *In re Dealer Mgmt. Sys. Antitrust Litig.*, 2024 WL 3509668, at *15 (N.D. Ill. July 22, 2024) ("courts handling antitrust class actions routinely endorse the practice of using regression models to ... measure damages on a classwide basis.") (collecting cases); *Turkey*, 2025 WL 264021, at *25 (same); *UEBT v. Sutter* Class Order at 25-30 (common issues predominate as to damages calculated by Dr. Leitzinger's regression analysis).

## 6. Rule 23(b)(3)'s Superiority Requirement is Met

Rule 23(b)(3)'s final requirement is superiority—*i.e.*, that a class action be "superior to other available methods for fairly and efficiently adjudicating the controversy." Fed. R. Civ. P. 23(b)(3). Given "the breadth of most antitrust classes" and "the significant cost" of litigating antitrust cases, the "superiority requirement is easily met in most antitrust cases." 6 Newberg & Rubenstein on Class Actions §20:54 (6th ed. 2025). Non-exclusive superiority factors to consider

[47] *See Bigelow v. RKO Radio Pictures*, 327 U.S. 251, 264-65 (1946) ("jury may make a just and reasonable estimate of the damage based on relevant data, and render its verdict accordingly"); *Story Parchment Co. v. Paterson Parchment Paper Co.*, 282 U.S. 555, 563-64 (1931) (similar); *Eastman Kodak Co. v. S. Photo Materials Co.*, 273 U.S. 359, 379 (1927) ("defendant whose wrongful conduct has rendered difficult the ascertainment of the precise damages suffered by the plaintiff, is not entitled to complain that they cannot be measured with the same exactness and precision as would otherwise be possible"); *Spray-Rite Serv. Corp. v. Monsanto Co.*, 684 F.2d 1226, 1243 (7th Cir. 1982) (similar; citing cases).

are: (1) "the class members' interests in individually controlling the prosecution or defense of separate actions"; (2) "the extent and nature of any litigation concerning the controversy already begun by or against class members"; (3) "the desirability or undesirability of concentrating the litigation of the claims in the particular forum"; and (4) "the likely difficulties in managing a class action." Fed. R. Civ. P. 23(b)(3). Generally, a class action is superior "to try[ing] thousands of separate cases alleging the same misconduct using the same proof." *Bruzek v. Husky Oil Operations Ltd.*, 520 F. Supp. 3d 1079, 1099 (W.D. Wis. 2021). Here, the Class presents identical legal and factual questions about AAH's contracts, market power, and the anticompetitive effects of the All Plans provision. The best method for adjudicating the identical claims of thousands of Class members, with numerous common questions, is through a single class action case.[48]

Superiority is also satisfied because, while Class members suffered meaningful harm, individual damages are generally insufficient to support the large costs of antitrust litigation on an individual basis.[49] There is no other pending litigation challenging the All Plans Provision on behalf of Class members, enabling this case to efficiently resolve all eligible claims. And the Eastern District of Wisconsin is the appropriate forum for all Class members to bring this litigation, as the Challenged Conduct was centered here, Network Vendor contracts were negotiated here, and affected providers and patients are here.

## IV. CONCLUSION

Plaintiffs respectfully request that the Court certify the proposed Class and appoint the proposed Class Representatives and Class Counsel.

[48] *See Messner*, 669 F.3d at 815 n.5 (finding it unnecessary to rule on superiority: "[t]here are so many common issues of law and fact relating to the issue of Northshore's liability, however, that the superiority requirement likely poses no serious obstacle to class certification here").

[49] *See Butler*, 727 F.3d at 801 ("[T]he more claimants there are, the more likely a class action is to yield substantial economies in litigation.").

Dated: June 2, 2026

Respectfully submitted,

*/s/ David F. Sorensen*

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**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that on June 2, 2026, a true and correct copy of the foregoing, with redactions for information designated as confidential, was filed with the Court via the CM/ECF system, which will send a Notice of Electronic Filing to all counsel of record. In addition, a true and correct copy of the sealed version was served upon counsel of record for AAH via email.

Dated: June 2, 2026

*/s/* David F. Sorensen
David F. Sorensen

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF WISCONSIN**

| | |
|---|---|
| URIEL PHARMACY HEALTH AND WELFARE PLAN; URIEL PHARMACY, INC.; HOMETOWN PHARMACY; AND HOMETOWN PHARMACY HEALTH and WELFARE BENEFITS PLAN, on their own behalf and on behalf of all others similarly situated,<br><br>Plaintiffs,<br><br>v.<br><br>ADVOCATE AURORA HEALTH, INC. and AURORA HEALTH CARE, INC.,<br><br>Defendants. | Case No. 2:22-cv-610<br><br>**REDACTED PUBLIC VERSION** |

**PLAINTIFFS' PROPOSED TRIAL PLAN**

Plaintiffs Uriel Pharmacy Health and Welfare Plan, Uriel Pharmacy, Inc., Hometown Pharmacy, and Hometown Pharmacy Health and Welfare Benefits Plan ("Plaintiffs") submit this Proposed Trial Plan to set forth the claims that will be tried on a Class-wide basis. Plaintiffs reserve the right to amend this Proposed Trial Plan prior to trial, including as a result of any issues that may arise regarding discovery, expert reports, changes in governing law, or any orders of the Court.

## I. INTRODUCTION

Plaintiffs represent a class (the "Class") defined as:

> All entities that purchased in-network Healthcare Services directly from Advocate Aurora Health, Inc. or Aurora Health Care, Inc. ("AAH") providers in Eastern Wisconsin at any time during the period from May 24, 2018 up to and including December 31, 2022 (the "Class Period"), to the extent such purchases were made pursuant to contracts between AAH and any of the following Network Vendors: Anthem/Blue Cross Blue Shield of Wisconsin, United Healthcare, Cigna Healthcare, Humana Inc., Wisconsin Physicians Services, Health Payment Systems, and/or Trilogy Health Solutions.[1] Excluded from the Class are AAH, and their officers, directors, management, employees, subsidiaries, or affiliates, judicial officers and their personnel, and all federal governmental entities.

Defendant AAH operates the most hospitals and the most hospital beds of any health system in Eastern Wisconsin. Plaintiffs allege that it abused that market dominance, however, to engage in anticompetitive conduct and overcharge Class members (self-funded employer health plans and commercial insurers) for Healthcare Services. [redacted]

[1] "Healthcare Services" are inpatient and outpatient facility claims (for use of a facility) and claims for professional services (for treatment by a healthcare professional). "Eastern Wisconsin" comprises the following Health Service Areas: Appleton, Brookfield, Burlington, Chilton, Cudahy, Elkhorn, Fond Du Lac, Fort Atkinson, Green Bay, Hartford, Kenosha, Kewaunee, Manitowoc, Marinette, Menomonee Falls, Milwaukee, Neenah, Oconomowoc, Oconto Falls, Oshkosh, Plymouth, Port Washington, Racine, Shawano, Sheboygan, Sturgeon Bay, Two Rivers, Watertown, Waukesha, West Allis, and West Bend.

[redacted]

AAH's wrongful conduct reduced competition and allowed it to charge supracompetitive prices for years—[redacted] That the Challenged Conduct inflated AAH's prices is clear, and will be proven with common evidence, including multiple benchmarks, economic analyses, and documents and testimony from AAH and other market participants. AAH's unlawful conduct caused all or virtually all Class members ("Payors"[2]) to be overcharged. The evidence at trial will focus on AAH's antitrust violation and will be entirely or primarily Class-wide.

## II. TRIAL PLAN OVERVIEW

All of Plaintiffs' claims arise under federal law, Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1-2, and are made privately actionable through Section 4 of the Clayton Act, 15 U.S.C.

[2] "Payors" include (1) commercial health insurers that offer coverage for fully-insured plans, and (2) self-funded Plan Sponsors that pay claims on behalf of their members, typically employees and their families. "Plan Sponsors" are entities that establish and manage health insurance plans for groups, such as employers that offer health insurance plans to their employees and unions that offer plans to their members. Plaintiffs are Plan Sponsors and self-funded Payors for Healthcare Services. Ex. 3, DR ¶9 & n.1.

§ 15(a). Plaintiffs propose to try all claims and defenses as to liability, impact (injury/causation), and damages on a Class-wide basis in a single trial.

Plaintiffs will seek a sum certain, an aggregate Class damages award, in a single jury verdict, as well as such other relief as may be warranted. Mandatory trebling, attorneys' fees, and costs are determined by law pursuant to Section 4 of the Clayton Act, 15 U.S.C. § 15(a).

## III. PROVING LIABILITY AND IMPACT THROUGH COMMON EVIDENCE

Plaintiffs will establish liability for all claims and rebut all defenses with predominantly common evidence (*i.e.* evidence that is applicable to the Class as a whole, not individual to its members). The issues applicable to liability, which Plaintiffs will prove and/or rebut (as appropriate) through common evidence (if not already decided at summary judgment) include:

a) Whether AAH engaged in the Challenged Conduct in Eastern Wisconsin.

b) Whether the Challenged Conduct was an unreasonable restraint of trade.

c) Whether AAH had market power and used it to impose and maintain the Challenged Conduct.

d) Whether the Challenged Conduct had anticompetitive effects that outweigh any cognizable procompetitive benefits.

e) Whether antitrust impact (i.e., an overcharge) to the Class can be proven with common evidence.

f) Whether aggregate Class-wide damages can be reliably measured.

This common evidence will include (1) witness testimony and internal documents from AAH, other healthcare providers[3], and Network Vendors attesting to [redacted]

[3] Healthcare providers or providers are health facility organizations or systems licensed to provide health care diagnosis and treatment services. AAH is a healthcare provider.

[redacted]; (2) economic literature and empirical evidence regarding the effects of suppressions of selective contracting in Healthcare Services; (3) analysis from testifying experts[4] regarding AAH's market power, Class-wide injury in the form of overcharges, and damages. All of this evidence will be common to the Class as a whole rather than individual to its members.

## IV. PROVING DAMAGES THROUGH COMMON EVIDENCE

Plaintiffs will establish the quantum of overcharge damages owed to the Class in the aggregate under Section 4 of the Clayton Act, 15 U.S.C. § 15(a), using evidence applicable to the Class as a whole rather than individual to its members.

Plaintiffs will present expert testimony from expert economist Jeffrey J. Leitzinger, Ph.D. that, based on robust regression analyses, Class member payments for Healthcare Services provided by AAH would have been [redacted] lower absent the challenged conduct. To calculate damages, he will apply that [redacted] overcharge to the total amount of Class member payments for Healthcare Services provided by AAH.

Plaintiffs intend to use evidence common to the Class as a whole, rather than individual to its members, to calculate such damages. This evidence includes:

a) Data reflecting the actual prices paid by Class members for Healthcare Services from AAH in Eastern Wisconsin during the Class Period;

b) Internal documents from AAH and AAH's outside consultants, [redacted] and

[4] Plaintiffs' experts are (1) Jeffrey J. Leitzinger, Ph.D., an economist, (2) David Dranove, Ph.D., a preeminent healthcare economist, and (3) Patrick S. Romano, M.D., M.P.H.

c) Expert analysis and opinion, applicable to all Class members on a Class-wide basis.

## V. ENTRY OF JUDGMENT AND POST-JUDGMENT PROCEEDINGS

If the jury renders a verdict for AAH, judgment for AAH would enter. Such a verdict and judgment would be against the Class as a whole, and it would not differ between or among Class members.

If the jury renders a verdict for the Class, issues of trebling the jury verdict (a matter of simple verdict molding) and of awarding attorneys' fees, costs, and post-judgment interest would be determined by the Court under applicable law, including Section 4 of the Clayton Act, 15 U.S.C. § 15(a). Such a verdict would be in favor of the Class as a whole and would not differ between or among its members. A molded judgment in a total sum on the basis of aggregate Class-wide damages would issue on behalf of the Class. Allocation of monies recovered under the judgment would take place, upon usual proceedings for the allocation of such recovery, in proportion to its purchases of Healthcare Services from AAH providers in Eastern Wisconsin during the Class Period.

Dated: June 2, 2026

*Respectfully submitted,*

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**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that on June 2, 2026, a true and correct copy of the foregoing, with redactions for information designated as confidential, was filed with the Court via the CM/ECF system, which will send a Notice of Electronic Filing to all counsel of record. In addition, a true and correct copy of the sealed version was served upon counsel of record for AAH via email.

Dated: June 2, 2026

*/s/* David F. Sorensen
David F. Sorensen