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, Plaintiffs, v. ADVOCATE AURORA HEALTH, INC. and AURORA HEALTH CARE, INC., Defendants.	Case No. 2:22-cv-610

PLAINTIFFS' MOTION TO EXCLUDE
OPINIONS OFFERED BY MR. JONATHAN ORSZAG

Pursuant to Federal Rules of Evidence 702 and 703, and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), 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 excluding certain opinions offered by defense expert Jonathan Orszag. In support of this motion, Plaintiffs rely on (1) the evidence and argument in their accompanying memorandum of law, (2) the Declaration of Yinka Onayemi and the exhibits thereto, and (3) any further evidence or argument to be presented to the Court in connection with this motion. A proposed order is filed herewith.

Respectfully submitted,

Dated: June 2, 2026

/s/ Michael Lieberman

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Caitlin G. Coslett
Michaela L. Wallin
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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/ Michael Lieberman
Michael Lieberman

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, Plaintiffs, v. ADVOCATE AURORA HEALTH, INC. and AURORA HEALTH CARE, INC., Defendants.	Case No. 2:22-cv-610

DECLARATION OF YINKA ONAYEMI IN SUPPORT OF PLAINTIFFS' MOTION TO EXCLUDE

I, Yinka Onayemi, subject to the penalties of perjury, do hereby declare that I am an attorney at the law firm Fairmark Partners, LLP, counsel for Plaintiffs. I am an attorney duly authorized to practice law in New York and am admitted in this Court. I submit this Declaration in support of Plaintiffs' Motion to Exclude Opinions Offered By Mr. Jonathan Orszag.

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

1. Fairmark Partners, LLP and Berger Montague PC have served as counsel for Plaintiffs and the proposed Class.

2. The following documents, attached hereto, are cited in Plaintiffs' Memorandum of Law in Support of their Motion to Exclude Opinions Offered by Mr. Jonathan Orszag. 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.

3. Attached as Exhibit 1 is a true and correct copy of the Expert Report of Jonathan Orszag dated January 20, 2026.

4. Attached as Exhibit 2 is a true and correct copy of the Expert Report of David Dranove, Ph.D. dated November 21, 2025 (filed under seal).

5. Attached as Exhibit 3 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).

6. Attached as Exhibit 4 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 5 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 6 is a true and correct copy of the Stipulation of Designated 30(b)(6) Testimony dated October 31, 2025 (filed under seal).

9. Attached as Exhibit 7 is a true and correct copy of 2003 Aurora Healthcare presentation (AAHEDWI01645637-849).

10. Attached as Exhibit 8 is a true and correct copy of the transcript of Jonathan Orszag's deposition on March 5, 2026. (filed under seal).

11. Attached as Exhibit 9 is a true and correct copy of annotations regarding the Mercer Study (AAHEDWI01501491-502) (filed under seal).

12. Attached as Exhibit 10 is a true and correct copy of Metro Milwaukee Health Care: Studies on Costs How We Can Turn the Tide dated July 14, 2003 (AAHEDWI01587785-809) (filed under seal).

13. Attached as Exhibit 11 is a true and correct copy of Redefining Value: The 4Square & its Impact on Advocate Aurora North and the Business Community (AAHEDWI00311317-23) (filed under seal).

14. Attached as Exhibit 12 is a true and correct copy of an excerpt of the transcript of Joanne Beck's deposition on July 31, 2025 (filed under seal).

15. Attached as Exhibit 13 is a true and correct copy of an excerpt of the transcript of Eric Stotlar's deposition on August 19, 2025 (filed under seal and also publicly, with redactions).

16. Attached as Exhibit 14 is a true and correct copy of Current State Summary.xlsx dated April 22, 2022 (AURORA00001869) (filed under seal).

17. Attached as Exhibit 15 is a true and correct copy of the Corrected Expert Report Declaration of Dr. Robert T. Willig In Support of Defs.' Opp. to Class Cert., *Sidibe v. Sutter Health*, No. 12-cv-4854 (N.D. Cal. Nov. 8, 2018).

18. Attached as Exhibit 16 is a true and correct copy of Expert Reply Report of David Dranove, Ph.D. dated March 23, 2026 (filed under seal).

19. Attached as Exhibit 17 is a true and correct copy of Messages between Jennifer Atkins and Daniel Stahlkopf dated March 10, 2022 (AAHEDWI02143440-43) (filed under seal).

20. Attached as Exhibit 18 is a true and correct copy of an excerpt of the transcript of Paul Maxwell's deposition on June 5, 2025 (filed under seal and also publicly, with redactions).

21. Attached as Exhibit 19 is a true and correct copy of the transcript of Titus Muzi's deposition on June 2, 2025 (filed under seal).

22. Attached as Exhibit 20 is a true and correct copy of Email from Jennifer Atkins to Larry Lenz dated December 13, 2022 (AAHEDWI01188952) (filed under seal).

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

/s/ Yinka Onayemi
Yinka Onayemi

Exhibit 7

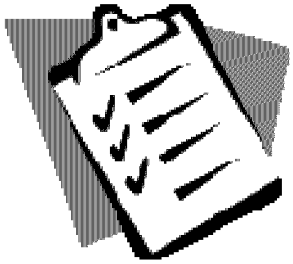
Aurora HealthCare

2003 Aurora Healthcare

Presented by:

Gerald W. Frye, CLU, RHU, REBC
Greg Herrle, FSA

Agenda

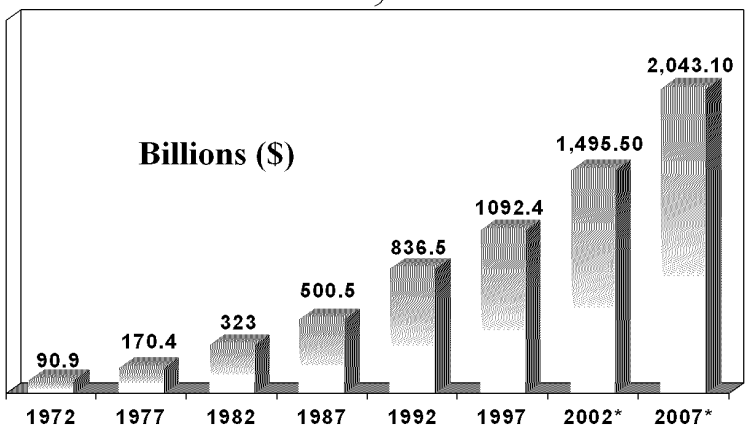


- Overview of healthcare trends
  - Healthcare economics
  - Milwaukee market update
  - What are the cost drivers?
  - Hospital Report Card
- What can employers do?
  - Increase employee cost awareness/participation
  - Consumer-driven healthcare
  - Network management
  - Disease Management
  - Integrated disability management

Overview of Trends

Trends | Cost Drivers | Employers

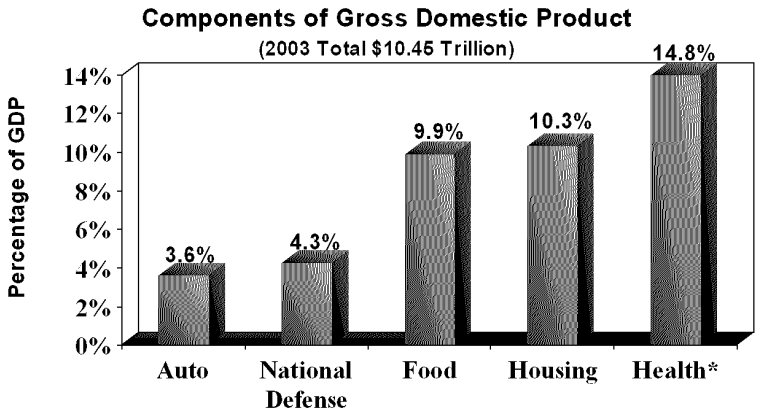
National Health Expenditures, United States, 1972 to 2007



*Estimated

Source: U.S. Health Care Financing Administration, Office of National Health Statistics, 1998.

Healthcare is the Largest Sector of the U.S. Economy

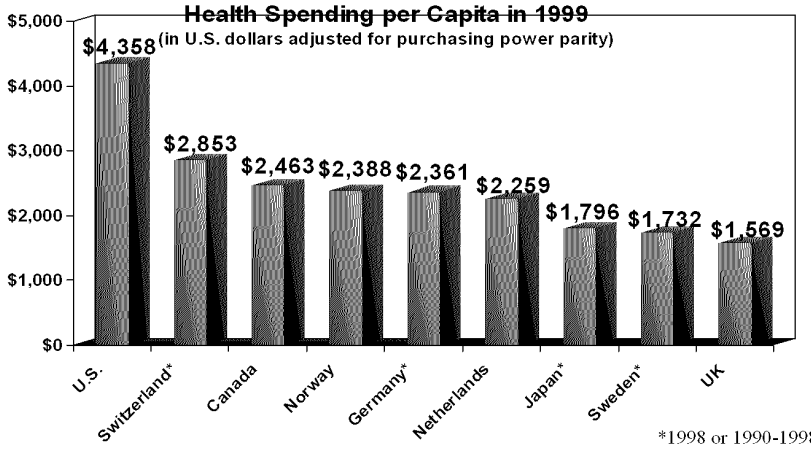


*Projected

Source: Bureau of Economic Analysis, 2003; Centers for Medicare and Medicaid Services, 2003b

Trends | Cost Drivers | Employers

Americans Spend Much More Per-Person on Healthcare than People in Other Countries



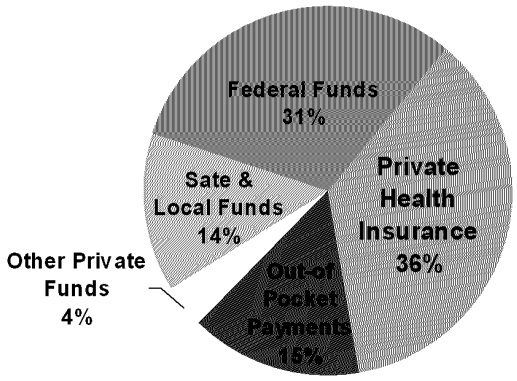
Source: Organization for Economic Cooperation and Development (OECD), 2001, as reported by Reinhardt et al., 2002

Distribution of Health Expenditures

Government **Federal, State, Local**	**47%**
Insurance Plans **Employers, Trusts, Individual**	**34%**
Patients **Liability, Out-of-Pocket**	**19%**

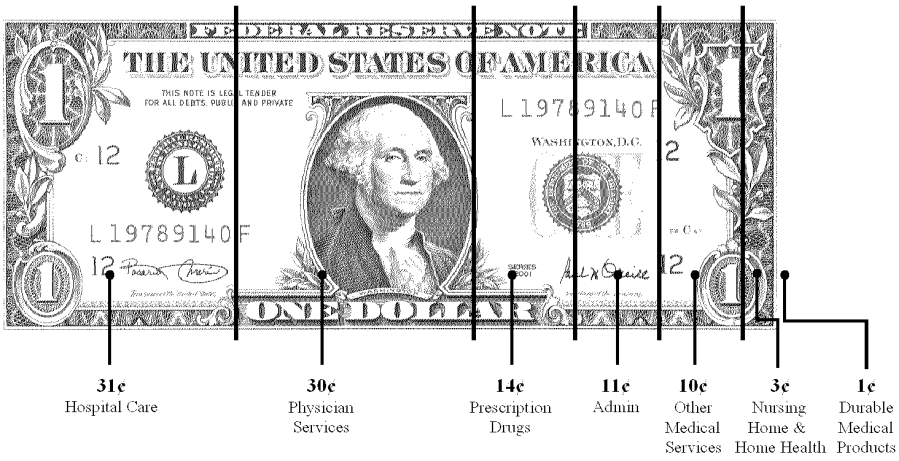
Source: Department of Health & Human Services, 2000

Distribution of Funding Sources for Health Services and Supplies Expenditures, 2001



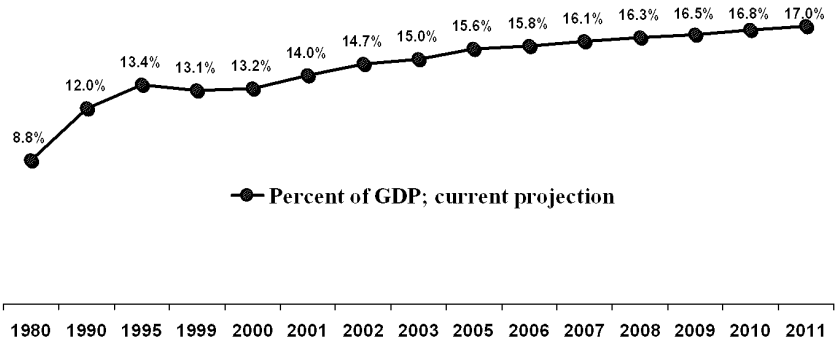
Source: Centers for Medicare and Medicaid Services, 2003d

Private Insurance Healthcare Dollar, 2001



Source: Centers for Medicare and Medicaid Services, 2002; Blue Cross and Blue Shield Association Analysis

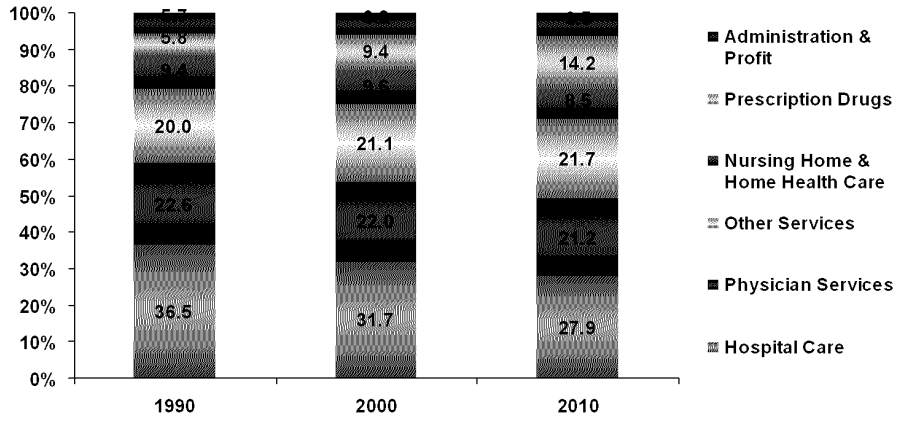
National Health Expenditures as a Share of the GDP, 1980-2011



Source: Heffler S, Smith S, Won G, Clemens MK, Keehan S, Zezza M. Health spending projections for 2000-2011: the latest outlook. Health Affairs. 2002;21(2):207-218.

Trends | Cost Drivers | Employers

National Health Expenditures by Service Type, 1990 - 2010

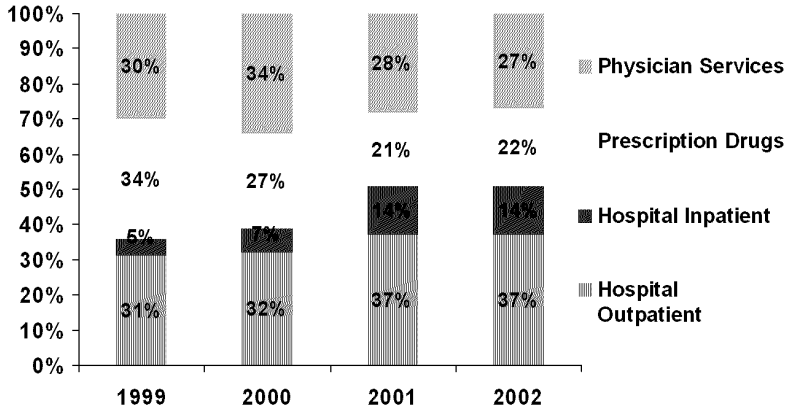


Source: CMS, Office of the Actuary, National Health Statistics Group.

Distribution of National Health Expenditures by Service Type, 1990 - 2010

Trends | Cost Drivers | Employers

Shares of Overall Health Care Spending Growth, 1999-2002

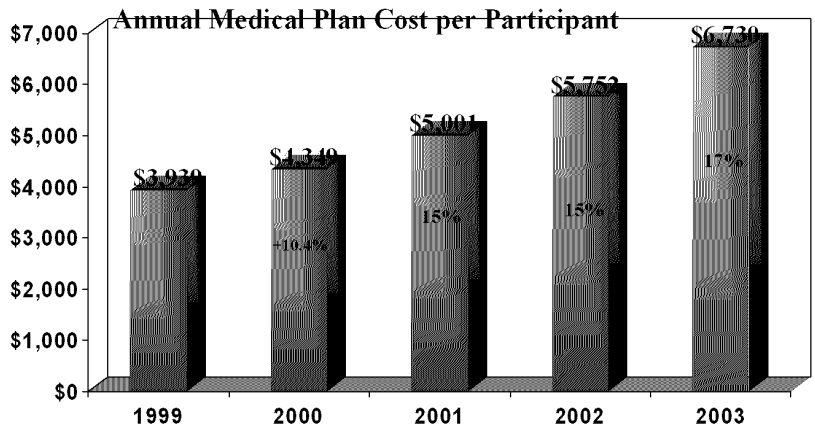


Source: Milliman USA Health Cost Index ($0 deductible)

Rapid growth in hospital spending per privately insured person – increasingly driven by price inflation rather than increased use of services – accounted for more than half of the overall spending increase (51%) for the second straight year.

Trends | Cost Drivers | Employers

Escalating Medical Costs
No Relief for 2003

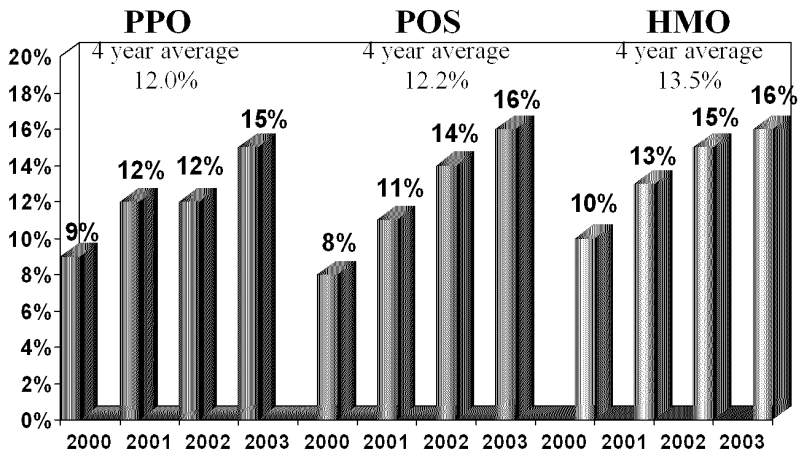


Source: Deloitte & Touche/Business & Health Employer Health Care Strategy Survey, July 15, 2002

Sources: CFO.com, July 22, 2002, based on Hewitt Associates data; and Milliman USA, Press Release, July 1, 2002

Trends | Cost Drivers | Employers

All Plan Types Affected



Source: Towers Perrin 2003 Health Care Cost Survey

Trends | Cost Drivers | Employers

Trend Drivers, 2001-2002

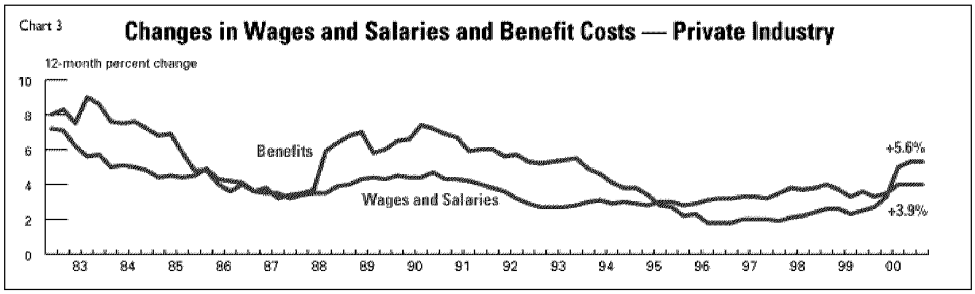
Trend Factors	Percentage Points	Percent of Total Increase
Medical Trend	13.7	100
General Inflation (CPI)	2.5	18
Drugs, Medical Devices & Medical Advances*	3.0	22
Rising Provider Expenses	2.5	18
Gov't Mandates & Regulation	2.0	15
Increased Consumer Demand	2.0	15
Litigation & Risk Management	1.0	7
Other Categories	0.7	5

Source: PricewaterhouseCoopers analysis, April 2002.

*This percentage does not reflect potential future savings from drugs, medical devices and other medical advances.

Factors Driving Rising Costs in Healthcare Premiums (2001-2002)

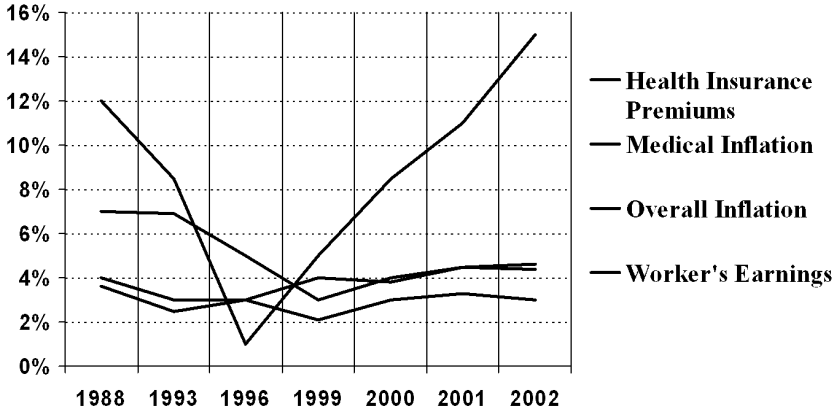
Wages vs. Benefit % Changes



Source: Published in Employee Benefit News, March 2001.
Bureau of Labor Statistics, Employment Cost Index.

Trends | Cost Drivers | Employers

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2002

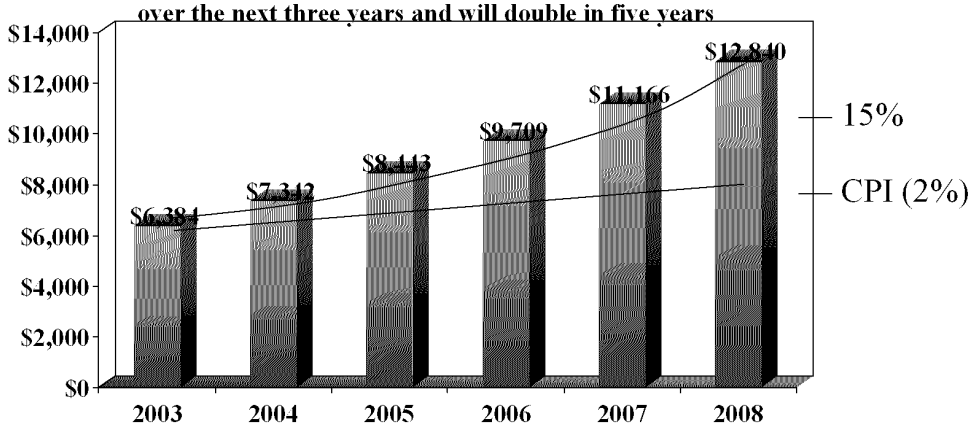


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999,2000, 2001; KPMG Survey of Employer-Sponsored Health Benefits: 1988,1993,1996. Estimated for 2002.

Trends | Cost Drivers | Employers

Potential Cost Implications

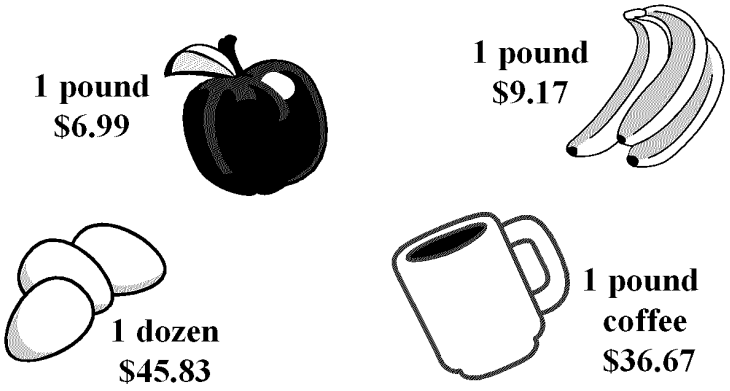
If current trends continue, health care costs will increase 50% over the next three years and will double in five years



Source: Towers Perrin 2003 Health Care Cost Survey

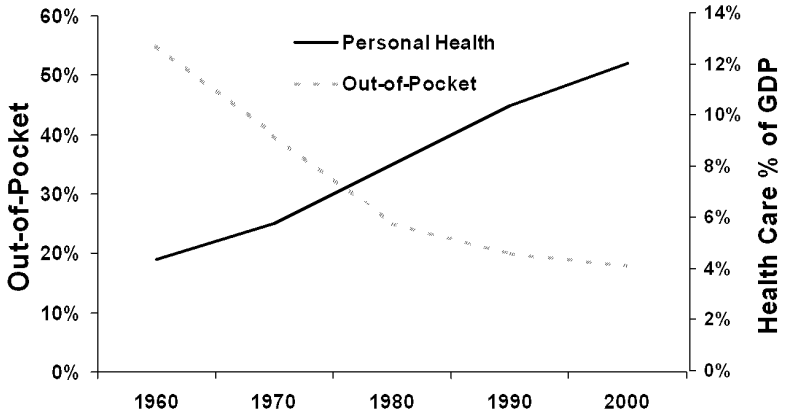
Food for Thought….

What groceries would cost if prices had increased as fast as health care costs since the 1930s



Source: Colonial Life & Accident Insurance Company

Percent Paid Out-of-Pocket and Percentage of GDP Spent on Personal Health Care Expenditures: 1960-2000



Source: Bureau of Labor Statistics

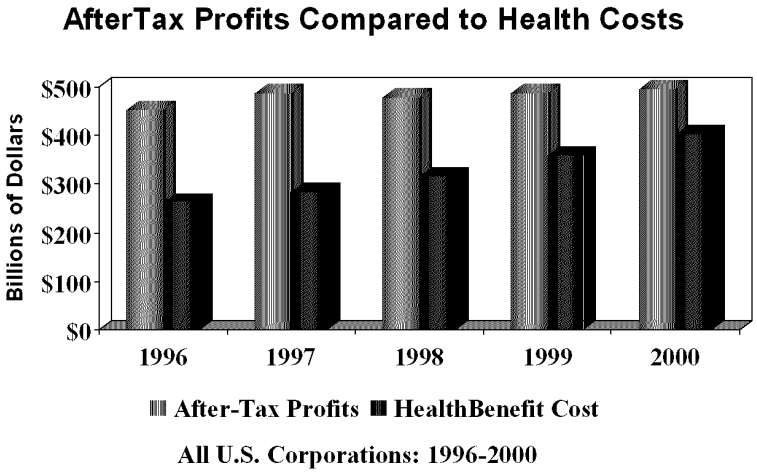
Consumer Out-of-Pocket Levels

Year	% of Health Care Expenditures	% of GDP
1930	87.5%	3.0%
1940	81.3%	2.8%
1950	65.5%	2.4%
1960	55.2%	2.4%
1970	39.7%	2.4%
1980	27.1%	2.1%
1990	22.5%	2.4%
1995	16.9%	2.0%
2000	17.2%	2.0%

Source: Milliman, USA, *Health Insurance Underwriting Cycle Effect on Health Plan Premiums and Profitability*, April 2003.

Trends | Cost Drivers | Employers

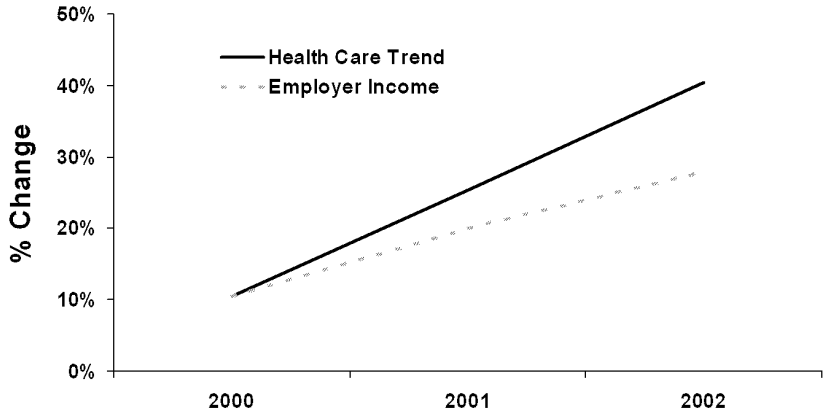
Health Costs vs. Profit



Source: The National Data Book: 2001 & IRS Data Reports

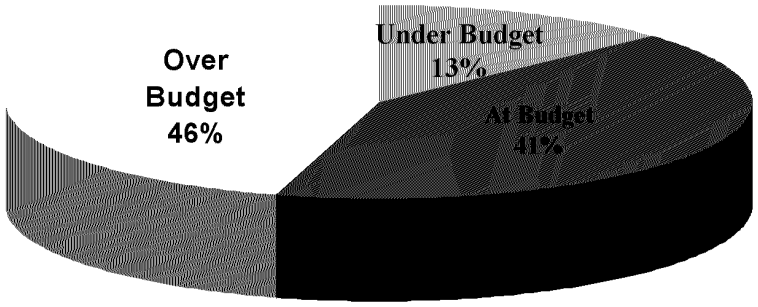
Trends | Cost Drivers | Employers

Health Care Trend vs. Employee Income



* Data from Seven Milwaukee Based Companies

Health Care Costs Relative to Budget - 2002

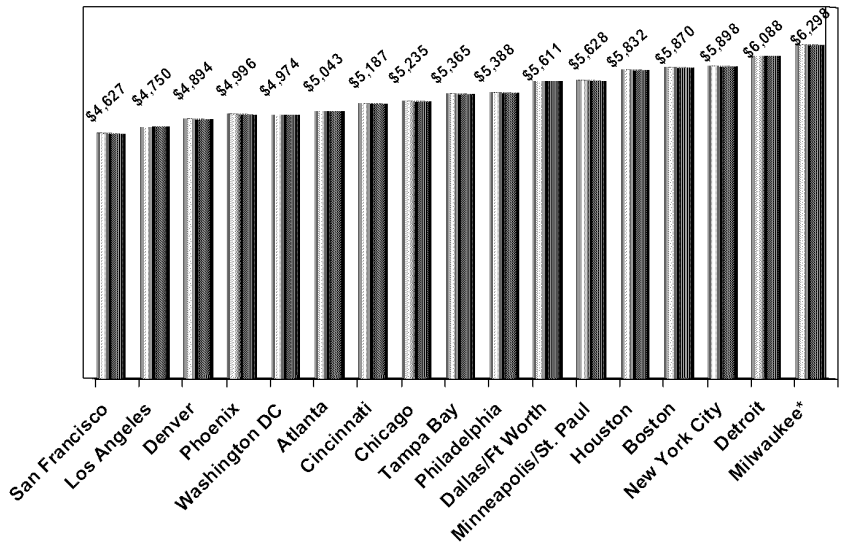


Numbers do not total 100% due to rounding

Source: Eighth Annual Washington Business Group on Health/Watson Wyatt Survey Report

Trends | Cost Drivers | Employers

2002 Health Care Costs Per Employee



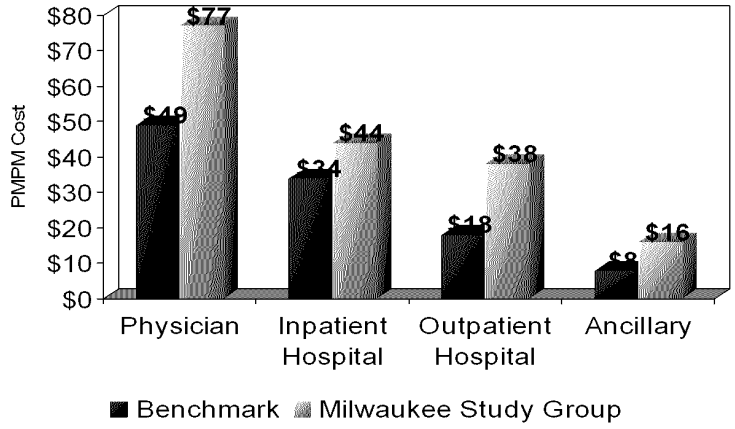
Source: Hewitt Health Value Initiative TM
* Milwaukee Source: William M. Mercer Inc.

Milwaukee Market

- March 2002 study results
  - Milwaukee 55% higher than comparable Midwest cities
    $6,298 PEPY vs. $4,063 PEPY
  - 31% attributable to provider charges
  - Cost shifting from Medicare/Medicaid/Uninsured is less in Milwaukee than the Midwest average

Source: Mercer and U.S. Department of Commerce, Bureau of Economic Analysis.

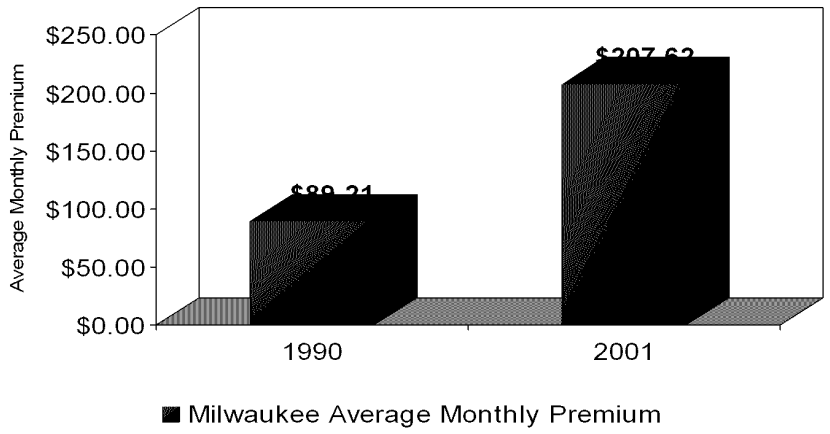
2000 Per Member Per Month (PMPM) Costs vs. Benchmarks



Source: Milliman USA and U.S. Department of Commerce, Bureau of Economic Analysis.

Trends | Cost Drivers | Employers

Average Milwaukee Premium



Source: Study by Merton D. Finkler at Lawrence University Appleton, WI

Physician Reimbursement Level vs. Cost of Living Indexes

	As Percent Of National Average Fees	Cost of Living Indexes	
		Overall	Housing
Milwaukee	144%	100%	107%
Chicago	105%	136%	185%
Cleveland	85%	104%	96%

Sources: Milliman USA Study; ACCRA Cost of Living Index, 2002

Physician Reimbursement Level vs. Cost of Living Indexes

	Blended	Cost of Living Indexes	
	RBRVS	**Overall**	**Housing**
Milwaukee	140%	100%	100%
Midwest	113%	108%	119%
Chicago	122%	125%	165%

Percentage of Local Medicare – 50th Percentile

	Chicago	St. Louis	Detroit	Minneapolis	Cincinnati	Milwaukee
Medicine	0.98	0.92	0.84	1.06	0.87	1.22
Surgery	1.25	1.19	1.15	1.43	1.11	2.21
Radiology	1.09	0.94	0.89	1.21	0.92	1.89
Pathology	0.90	0.85	0.61	1.03	0.69	2.24

Source: Milliman, 2002

Ratio to Non-Milwaukee Average By Type of Service

	Chicago	St. Louis	Detroit	Minneapolis	Cincinnati	Milwaukee
Medicine	**1.08**	**0.90**	**0.94**	**1.05**	**0.86**	**1.22**
Surgery	**1.05**	**0.88**	**1.00**	**1.06**	**0.83**	**1.67**
Radiology	**1.12**	**0.83**	**0.93**	**1.09**	**0.82**	**1.71**
Pathology	**1.11**	**1.02**	**0.75**	**1.25**	**0.83**	**2.70**

Source: Milliman, 2002

Typical Lab Encounter

Averages

	CPT	Allowed	Paid	Lab Card
Comprehensive Metabolic	80053	$60.58	$25.44	$6.78
Lipid Panel	80061	$116.84	$29.89	$8.98
TSH	84443	$115.14	$26.05	$16.82
CBC	85025	$62.22	$16.03	$5.50
	Total	$354.78	$97.42	$38.08

Source: LabOne

Trends | Cost Drivers | Employers

Prescription Drug Facts, 2002

- 14.3% increase
- 4th consecutive year with increase of 14% or more
- Total drug expenditures were $160.9 billion

Source: Medcohealth Drug Trend Report, 2002

Prescription Drug Facts

•17.1% increase in Rx spending in 2001

•2001 is 4th consecutive year with increase of 17% or more

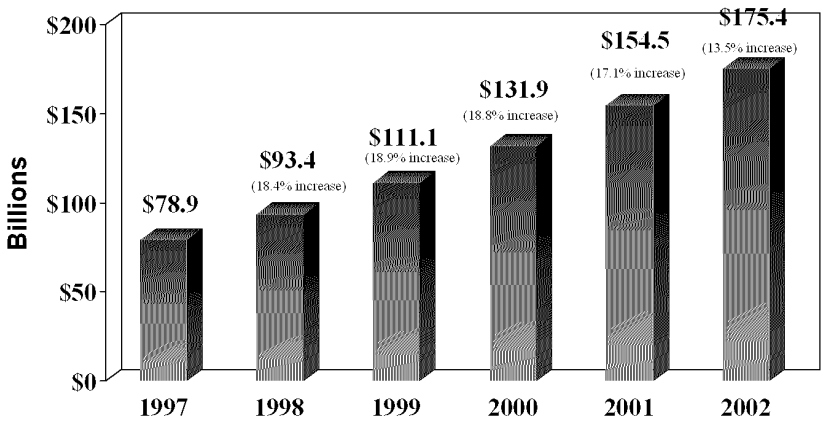
•Total drug expenditures in 2001 were $154.5 billion

•Of the almost 9,500 prescription drugs on the market, the top 50 accounted for 44.4% of drug expenditures

•Increase in drug expenditures for top 50 was 21.4% and remaining was 13.8%

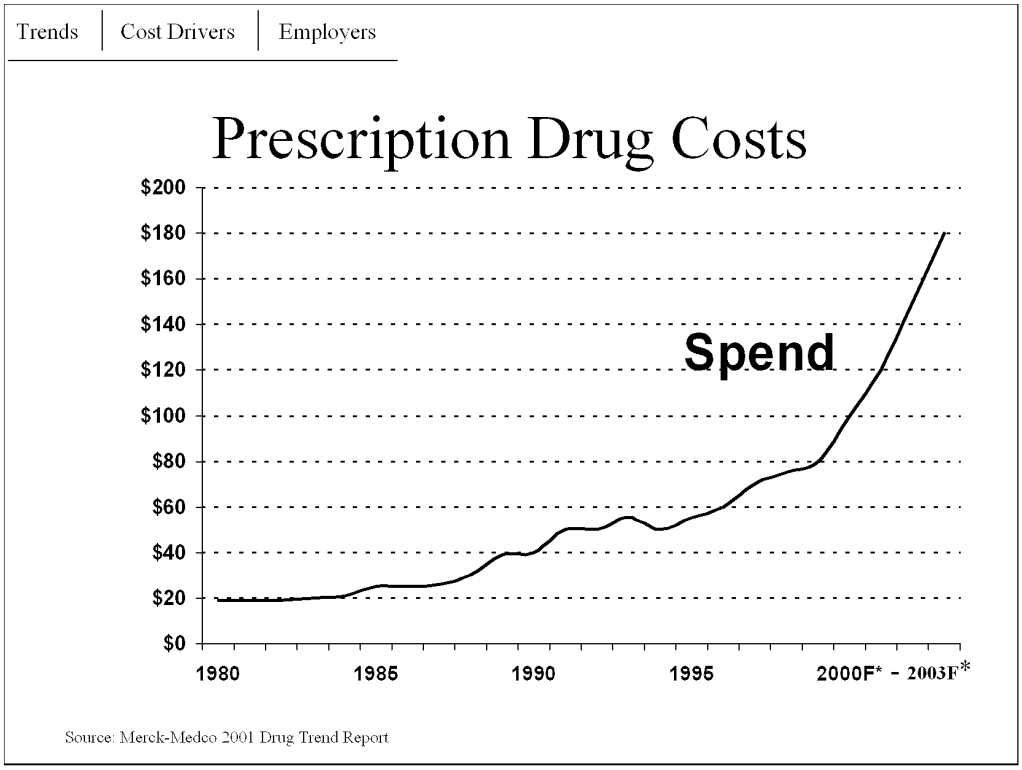
Trends | Cost Drivers | Employers

Retail Spending on Rx in the U.S.



Projections
2003-2007: 11.7% per year; 2008-2011: 10.3% per year

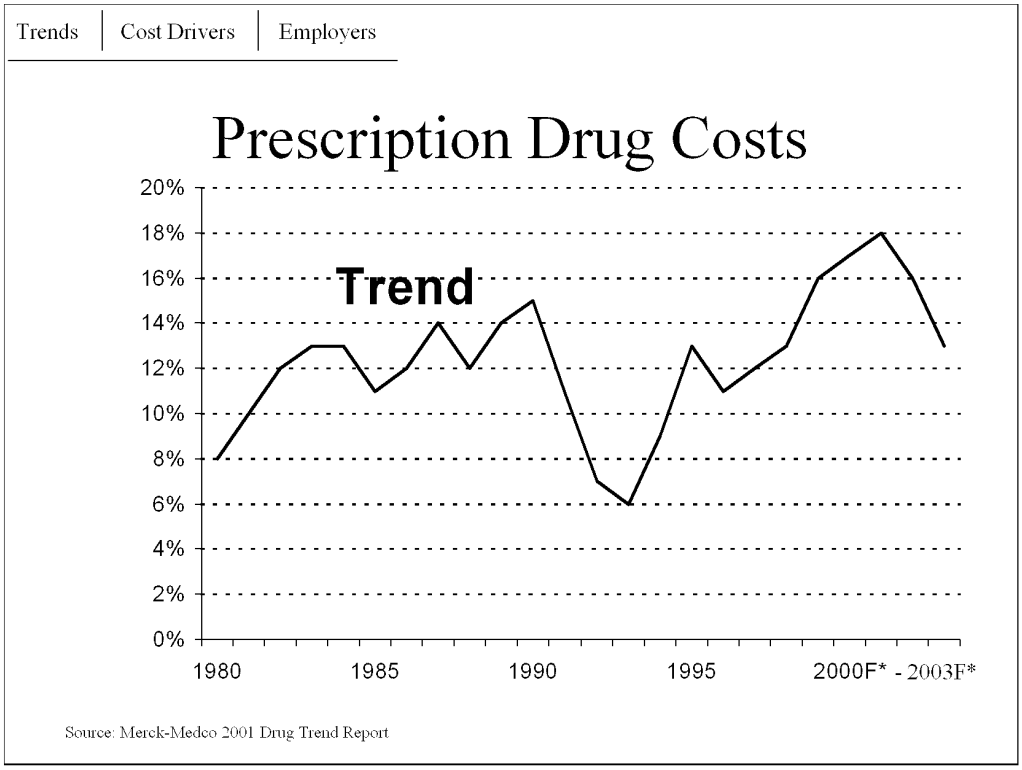
Source: American Institutes for Research (AIR) analysis of Scott-Levin data.



Prescription Drug Expenditures, 1980 – 2003* (*Forcasted)

New drugs and direct-to-consumer advertising continue to drive trend and contribute to higher spend.

Drug utilization, inflation, and drug mix (in that order) drive increased spend.

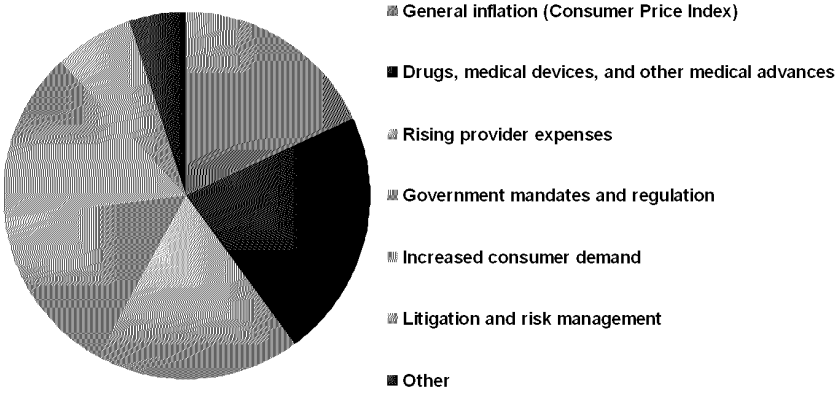


Annual Increase in Prescription Drug Expenditures 1980 – 2003* (*Forcasted)

Drug spend and drug trend remain high, though trend should moderate in the near future and new generics become available for highly utilized brand-name drugs.

What are the Cost Drivers?

Factors Driving Rising Costs in Healthcare, 2001-2002



Source: American Association of Health Plans. The factors fueling rising healthcare costs. New York, NY: PricewaterhouseCoopers, April 2002. Available at: http://bcbshealthissues.com/issues/healthcarecosts. Accessed August 8, 2002.

Healthcare Economics

Cost = Price x Volume

Price & Volume Drivers in Health Care

Employer / Plan	Members	Providers	Vendors
P_{E1} Plan Design	P_{M1} Location of Services	P_{P1} Unit Prices	P_{V1} Network Contracting
P_{E2} Vendor Oversight	P_{M2} Mix of Services	P_{P2} Unbundling/Upcoding	P_{V2} Depth of Contracting
	P_{M3} Severity of Services	P_{P3} Referral Patterns/Paths	P_{V3} Administration Efficiency
V_{E1} Plan Design	V_{M1} Health Status	V_{P1} Rx Management	V_{V1} Claim Processing Efficiency
V_{E2} Contributions	V_{M2} Lifestyle	V_{P2} Practices	V_{V2} Claim Review
V_{E3} Policies & Practices	V_{M3} Frequency of Services	V_{P3} Billing Procedures	V_{V3} UR/CM
V_{E4} Wellness	V_{M4} Preferences & Expectations	V_{P4} Outcomes	V_{V4} Disease Management
V_{E5} Vendor Oversight			V_{V5} Demand Management

Trends | Cost Drivers | Employers

Cost =

$$(P_{E1} + P_{E2} + P_{M1} + P_{M2} + P_{M3} + P_{P1} + P_{P2} + P_{P3} + P_{V1} + P_{V2} + P_{V3})$$

$$\mathbf{x}$$

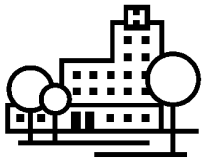
$$(V_{E1} + V_{E2} + V_{E3} + V_{E4} + V_{E5} + V_{M1} + V_{M2} + V_{M3} + V_{M4} + V_{P1} + V_{P2} + V_{P3} + V_{P4} + V_{V1} + V_{V2} + V_{V3} + V_{V4} + V_{V5})$$

Healthcare Cost Drivers for Private Payors – Plans

- Eligibility Management
  - Contributions
- Plan Design
  - Relative Benefit Levels
  - Wellness
- Inadequate Decision Support
  - Data Analysis
- Lack of Integrated Absence Management
- Lack of Consistent Quality Benchmarking Standards
- Inconsistent or Inefficient Communication

Healthcare Cost Drivers for Private Payors - Providers

- Outcomes
- Unit Prices & Utilization
- Market Issues
  - Consolidation
  - Specialty Facilities
  - Capital Expenditures
  - Shortages
    - Malpractice premiums
    - Nursing
- Uninsured Population
- Government Mandates & Cost-shifting
- Medical Errors
- Technology
  - Diagnostic methods & frequencies
  - Transplants



Trends | Cost Drivers | Employers

Healthcare Cost Drivers for Private Payors – Vendors

- Breadth, Depth & Quality of Network Contracting
- Administrative Efficiency
- Retreat from Managed Care
- Disease Management
  - UR/CM
  - Focused Illnesses
- Market Issues
  - Consolidation
  - Capital Expenditures
  - Litigation
- Government Mandates
- Demand Management

HUMANA

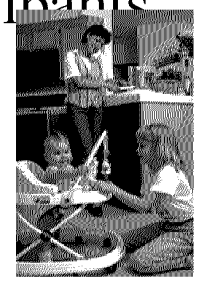
UnitedHealthcare
A UnitedHealth Group Company

Aetna

WELLPOINT

Logos of Humana, UHC, Aetna & Wellpoint here

Healthcare Cost Drivers for Private Payors - Participants



- Health Status
- Lifestyle
- Benefit Plan Coverage
  - Location & Mix of Services
  - Frequency & Severity of Services
- Media & Internet
- Preferences & Expectations
- Economic Status

Healthcare Cost Drivers for Private Payors - Participants

- Americans are eager consumers of healthcare
  - Aging population
  - Morbidity increases rapidly with age
  - Direct to consumer advertising
  - Internet access

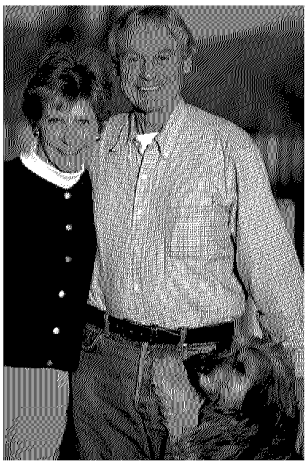
Aging U.S. Population

Year	Total Population	Number Age 65+	Percent Age 65+
1900	76.0	3.1	4.1
1950	150.7	12.2	8.1
2000	276.2	35.4	12.8
2010	300.4	40.0	13.3
2020	325.9	53.4	16.4
2030	350.0	70.3	20.1

In millions except percentages.

Source: U.S. Census Bureau

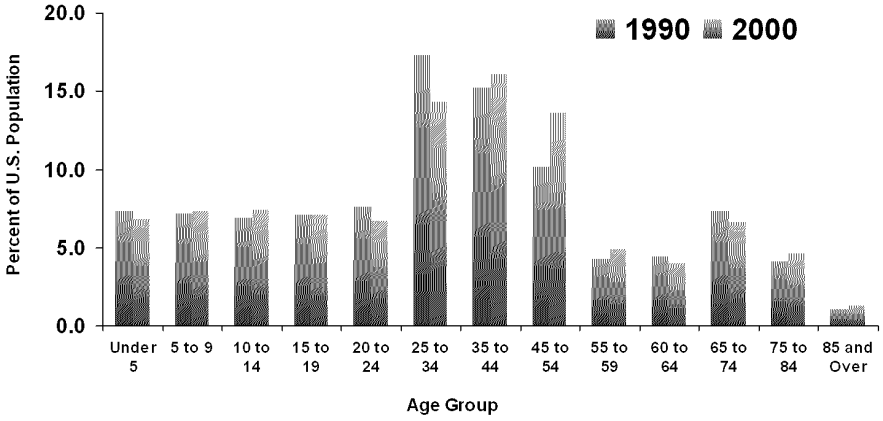
Aging



As Americans grow older they use more services. Baby boomers are just entering the 55 to 64 age group, where inpatient days per thousand are 58% higher than in the 45 to 54 age group, and 121% higher than in the 35 to 44 age group.

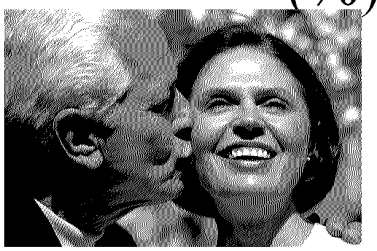
Source: National Hospital Discharge Survey, Centers for Disease Control and Prevention, 1998

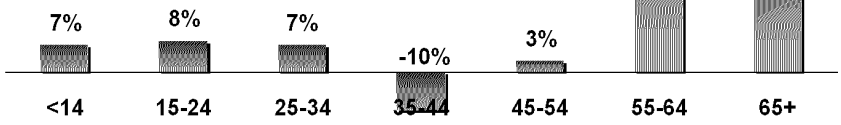
Percent of Total U.S. Population by Age Group, 1990 and 2000



Source: U.S. Census Bureau

Projected Change in Number of Americans by Age, 2000-2020 (%)

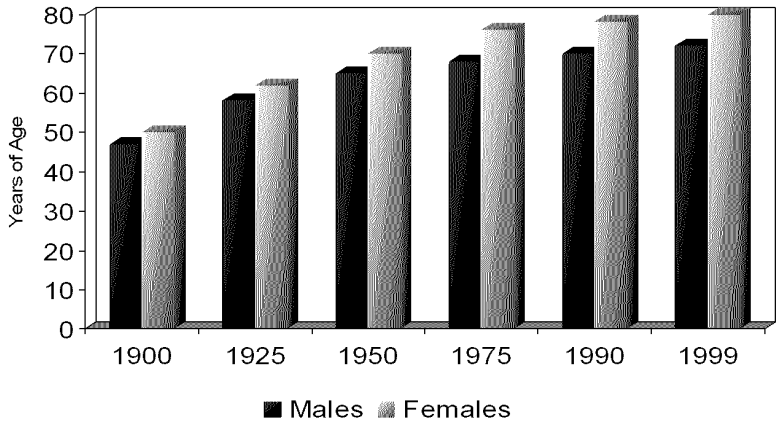




Source: Dychtwald K. Demographic shifts—the age wave. Managed Care. 2002;11(2):7-11.

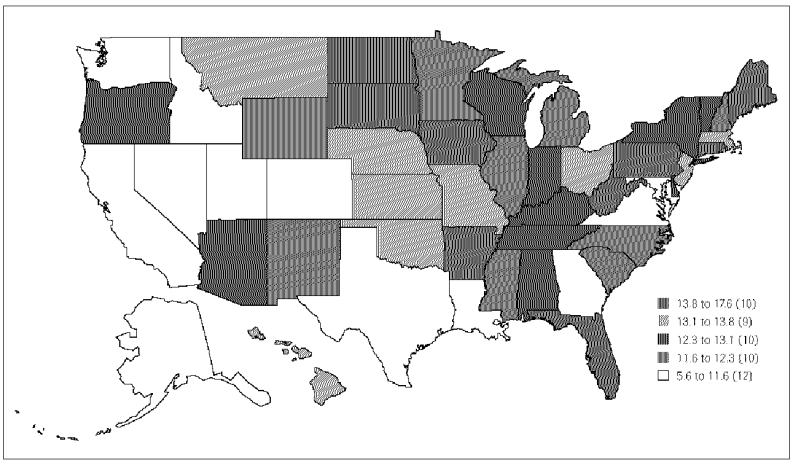
Trends | Cost Drivers | Employers

Life Expectancy at Birth



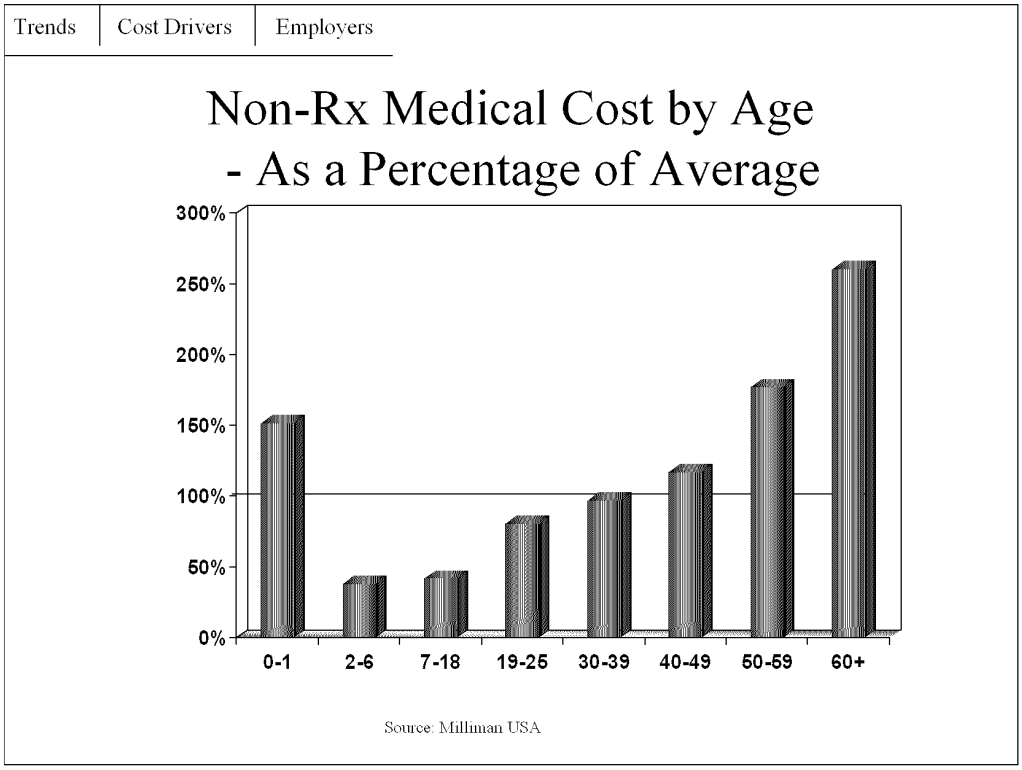
Source: Milliman USA

Persons 65+ as a Percentage of Total Population, 2000



Source: US Dept of Health and Human Services Administration on Aging. The older population—a profile of older Americans: 2001. Available at: http://www.aoa.dhhs.gov/aoa/STATS/profile/2001/1.html. Accessed March 19, 2001.

Trends | Cost Drivers | Employers

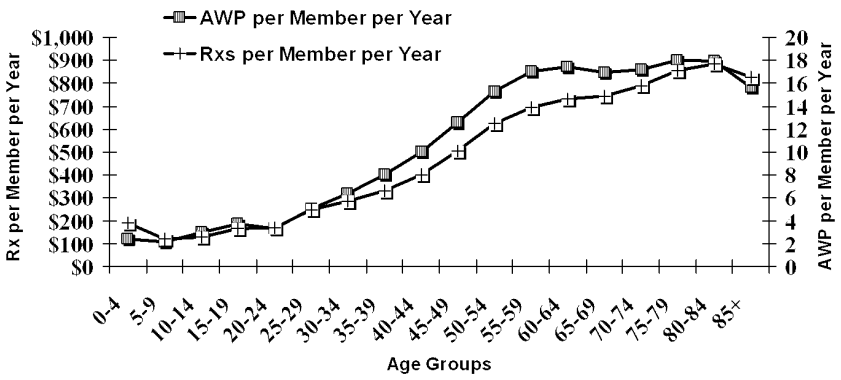


Medical Cost By Age

As A Pecentage Of Average

The various points reflect the cost by age relative to the entire population.

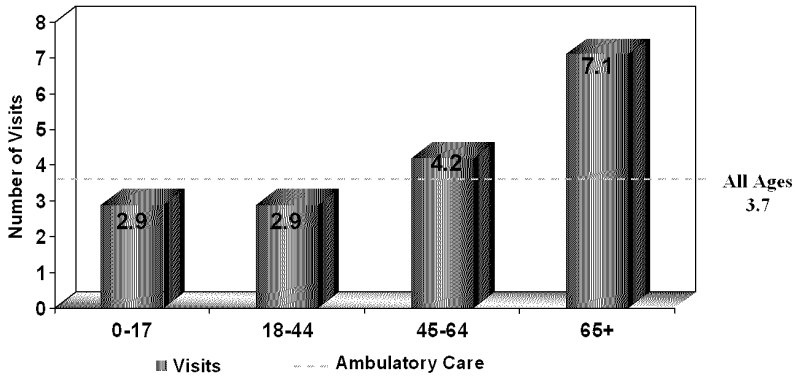
2001 Rx Consumption by Age



Source: Medco Health Solutions Inc.

Ambulatory Care Visits per Capita by Age, 2000

Seniors (65+) make about twice as many visits as the average person



Source: National Center for Health Statistics, 2002

Medical Cost By Age

As A Pecentage Of Average

The various points reflect the cost by age relative to the entire population.

Percent of Population Suffering from Specific Diseases, by Age and Disease, 1997

Condition	Age	%
Heart Disease	45 to 64 years	13.7
	65 to 74 years	27.5
	75 years and older	37.1
Diabetes	45 to 64 years	7.8
	65 to 74 years	14.7
	75 years and older	12.0
Arthritis	45 to 64 years	25.8
	65 to 74 years	33.7
	75 years and older	39.9

Source: Dept of Health and Human Services (DHHS). Centers for Disease Control and Prevention. Vital and Health Statistics. Summary Health Statistics for US Adults: National Health Interview Survey, 1997. Hyattsville, Md: DHHS; May 2002. Series 10, Number 205. DHHS Publication (PHS) 2002-1533.

Trends | Cost Drivers | Employers

Hospital Inpatient Cost Drivers

- 19% due to technology
- 18% related to hospital consolidation
  - every 1% increase in market share leads to a 2% increase in patient expenditures
- 15% due to hospital underutilization

Source: BCBS, *What's Behind the Rise: A Comprehensive Analysis of Healthcare Costs*, October 2002.

•19% of the rise in hospital inpatient cost increases is due to technology

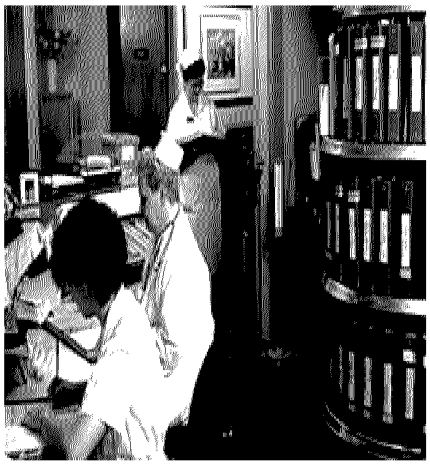
•18% of rising inpatient costs are related to hospital consolidation, with every 1% increase in market share due to consolidation leading to a 2% increase in inpatient expenditures

•Hospital underutilization accounts for 15% of cost increases

Trends | Cost Drivers | Employers

Hospital Inpatient Cost Drivers (cont.)

- 20% due to wages, including physician, nursing and other healthcare professions
  - Includes effect of the nursing shortage
- 10% due to population income



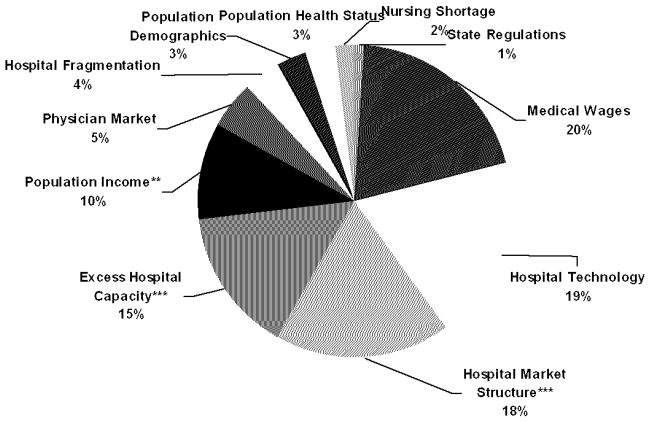
Source: BCBS, *What's Behind the Rise: A Comprehensive Analysis of Healthcare Costs*, October 2002.

•hospital wages-including physician, nursing and the wages of other healthcare professions-accounts for 20% of the rise in inpatient expenditures. This figure includes much of the effect of the nursing shortage, as the inability to find and retain nursing staff will tend to put upward pressure on wages; and

•population income, as measured by state per-capita disposable income, accounts for 10% of the rise in income

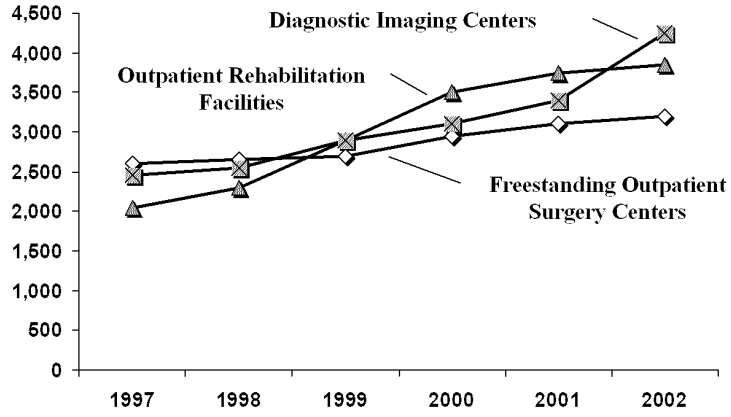
Trends | Cost Drivers | Employers

Contributions to Inpatient Expenditures, 1998-2001*



*Based on the experience of a large, nationally representative group health plan
**Higher incomes increase demand for healthcare
***Because hospitals have high fixed costs, excess capacity can drive up the cost per admission
****As measured by having more beds in hospitals that are for profit or part of hospital systems
Source: Hay, 2002

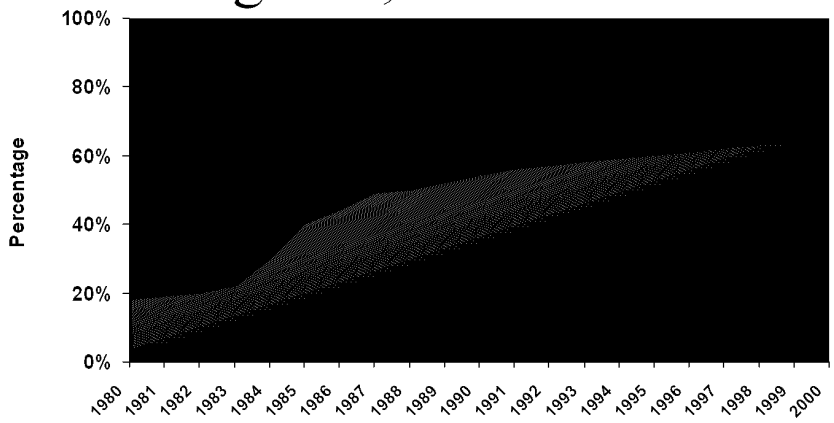
FOSCs, DICs, and CORFs, 1997 - 2002



Source: SMG Marketing Group.

Number of FOSCs, DICs, and CORFs, 1997 - 2002

Distribution of Hospital Outpatient and Inpatient Surgeries, 1980-2001



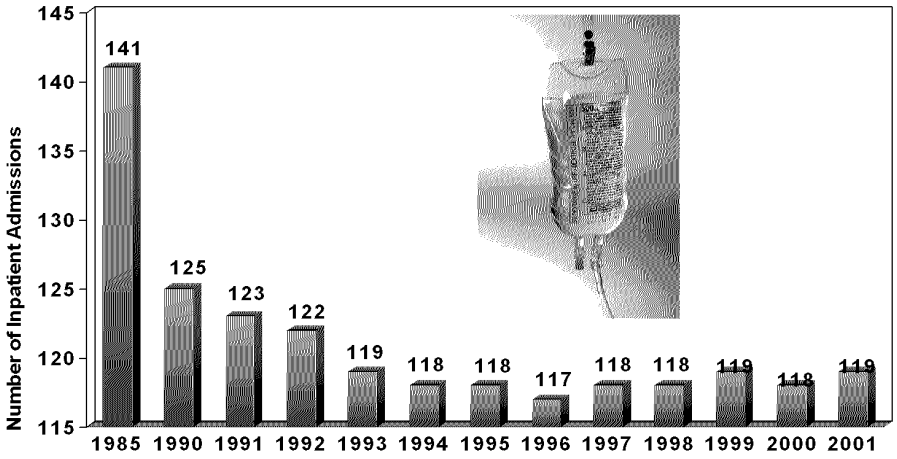
Source: American Hospital Association, 2003: The Lewin Group, 2002a

Hospital Costs

	1995	1996	1997	1998	1999	2000
Total Number of Discharges	34,789,502	34,872,474	35,406,187	34,874,001	35,467,673	36,417,565
LOS, days (mean)	5.2	5.0	4.9	4.8	4.7	4.6
LOS, days (median)	3.0	3.0	3.0	3.0	3.0	3.0
Charges, $ (mean)	$10,322	$10,646	$11,294	$11,789	$12,473	$13,815
Charges, $ (median)	$5,538	$5,737	$6,052	$6,400	$6,610	$7,139

Source: HCUPnet, Agency for Healthcare Research and Quality

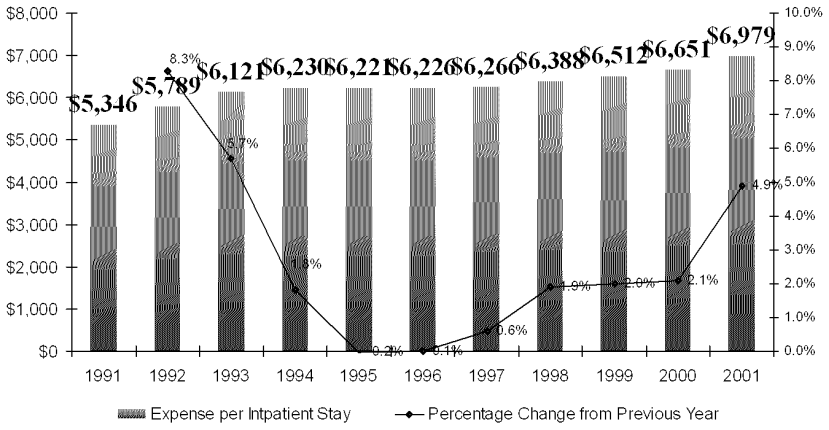
Number of Inpatient Admissions per 1,000 Population, 1985-2001



Source: American Hospital Association, 2003

Trends | Cost Drivers | Employers

Hospital Expenses per Inpatient Stay, 1991-2001



Source: American Hospital Association, 2003; Blue Cross and Blue Shield Association Analysis

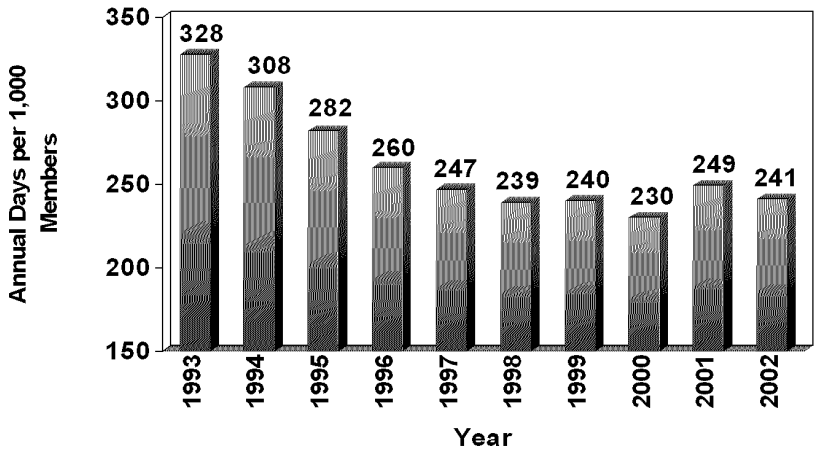
2002 Commercial Inpatient Costs

Region	Per Diem	Per Admit
West North Central	$1,634	$5,945
East North Central	1,501	6,017
West South Central	1,727	6,051
East South Central	1,404	5,795
Mountain	1,663	6,191
Mid-Atlantic	1,280	5,327
New England	1,585	6,183
Pacific	1,952	6,675
South Atlantic	1,699	5,746
Nationwide	$1,610	$6,013
25th Percentile	1,348	5,119
75th Percentile	1,838	6,552

Milliman 2002 HMO Intercompany Rate Survey

Trends | Cost Drivers | Employers

U. S. Commercial Inpatient Days



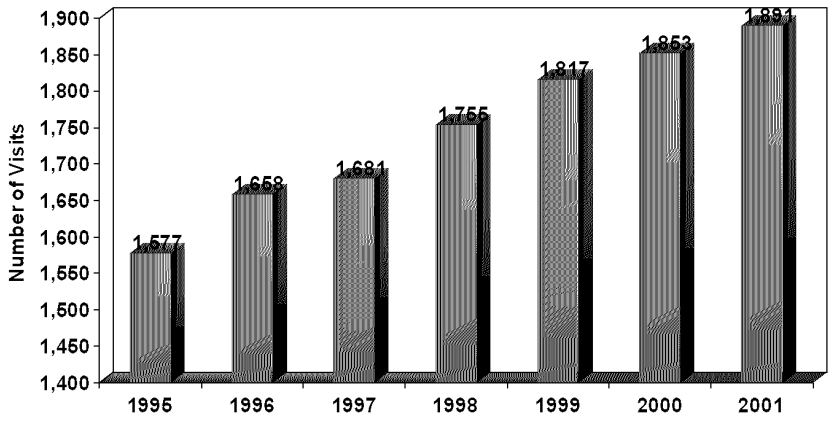
Milliman 2002 HMO Intercompany Rate Survey

2002 Commercial Inpatient Days per 1,000

Region	Days / 1,000
West South Central	283
East North Central	261
West North Central	250
New England	240
Mid Atlantic	233
South Atlantic	231
Mountain	223
Pacific	178
East South Central	NA
Nationwide	241
25th Percentile	209
75th Percentile	271

Milliman 2002 HMO Intercompany Rate Survey

Number of Outpatient Visits per 1,000 Population



Source: American Hospital Association, 2003

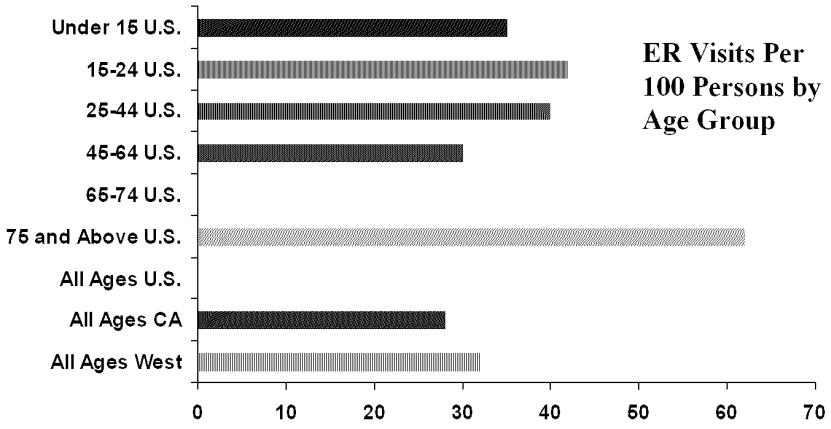
Emergency Room Use

In 1999, Americans went to the hospital emergency rooms 102.8 million times. It has been estimated that 55.4% of emergency room visits or 57 million were for nonurgent conditions, such as headaches, sore throats and stubbed toes. Cost for treatment is about *four times higher* in a hospital emergency room than in a health care provider's office.

Source: Centers for Disease Control and Prevention

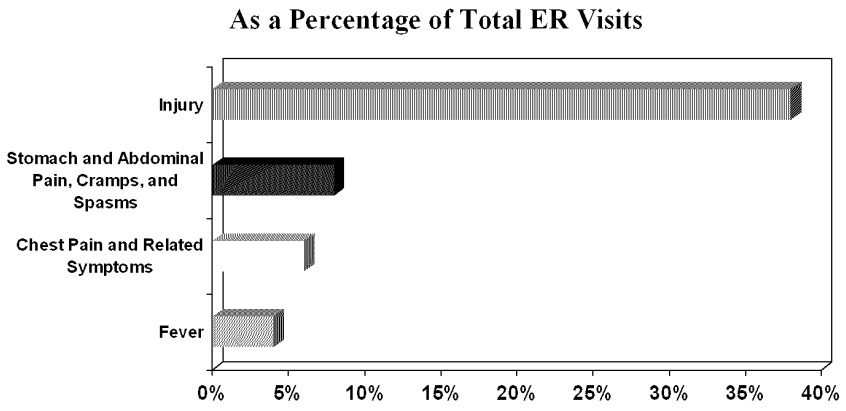
Trends | Cost Drivers | Employers

Who Uses the Emergency Room?



Source: NHMACS: Emergency Department Summary 1999, No. 320; Annual Utilization Report of Hospitals, OSHPD, 1999.

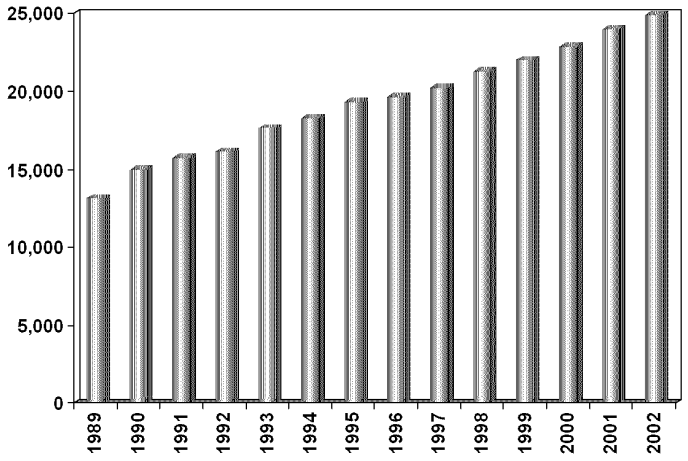
Principle Reasons for ER Visits



Source: NHMACS: National Center for Health Statistics: Emergency Department Summary 1999, No. 320;

Trends | Cost Drivers | Employers

Total Transplants



Organ:

Kidney
Kidney-Pancreas
Pancreas
Liver
Intestine
Heart
Lung
Heart-Lung

Source: UNOS (United Network for Organ Sharing)

Annual Number of Organ and Bone Marrow Transplants in the U.S., All Ages

Year	Heart	Lung	H-L	Liver	Kidney	Pancreas	K-P	Cornea	Bone-Marrow	Intestine
1995	2357	870	69	3924	11051	107	917	35300	11250	45
1996	2342	814	39	4072	11363	165	860	34668	12600	45
1997	2294	931	60	4176	11674	208	851	35209	13950	68
1998	2344	864	47	4502	12375	245	971	35861	21150	68
1999	2181	886	49	4707	12527	362	932	33020	18540	70
2000	2198	956	48	4954	13372	435	911	33260	15930	79
2001*	2209	1004	48	5202	14107	544	916	33759	16530	87
2002*	2220	1054	48	5462	14883	680	921	34265	17160	96

Source: Milliman USA, Inc., 2002 Organ & Bone Marrow Transplant Costs & Discussion Report
**2001 and 2002 values are Milliman estimates*

2002 Transplant Costs

Transplant	Total
Heart	**$391,800**
Liver	**$313,600**
Kidney	**$143,300**
Kidney/ Pancreas	**$195,500**
Pancreas	**$138,900**
Heart/Lung	**$504,400**
Lung	**$343,000**

Source: Milliman USA

...Continued

2002 Transplant Costs, cont.

Transplant	Total
Bone Marrow-Autologous	$243,800
Bone Marrow-Autologous Related	$362,100
Bone Marrow-Allogeneic Unrelated	$447,300
Intestine	$814,500

Source: Milliman USA

Organ Transplant Statistics

Waiting List Candidates	**82,213**	**As of 7/11/03**
Transplants January – April 2003	**8,335**	**As of 7/11/03**
Donors January – April 2003	**4,293**	**As of 7/11/03**

Source: UNOS (United Network for Organ Sharing)

Transplant Waiting List

- The number of patients awaiting organ transplants rose more than five times as fast as the number of transplant operations in the 1990s
- In 2001, there were 23,985 transplants performed in the United States, up 63% from 1990
- In February 2003, there were 80,435 people on the national transplant waiting list, more than three times as many as in 1990

Source: UNOS (United Network for Organ Sharing)

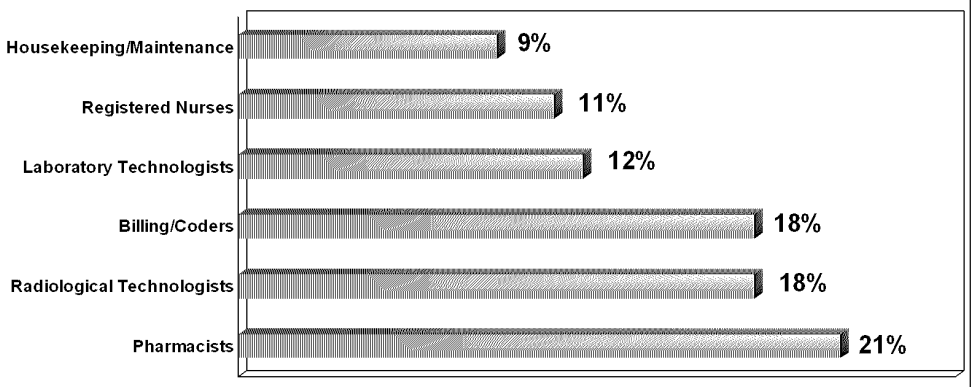
Transplant Waiting List

On February 24, 2003 The UNOS national patient waiting list for organ transplant included the following:

Type of Transplant	Patients Waiting for Transplant
kidney	53,653
liver	16,900
pancreas	1,387
kidney-pancreas	2,413
intestine	183
heart	3,825
heart-lung	196
lung	3,822
Total	**80,448**

Source: UNOS (United Network for Organ Sharing)

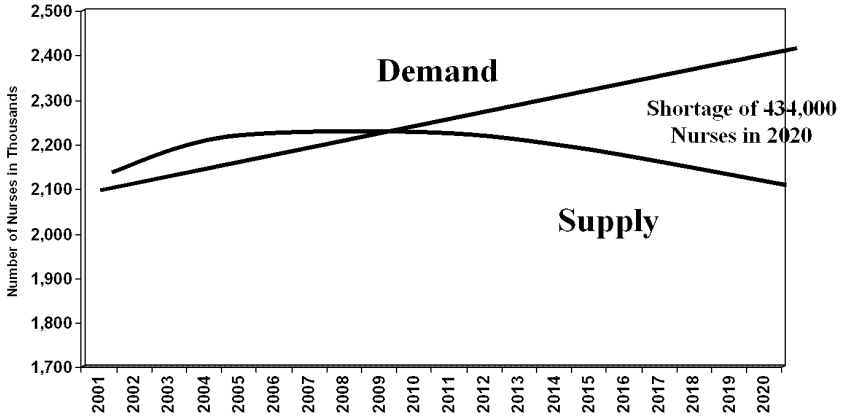
Unfilled, Budgeted Hospital Positions



Source: Selvam A. The state of the health care work force. Hospitals and Health Networks. 2001;75(8):41-48.

Trends | Cost Drivers | Employers

National Supply and Demand Projections for FTE Registered Nurses: 2000 to 2020



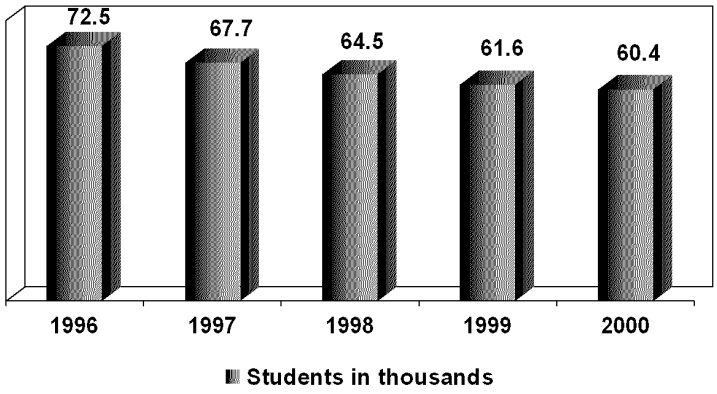
Source: U.S. Census Bureau and Health Resources and Services Administration, as reported in The Lewin Group, 2002

Hospitals spent $71M in 2001 using agency/traveling nurses to fill vacant slots (AHA 2002).

Each 1% increase in the gap between registered nurse demand and supply leads to a .5% - 1% increase in hospital inpatient expenditures per capita (Hay 2002).

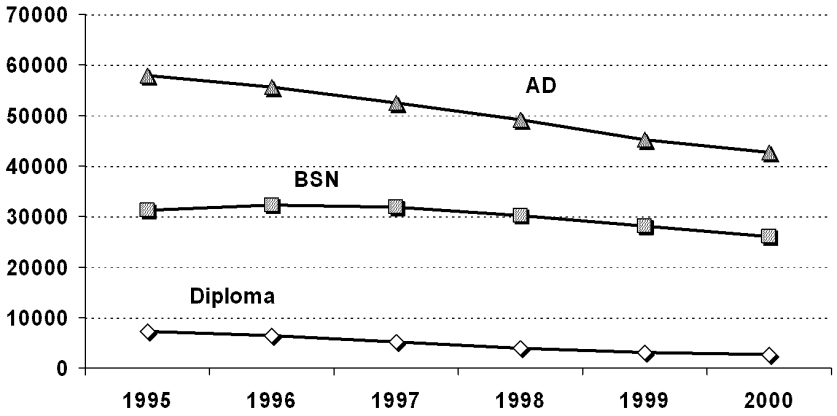
Nursing Students

Number of students enrolled in nursing programs has dropped significantly over the past 5 years



Source: Selvam A. The state of the health care work force. Hospitals and Health Networks. 2001;75(8):41-48.

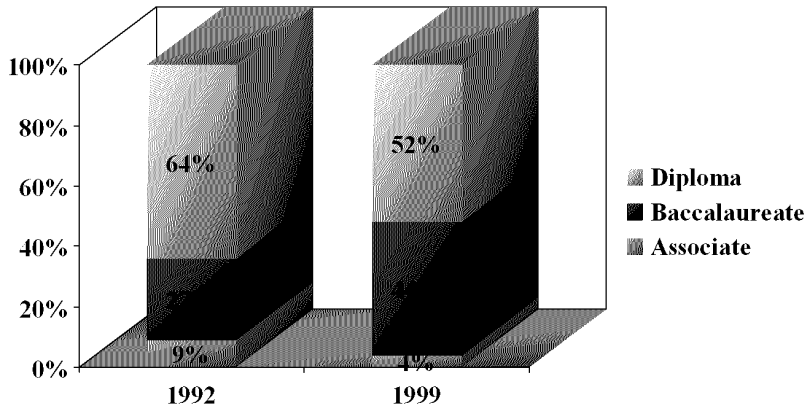
Total Number of RN Graduates by Degree Program, 1995-2000



Source: National Council of State Boards of Nursing, NCLEX

Trends | Cost Drivers | Employers

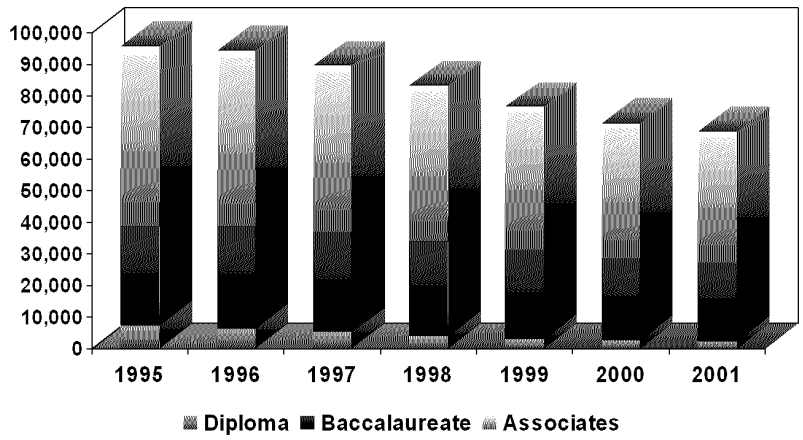
Distribution of RN Graduates by Educational Preparation



Source: National Council of State Boards of Nursing, NCLEX exam

Trends | Cost Drivers | Employers

Number of Candidates Taking the NCLEX-RN Exam

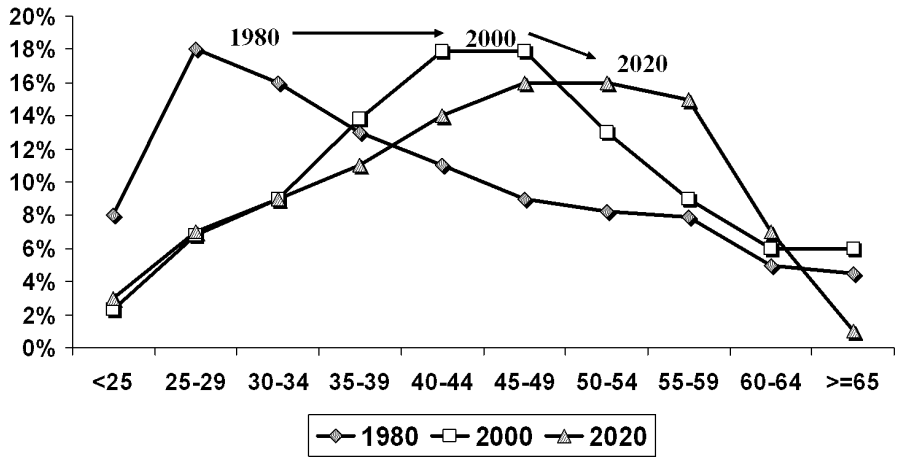


Source: American Association of Colleges of Nursing

Program	**1995**		**1996**		**1997**
		1998		**1999**	
	2000		**2001**		
Diploma	7,335		6,346		5,240
		3,978		3,161	
	2,679		2,310		
Bacc		31,195	32,278	31,828	
	30,142	28,107	26,048	24,832	
Associates	57,098	55,554	52,396	49,045	
	45,255	42,665	41,567		
Total		**96,438**	**94,178**	**89,464**	
	83,165	**76,523**	**71,392**	**68,159**	

Trends | Cost Drivers | Employers

Age Distribution of RNs: 1980, 2000 and 2020 Projected



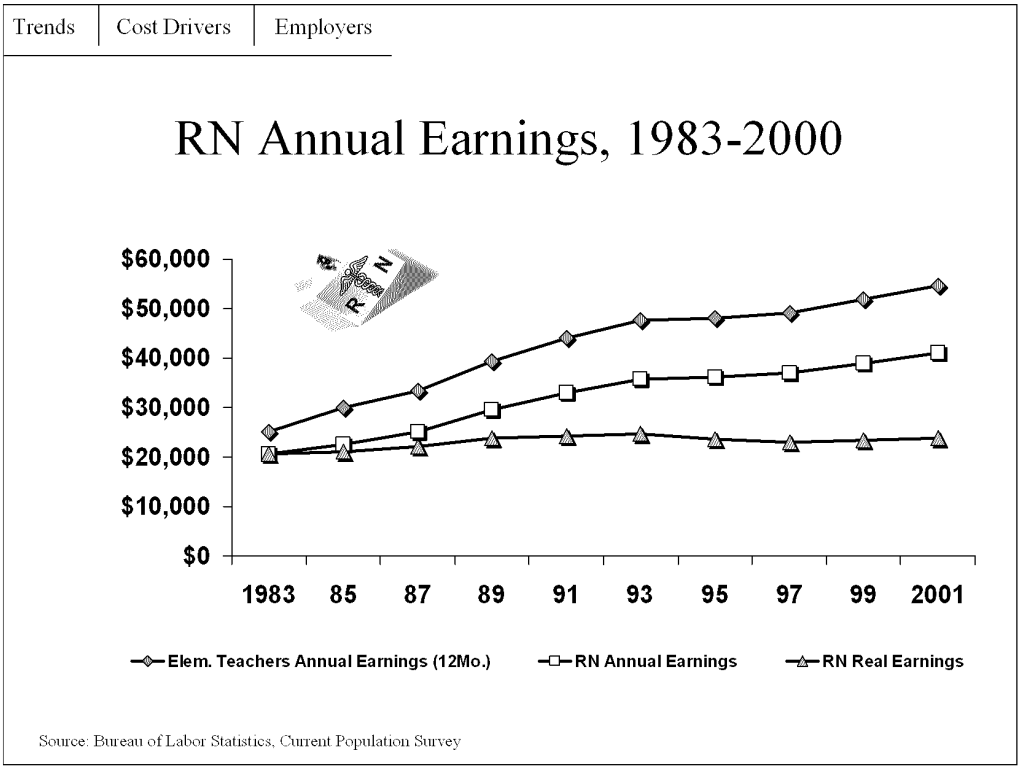
Source: Bureau of Health Professionals, RN Sample Survey and Supply Projections.

Trends | Cost Drivers | Employers

Fewer Younger Nurses

Registered nurses younger than 40:

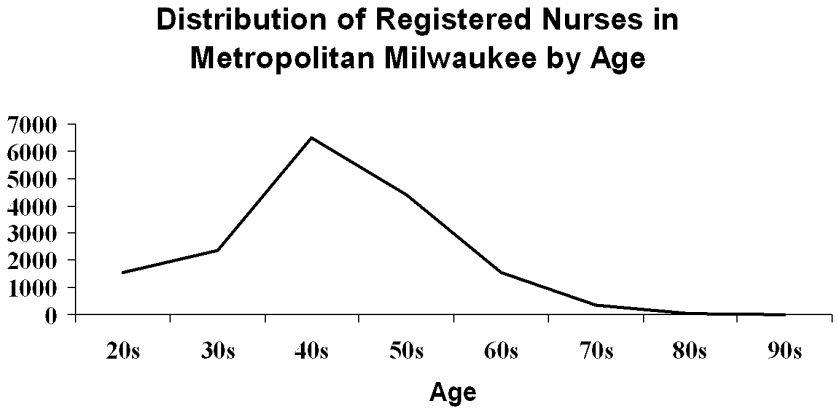
Source: Bureau of Health Professions



Actual Annual Earnings for RNs and Elementary School Teachers and "Real" Earnings for RNs: 1983-2000

Trends | Cost Drivers | Employers

Nurse Employment – Getting Older



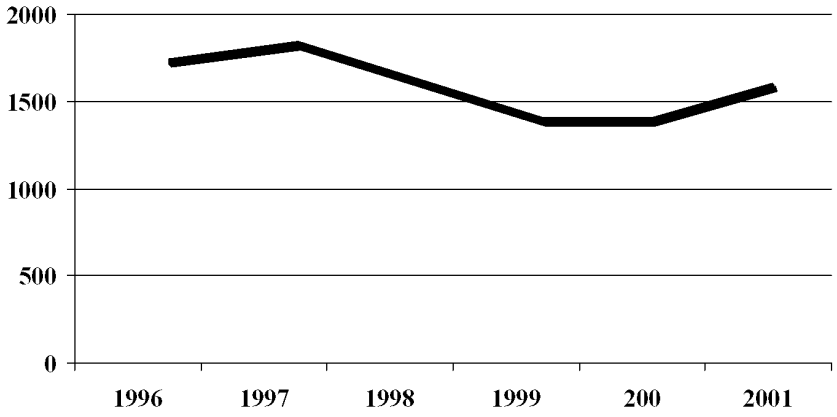
Source: Employment & Training Institute, University of Wisconsin-Milwaukee

More than one-third of all registered nurses in the area are in their 40s, and almost two-thirds are in their 40s or 50s.

Trends | Cost Drivers | Employers

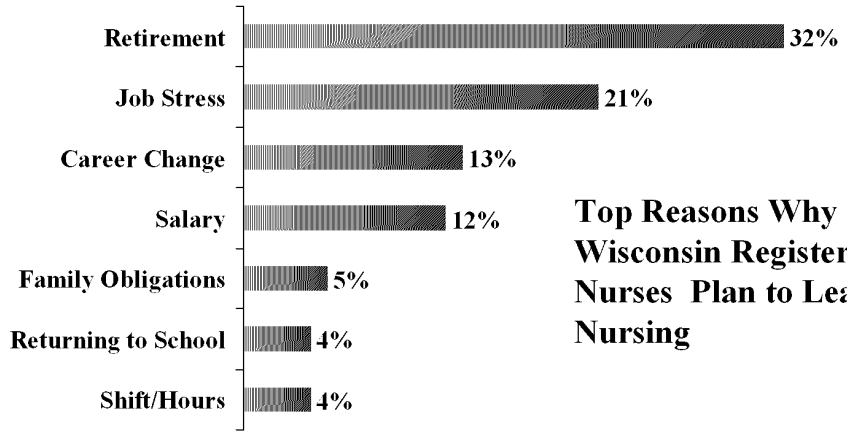
Licensing – Recent Drop

Number of New Wisconsin Nursing Graduates Passing the Registered Nurse Licensing Exam



Source: Wisconsin Department of Regulation and Licensing

Nursing – Leaving the Field

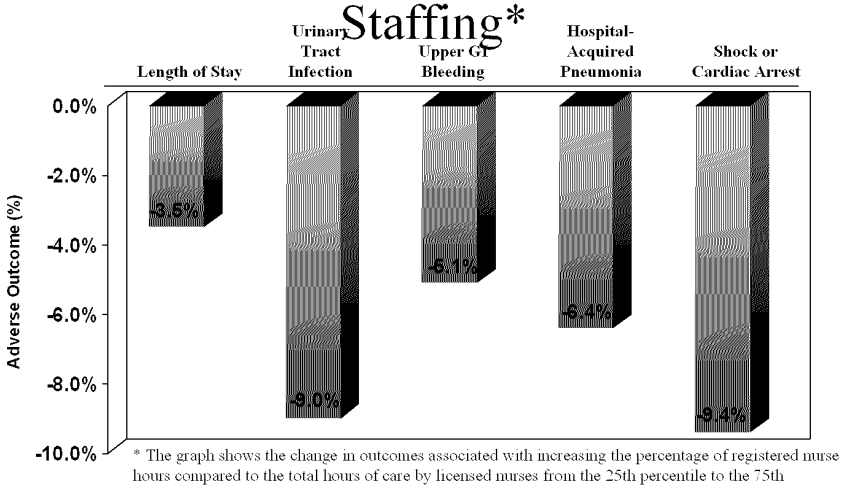


Top Reasons Why Wisconsin Registered Nurses Plan to Leave Nursing

Source: Wisconsin Bureau of Health Information

Trends | Cost Drivers | Employers

Decrease in the Rate of Adverse Inpatient Outcomes Associated with Increasing RN Staffing*

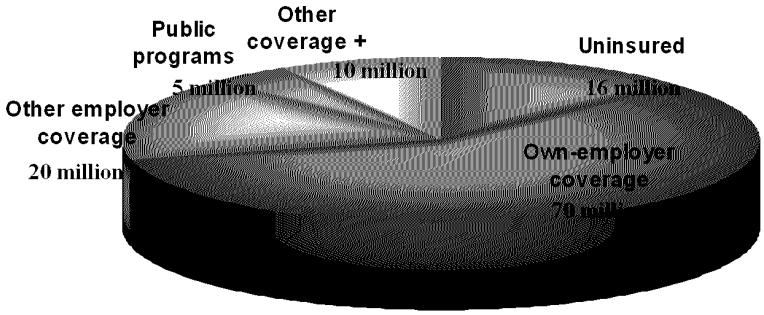


* The graph shows the change in outcomes associated with increasing the percentage of registered nurse hours compared to the total hours of care by licensed nurses from the 25th percentile to the 75th percentile.

Source: Needleman et al, 2002

Distribution of Insurance Coverage for Workers

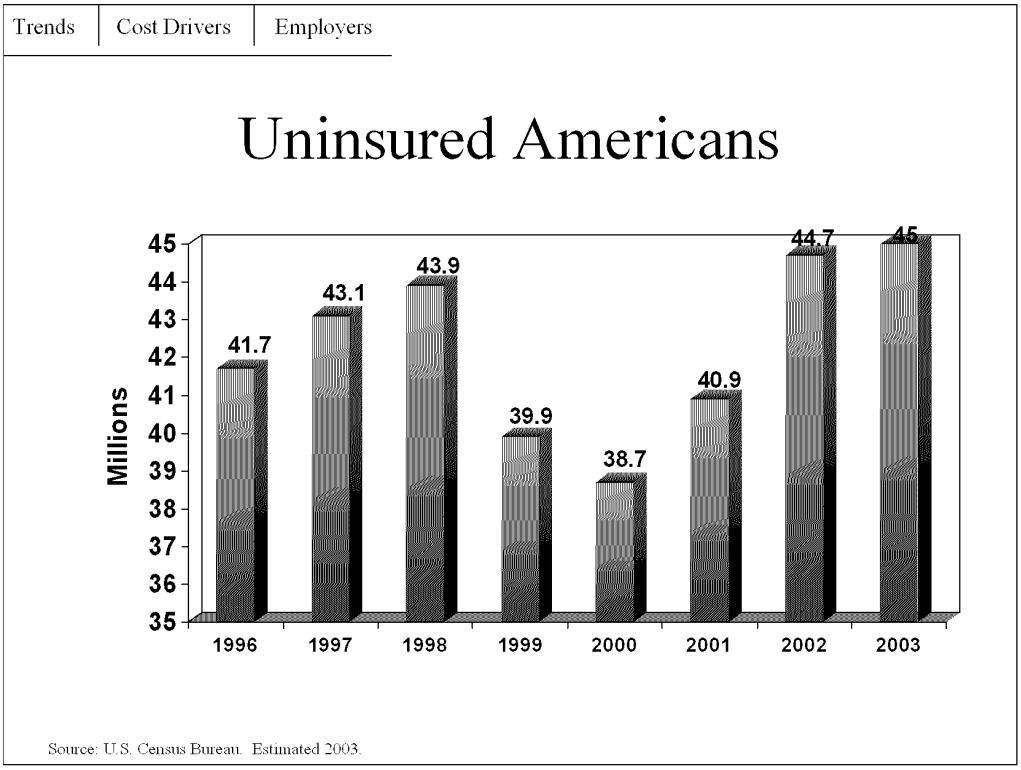
120 million workers, 19-64



+Includes those with individual insurance and don't know responses

Source: Analysis of the Commonwealth Fund 2001 Health Insurance Survey

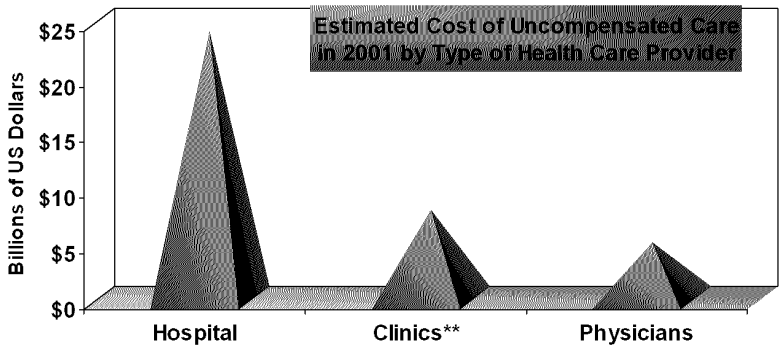
Trends | Cost Drivers | Employers



Growth in the Number of Uninsured Americans, 1996-2002

Healthcare for Uninsured People Adds to Overall Costs

In 2001, uncompensated healthcare for uninsured people cost about $36 billion.*



*Some of these costs are offset by funds such as federal payments to hospitals with a disproportionate share of uninsured patients.
**Includes VA and Indian Health Service Hospitals and other community health providers.
Source: Hadley and Holahan, 2003

Inpatient Hospital Care for Uninsured Patients is Costly

- 5.6% of all hospital discharges in the US - close to 1.9 million - are for uninsured patients
- These hospitalizations cost $9.7 billion to $11.6 billion, or 5.1% of all hospital inpatient costs
- Teaching hospitals account for 23% of the hospitalizations among the uninsured and 33% of the associated costs
- Admissions of uninsured patients for "ambulatory care sensitive" conditions like asthma and diabetes - many of which can be prevented through good outpatient care - cost $1.2 billion to $1.4 billion in 2001

Source: Siegrist, 2003, projected from hospital discharge data from 10 states for 200/2001.

Physician Services Cost Drivers

- 15% related to influence of current provider market structure as measured by:
  - supply of inpatient facilities
  - percentage of total beds in for-profit hospitals
  - percentage of physicians in medical groups with four or more physicians

Source: BCBS, *What's Behind the Rise: A Comprehensive Analysis of Healthcare Costs*, October 2002.

15% of the rise in physician costs are related to the influence of the current provider market structure, as measured by the supply of inpatient facilities, the percentage of total beds in for-profit hospitals and the percentage of physicians in medical groups with four or more physicians

Physician Services Cost Drivers (continued)

- 11% due to medical technology
- 7% due to physician and specialist supply
- 11% due to:
  - provider payment factors
  - provider operating costs
  - healthcare regulation
  - health status account

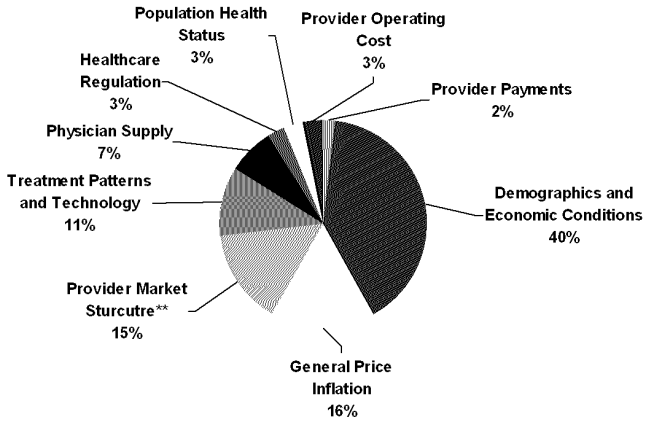
Source: BCBS, *What's Behind the Rise: A Comprehensive Analysis of Healthcare Costs*, October 2002.

•11% of physician costs are due to medical technology

•Physician and specialist supply account for 7% of the growth

•In total, provider payment factors, provider operating costs, healthcare regulation and health status account for 11% of the growth in physician costs

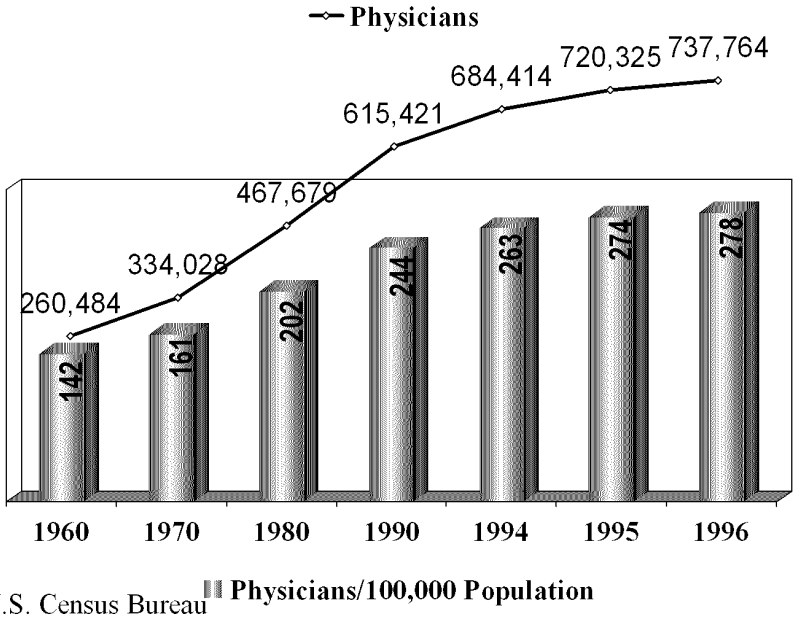
Relative Importance of Physician Cost Drivers, 1998-2001*



*Based on the experience of a large, nationally representative, group health plan
**This includes the percentage of hospitals that are for-profit or in networks and the number of diagnostic imaging centers and rehabilitaiton centers per 1,000 population
Source: The Lewin Group, 2002b

Trends | Cost Drivers | Employers

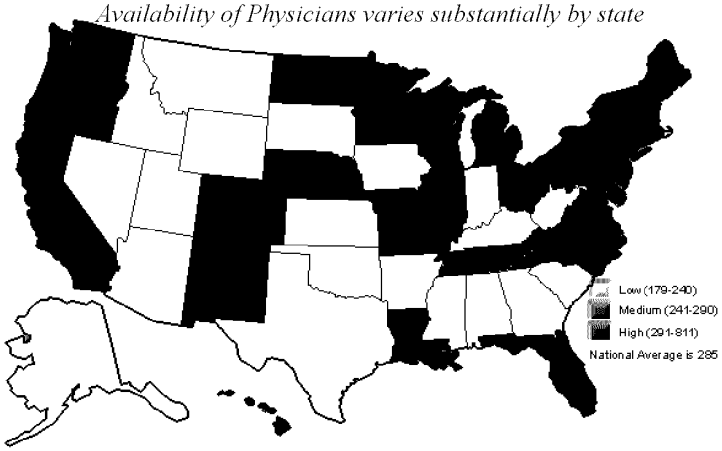
Number of Physicians in the U.S.



Source: U.S. Census Bureau

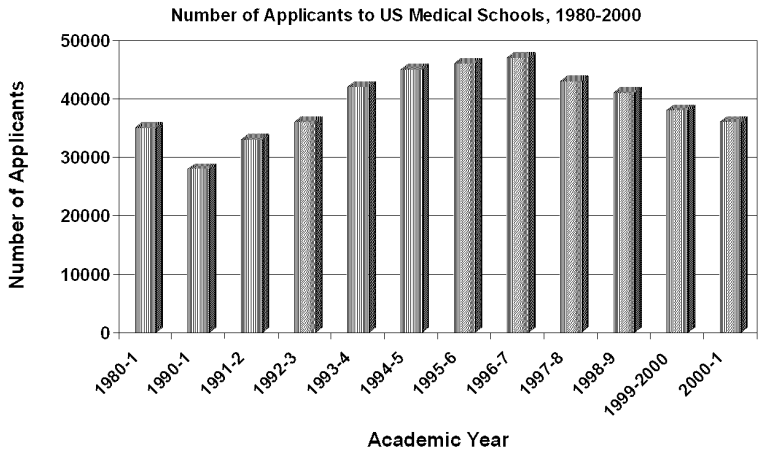
Number of Physicians per 100,000 Persons by State

Availability of Physicians varies substantially by state



Source: Physician Characteristics and Distribution in the US 2001-2002. American Medical Association. Kaiser Family Foundation State Health Facts Online.

Applications to US Medical Schools Fall for Fourth Year



Applications to US medical schools fall for fourth year

Deborah Josefson *San Francisco*

Applications to medical schools in the United States have declined for the fourth consecutive year, according to a survey sponsored by the Liaison Committee on Medical Education. The committee's questionnaire was completed last year by all 125 medical schools in the United States.

Applications have plummeted since reaching a high of 47000 in 1996. However, they are still well above the low reached in 1988, when only 27000 students applied for admission. Nevertheless, many schools are worried that a trend in falling applications has been established. In the year 2000 there were 37092 applications for the first year class and 17538 acceptances.

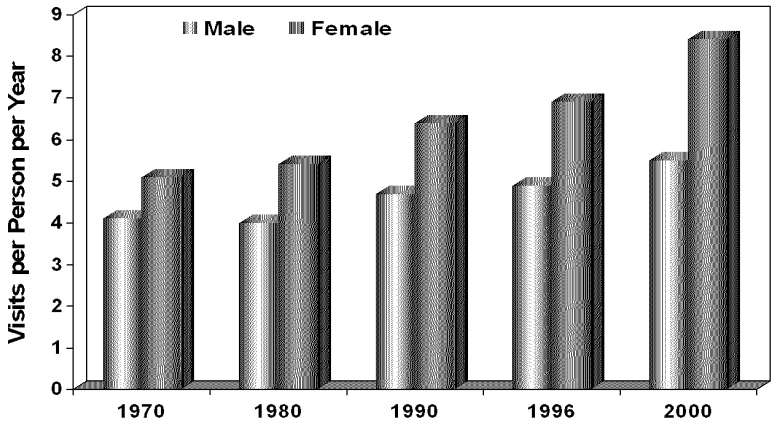
The number of applicants shrank by 3.7% from 1999. Of these applicants, 17274 were women, a 0.9% drop from 1999. But the percentage of women entering the first year of medical school has remained essentially the same, at 46%.

In 2000 the ratio of overall applications to acceptances was slightly greater than 2 to 1, and the grade point averages and scores in the admission tests were virtually identical to those of entering students in 1999 (*JAMA* 2001;286:1049-55).

Among the reasons cited for the decline are the drop in doctors' income, reduced autonomy spawned by managed care, a perceived loss of prestige in the profession, and the long period of training

Trends | Cost Drivers | Employers

Increase in Physician Visits



Source: U.S. National Center for Health Statistics, *Vital and Health Statistics*

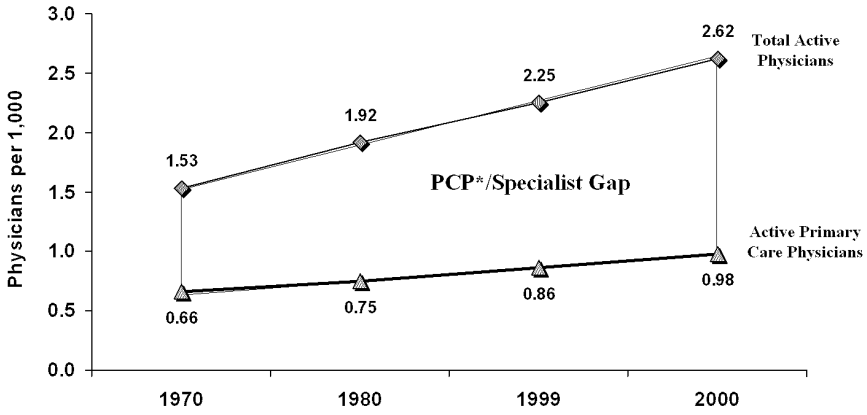
Some of the increase in doctor's office visits can be accounted for by the simple fact that there are more people. But if we look closer, we can see that even accounting for population increase, there is still a steady rise in the average number of office visits per person.

Many plans use office visit copayments to help curtail the number office visits. Studies have shown that in plans without an office visit copayment, frequency of visits is the highest.

These figures are not based on the individual client's claims, but the same trend is occurring here. Getting utilization under control is a major challenge for the coming year. If the number of services continues to escalate, next year's rate increase could be worse than this year's.

Trends | Cost Drivers | Employers

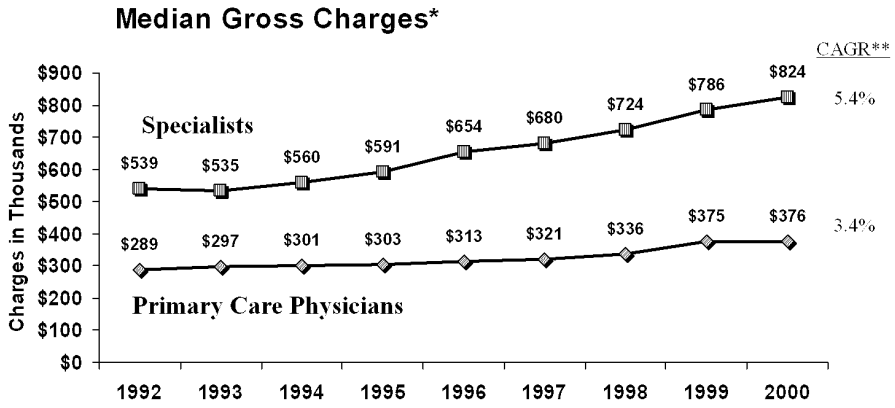
Active Physicians per 1,000 Persons, 1990 - 1999



Source: Lewin Group Analysis of Area Resource File and U.S. Bureau of the Census statistics.

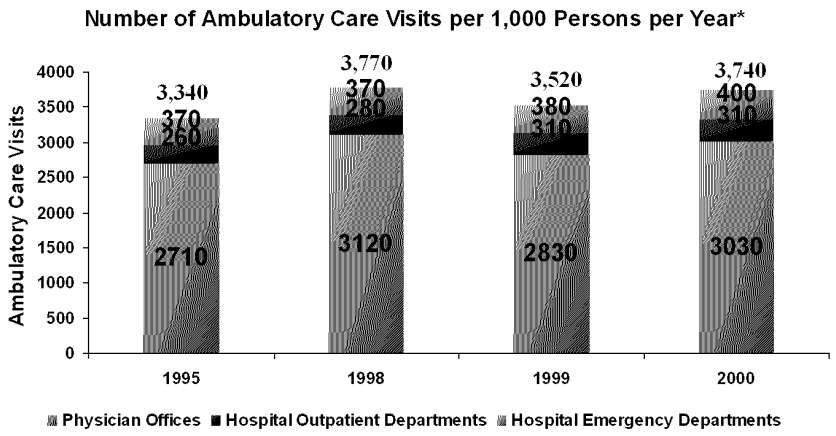
Specialist Charges vs. PCP Charges

Specialists' charges are more than two times higher than primary care physicians' charges, and they are growing at a much faster rate



*Excludes technical charges
**Compound Annual Growth Rate
Source: Medical Group Management Association, 1997, 2001

Eighty Percent of Ambulatory Visits are Made in Physician Offices

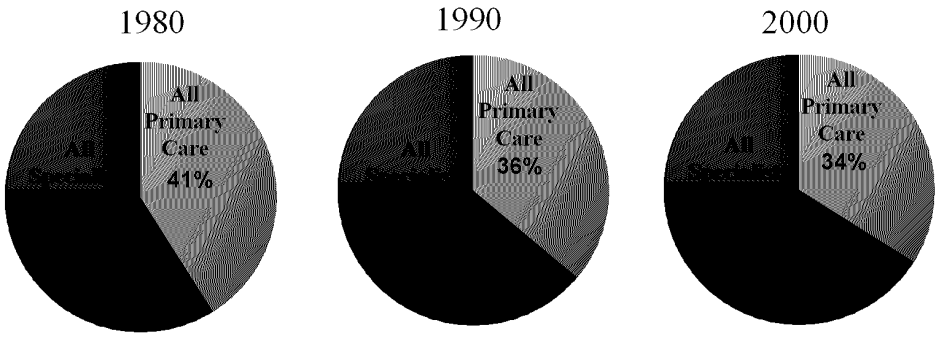


* Age-adjusted
Source: National Center for Health Statistics, 2002

Trends | Cost Drivers | Employers

Specialists Have Increasing Share of Office Visits

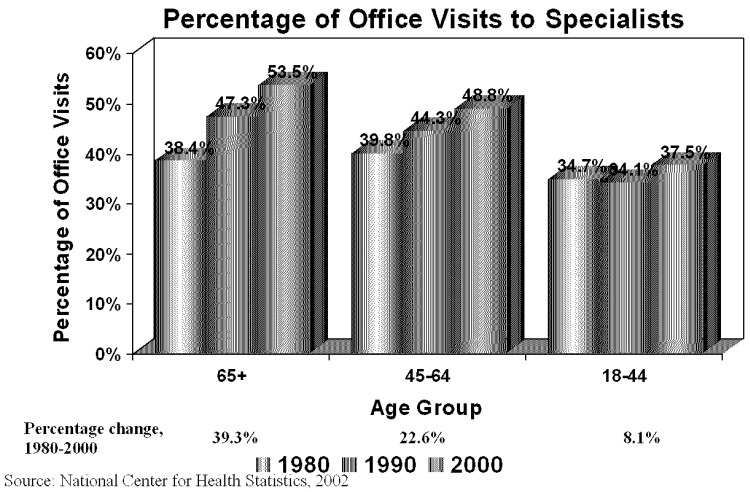
Percentage of Office Visits to Primary Care Physicians and Specialists



Source: National Center for Health Statistics, 2002

Trends | Cost Drivers | Employers

Visits to Specialists Have Risen Faster for Those 65 and Older



Source: National Center for Health Statistics, 2002

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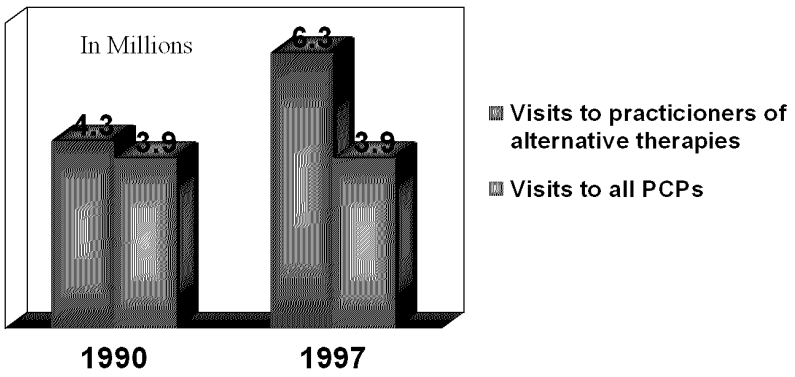
Types of Alternative Care Covered by HMOs (1999)

Alternative Care	% Covered	Alternative Care	% Covered
Chiropractic	65%	Stress Management	4%
Acupuncture	31	Tai Chi	3
Massage Therapy	11	Yoga	3
Vitamin Therapy	6	Biofeedback	2
Relaxation Therapy	5	Naturopathy	2
Herbal Therapy	4	Nutritional Therapy	2
Homeopathy	4	Hypnotherapy	2
Guided Imagery	4	Reflexology	1
Acupressure	4	Meditation	1

Source: VHA, Inc. Health Care 2001: A Strategic Assessment of the Health Care Environment in the United States. New York, NY: Deloitte & Touche LLP. *Note: Respondents could choose up to 5 priorities*

Alternative Therapies vs. PCP Visits



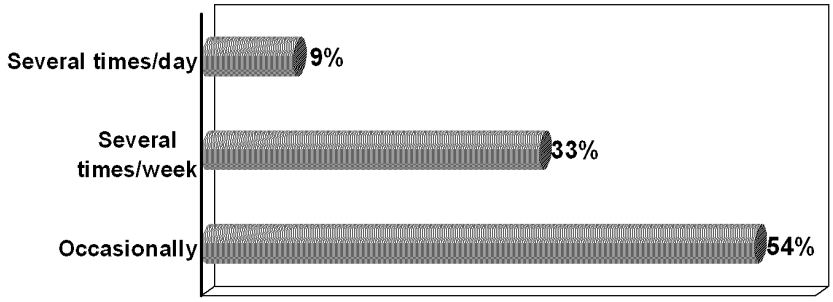
Source: Eisenberg DM, Davis RB, Ettner SL, et al. Trends in alternative medicine use in the United States, 1990-1997. JAMA. 1998;280:1569-1575.

Approaches Patients Use to Pressure Physicians for Treatment

Patient Pressure	Frequency (N)
Explicit request	
Patients directly request antibiotic treatment for problem.	6% (17)
Presenting the chief complaint	
Candidate diagnosis	
Patients report a possible diagnosis.	6 (18)
Implied candidate diagnosis	
Patients report symptoms that index a specific condition.	16 (48)
Portraying severity of illness	
Patients portray sever severe symptoms as well as an inability to conquer this illness on their own.	33 (99)
Appeals to nonmedical circumstance	
Appealing to life-world circumstances	
Patients report an important event that makes the case for it being imperative that they get well quickly.	6 (16)
Previous positive experience with antibiotics	
Patients suggest that they have an illness for which they have gotten an antibiotic in the past. Several variations on this theme were observed.	13 (39)

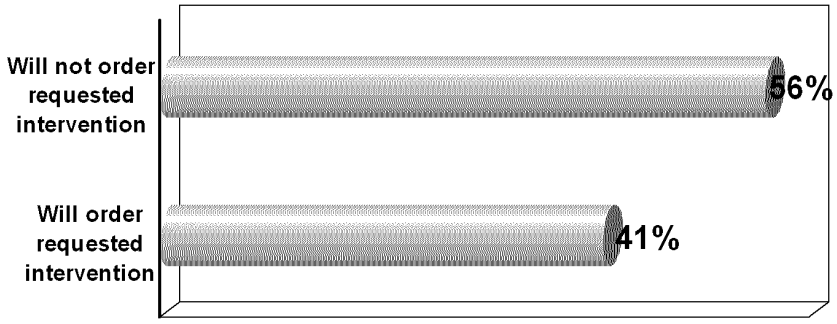
Source: Scott JG. Antibiotic use in acute respiratory infections and the ways patients pressure physicians for a prescription. J Fam Pract. 2001;50:853-858.

Physician Encounters of Patient Insistence on Non–Cost-Effective Care



Source: Sacramento Healthcare Decisions. Cost-Effectiveness as a Criterion for Medical and Coverage Decisions. October 2001.

Physician Reaction to Patient Treatment Insistence



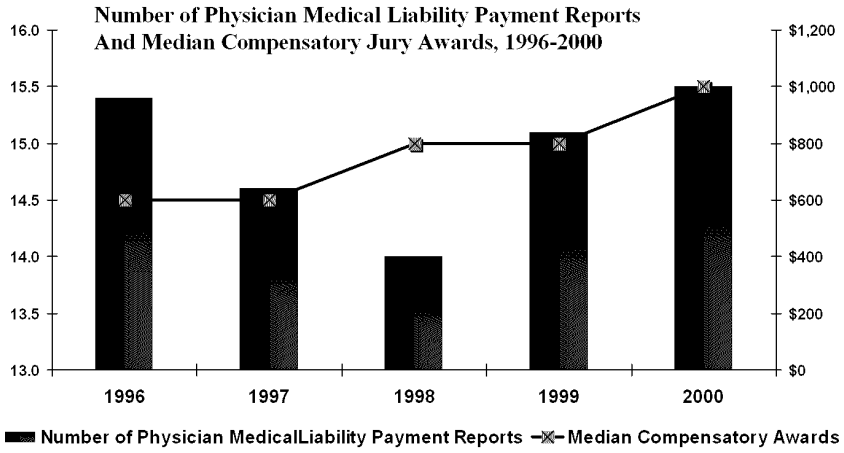
Source: Sacramento Healthcare Decisions. Cost-Effectiveness as a Criterion for Medical and Coverage Decisions. October 2001.

Malpractice Premiums

- Medical malpractice premiums are forcing many doctors to stop practicing high-risk specialties, such as brain surgery, orthopedic surgery, and delivering babies

Trends | Cost Drivers | Employers

The rapid Growth in the Number of Jury Awards is Driving Up the Cost of Medical Malpractice Insurance



Source: Number of Medical Liability Payment Reports; national Practitioner Databank, Annual Report 2000.
Median Compensatory Jury Awards: Jury Verdict Research, Medical Malpractice: Verdicts, Settlements and Statistical Analysis, 2002, as reported by Lewin Group, 2002b

Malpractice Premiums

Top 10 states for the total amount of money paid out by insurers to cover malpractice jury award losses in 2000

State	Total
New York	$632,996,221
Pennsylvania	$352,309,905
Florida	$321,079,744
Illinois	$271,050,075
Texas	$217,518,136
Ohio	$205,148,823
California	$200,832,517
New Jersey	$191,540,088
Massachusetts	$120,874,822
Washington, D.C.	$98,753,106

Source: Pennsylvania Medical Society

Soaring Malpractice Premiums

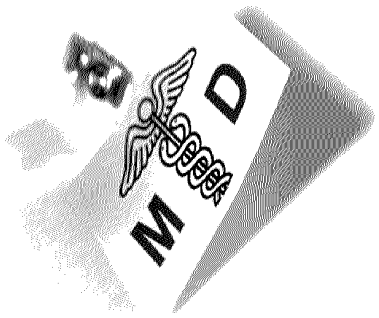
State	Internists	General Surgeons	OB/GYN
Florida	$26,896 - $50,774	$63,189 - $159,166	$143,249 - $202,949
Michigan	$18,376 - $40,233	$66,611 - $94,195	$87,444 - $123,890
Illinois	$15,539 - $28,153	$50,021 - $70,018	$88,928 - $110,091
Ohio	$10,853 - $16,270	$33,39 - $60,021	$58,131 - $95,310

Source: Medical Liability Monitor

Trends	Cost Drivers	Employers

Malpractice Premium Defensive Measures

- Practicing defensive medicine
- Deferring hiring of new staff sparking patient backlogs
- Ceasing to practice certain high-risk specialties
- Moving practices to regions with lower medical malpractice insurance costs



Source: Insure.com, Soaring Malpractice Premiums Bleed Doctors, Rob Consumers, April 3, 2002

Doctors being forced to take defensive measures

•Practicing defensive medicine by ordering additional, sometimes unnecessary medical tests that insurers may be reluctant to pay for

•Deferring the hiring of new staff sparking patient backlogs and making it difficult for patients to get timely appointments

•Ceasing to practice certain high-risk specialties such as obstetricians/gynecologists

•Moving their practices to regions with lower medical malpractice insurance costs. Regions with high liability costs may have difficulty attracting new doctors, creating a lack of consumer choice of physicians.

Trends | Cost Drivers | Employers

Doctors Pay Small Portion of Revenue for Insurance

Malpractice Insurance

	2001 Median Revenue	2001 Median Compensation*	Avg. Paid	Pctg. of Revenue
Cardiologist (surgical)	$731,904	$632,209	$11,008	1.5%
Family Practitioner (non OB/GYN)	$287,239	$146,601	$5,895	2.1%
General Surgeon	$497,633	$257,509	$21,641	4.3%
Internist	$288,494	$149,020	$8,238	2.9%
OB/GYN	$501,634	$231,000	$33,669	6.7%
Orthopedic Surgeon	$678,186	$354,184	$21,030	3.1%
Pediatrician	$321,935	$150,000	$6,628	2.1%

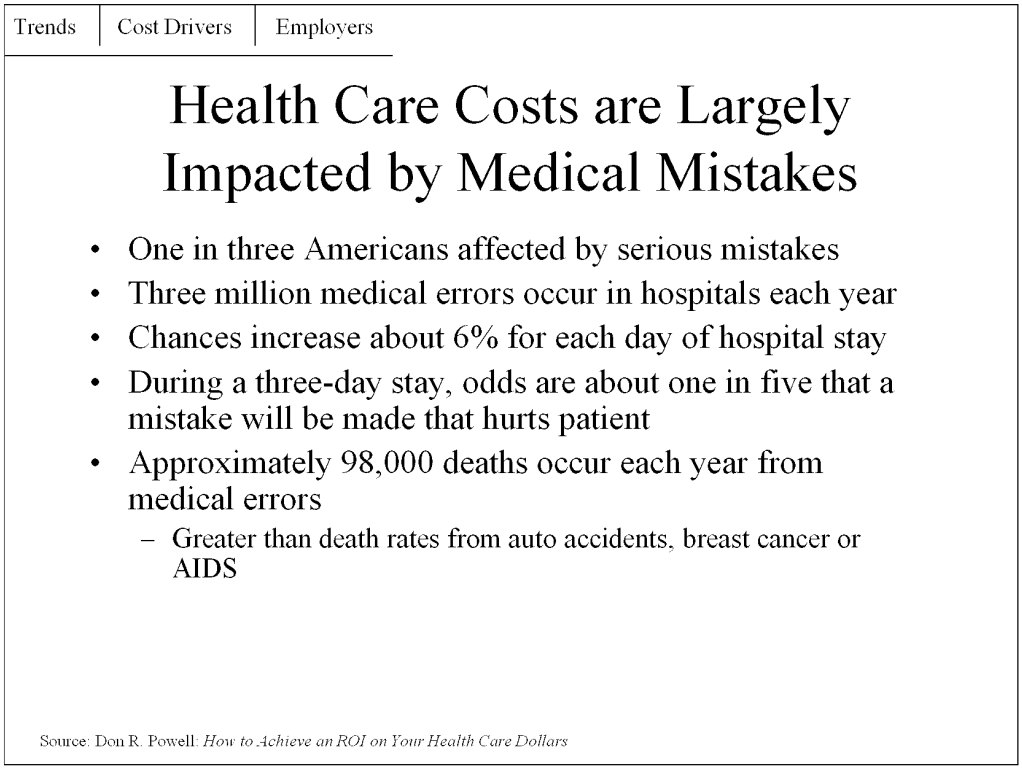
*Pre-tax earnings after all expenses; the median is the point at which half made more , half less
Source: Two surveys of earnings and expenses published by Medical Economics magazine; USA TODAY research

Doctors' malpractice insurance fees vary depending on their specialties and where they practice. The chart shows the average amounts that U.S. doctors paid in 2001 for malpractice insurance as a percentage of revenue.

Unnecessary Surgeries

- Arthroscopic knee surgeries for osteoarthritis which cost an average of $5,000 are reported to be ineffective by the New England Journal of Medicine.
- The Houston Veterans Affairs Medical Center operated on some patients, but only sedated and made minor skin incisions in others.
- Two years later patients in both groups reported less pain and better mobility.

Source: U.S. News & World Report, July 22, 2002



One in three Americans affected by serious mistakes

Three million medical errors occur in hospitals each year

Chances of being injured increase about 6% for each day of hospital stay

During a three-day stay, odds about one in five that a mistake will be made that hurts patient

Approximately 98,000 deaths occur each year from medical errors

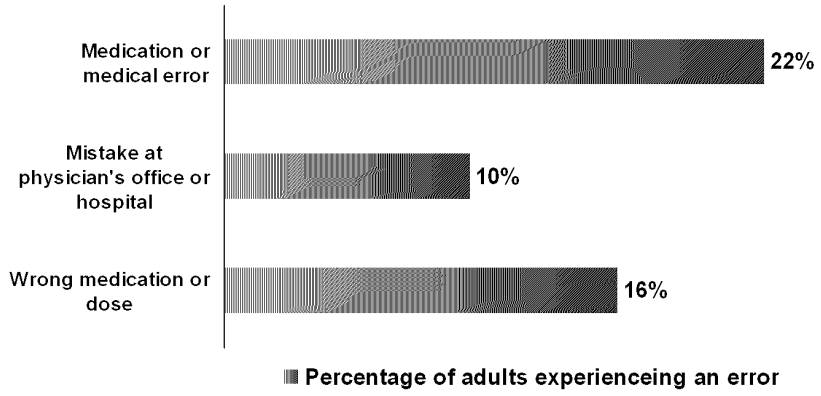
Greater than death rates from auto accidents, breast cancer or AIDS

Types of Medical Errors

Incident	% Citing
Medical mistakes	**42%**
Misdiagnosis or wrong treatment	**40%**
Medication error	**28%**
Mistakes during medical procedure	**22%**

Source: Don R. Powell: *How to Achieve an ROI on Your Health Care Dollars*

Reported Rate of Medical Errors

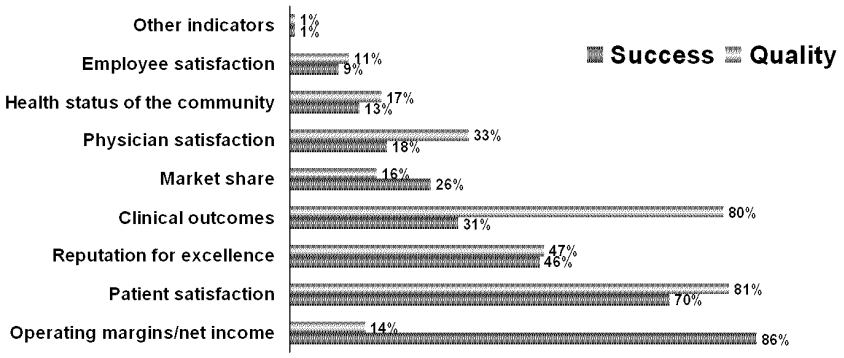


Source: Davis K, Schoenbaum SC, Collins KS, et al. Room for Improvement: Patients Report on the Quality of Their Health Care. New York, NY: The Commonwealth Fund; April 2002.

Why Can't We Define Quality & Benchmark to Standards?

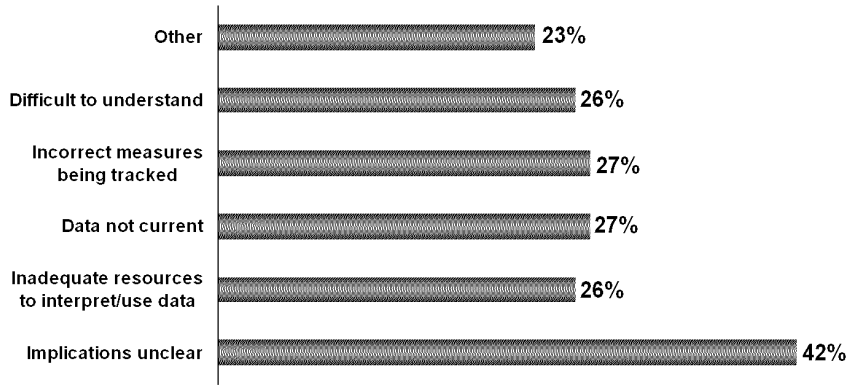
- Variations in care estimated to result in extra cost of 30%
- Best practices examples from Manufacturing
  - Bergstrom
  - Lands' End
  - Manu-tronics, Inc.

Comparison of Success and Quality Indicators



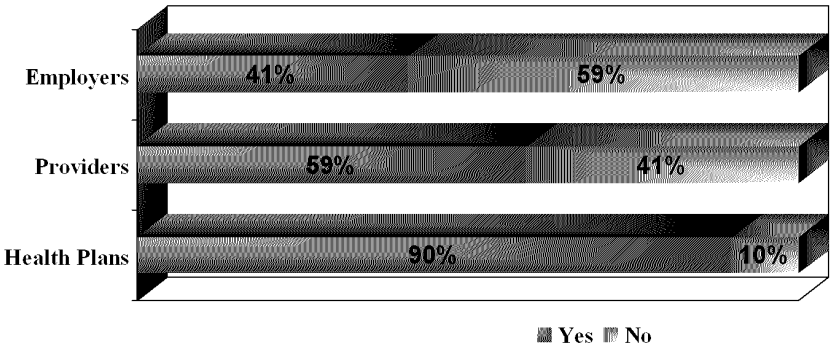
Source: VHA, Inc. Health Care 2001: A Strategic Assessment of the Health Care Environment in the United States. New York, NY: Deloitte & Touche LLP.

Employer-perceived Problems with Quality of Care Information



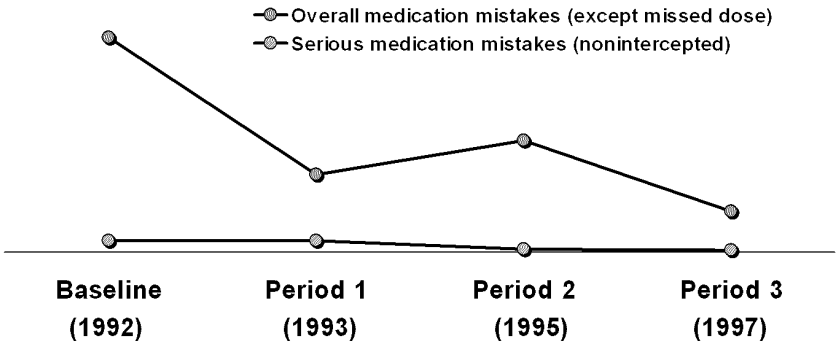
Source: Watson Wyatt Worldwide. Changing Role of Health Care Benefits. A Survey of Employers, Providers, and Health Care Plans. Sixth Annual Survey Report 2001. Washington, DC: Watson Wyatt Worldwide; 2001:1-16.

Are Cost Pressures Hurting Quality?



Source: Watson Wyatt Worldwide. Changing Role of Health Care Benefits. A Survey of Employers, Providers, and Health Care Plans. Sixth Annual Survey Report 2001. Washington, DC: Watson Wyatt Worldwide; 2001:1-16.

Rx Automated Entry Systems Prevent Medication Errors



Source: Leatherman S, McCarthy D. Quality of Health Care in the United States: A Chartbook. New York, NY: The Commonwealth Fund, April 2002.

Quality and Cost Relationship

- Examples of cost of poor-quality care
  - 30% of direct costs = $390 billion per year for 2000
  - $1,700 to $2,000 per employee per year for a typical employer
  - Drug misuse -- > 200,000 deaths and $300 billion per year
  - Overuse of antibiotics -- up to $5 billion per year
  - Inadequate care after heart attack -- 18,000 unnecessary deaths

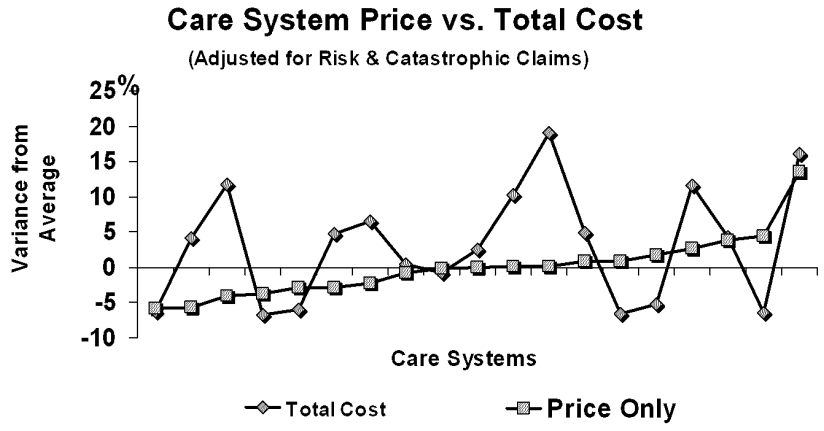
- Purchasers promote poor-quality care by:
  - Contracting on price without examining plan and provider performance
  - Using transaction, rather than outcome based, payment methods
  - Failing to engage the consumer on quality issues

  - "Reducing the Costs of Poor-Quality Health Care" Midwest Business Group on Health, 2002

Source: PatientChoice

Trends | Cost Drivers | Employers

Total Costs And Quality Vary Widely
Price Does Not Predict Cost

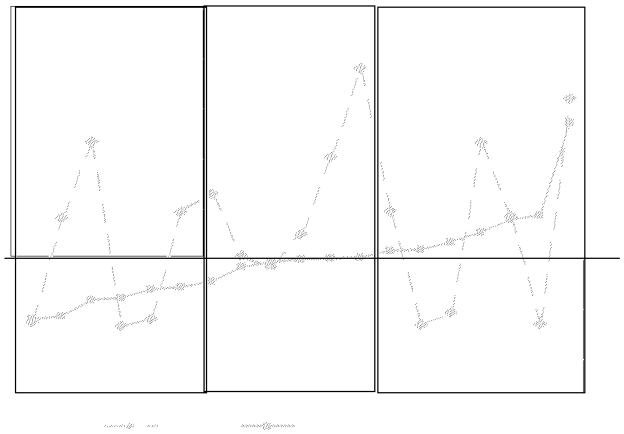


Source: PatientChoice

Each letter represents a care system. Red line includes the relative prices charged by each care system, including hospital and professional fee levels. The dark line includes their actual cost performance which includes both the effect of their fee levels and their risk adjusted, catastrophic adjusted utilization of services.

Trends | Cost Drivers | Employers

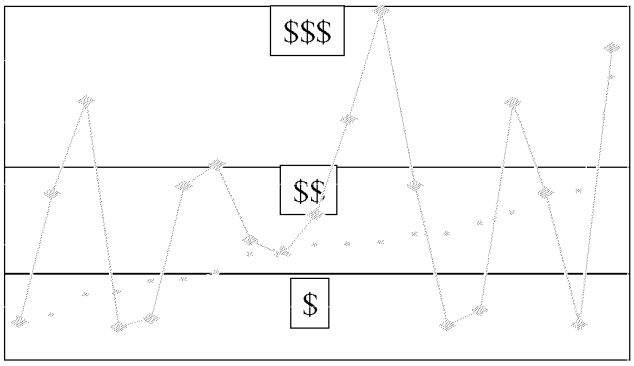
Encouraging Patients to Choose Providers on Price Alone Can Increase Total Cost



Source: PatientChoice

Each letter represents a care system. Red line includes the relative prices charged by each care system, including hospital and professional fee levels. The dark line includes their actual cost performance which includes both the effect of their fee levels and their risk adjusted, catastrophic adjusted utilization of services.

Patient Choice Encourages Provider Choice Based on Total Costs and Quality



Source: PatientChoice

Each letter represents a care system. Red line includes the relative prices charged by each care system, including hospital and professional fee levels. The dark line includes their actual cost performance which includes both the effect of their fee levels and their risk adjusted, catastrophic adjusted utilization of services.

Why Are Rx Costs Rising?

- Aging and less healthy population
- More chronic illnesses diagnosed and treated
- Doctors using wider variety of drugs more often
- Health plans cover more prescription drugs
- New medicines heavily marketed
- New versions of blockbuster drugs

Source: The National Institute for Health Care Management Research and Education Foundation (NIHCM)

•Increase in incidence and prevalence of chronic conditions due to aging and less healthy population

•Doctors diagnosing and treating chronic illnesses at higher rate than in past

•Doctors using wider variety of drugs more often

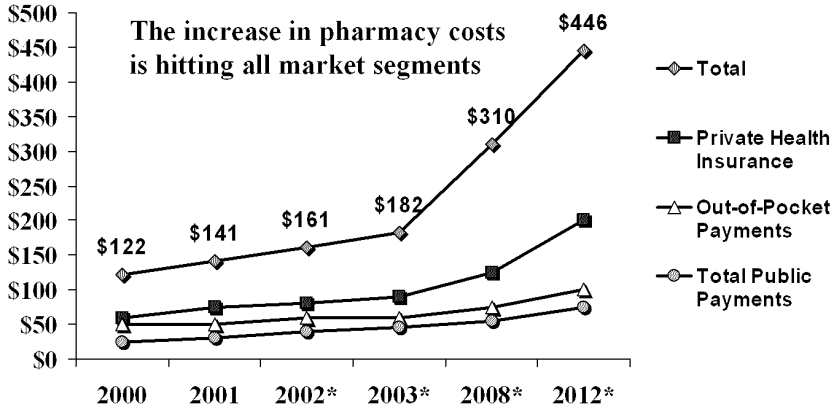
•Managed care health plans covering more costs for prescription drugs than traditional health insurers did a decade ago

•Newly-approved medicines being more heavily marketed to doctors and consumers

•Many brand name drugs companies extending the "franchise" of their blockbuster drugs by spinning off new versions

Trends | Cost Drivers | Employers

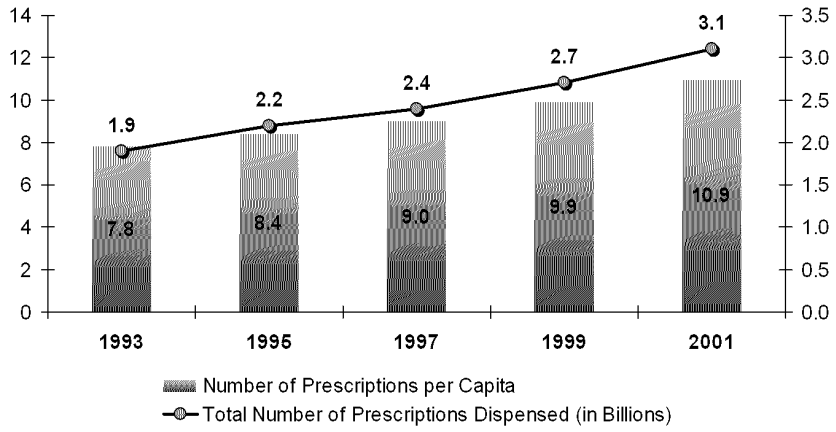
Pharmacy Spending by Payer



*Projected
Source: Centers for Medicare and Medicaid Services, 2003c

Trends | Cost Drivers | Employers

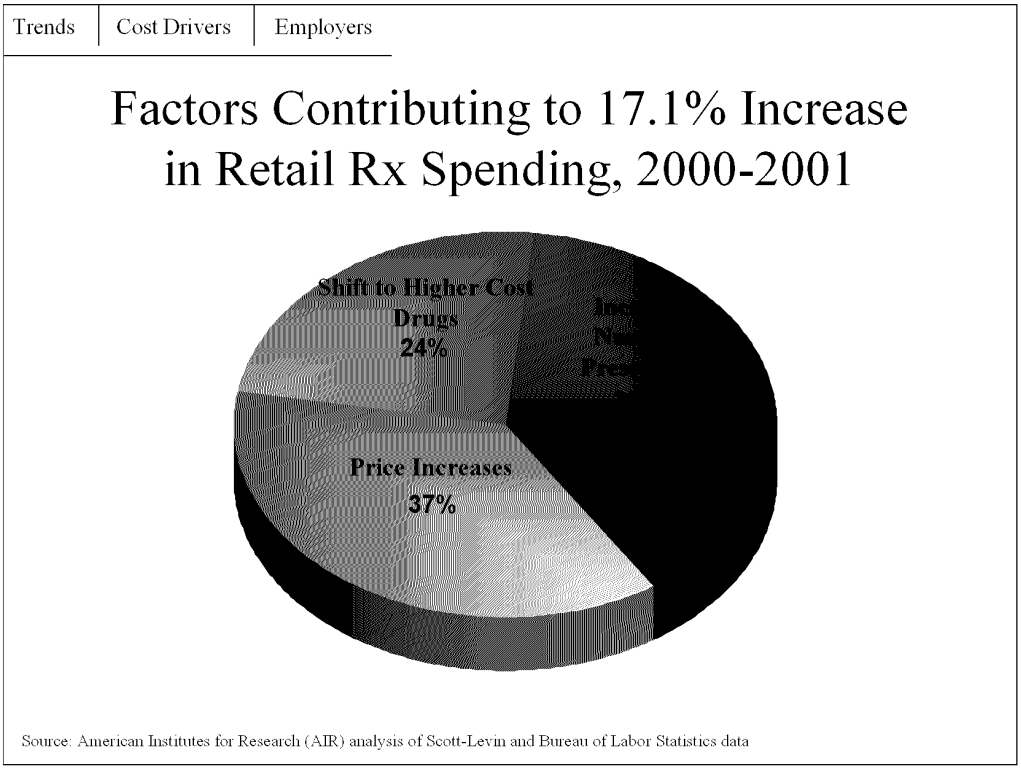
Prescriptions per Capita and Total Prescriptions Dispensed



Source: National Institute for Health Care Management, 2002;
U.S. Census Bureau, 2002.
Blue Cross and Blue Shield Association Analysis.

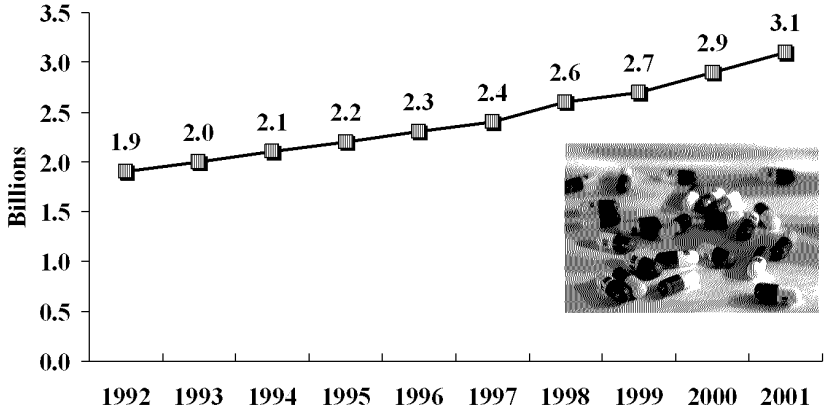
Drivers of Drug Utilization

- Promotional spending
- New medical guidelines
  - May call for more aggressive treatment of disease
- Outpatient setting
  - Drugs covered under pharmacy plan instead of medical plan
- Increased compliance
  - More convenient dosage, increased consumer awareness, fewer side effects
- Off-label use



Factors Contributing to 17.1% Increase in Retail Prescription Drug Spending, 2000-2001

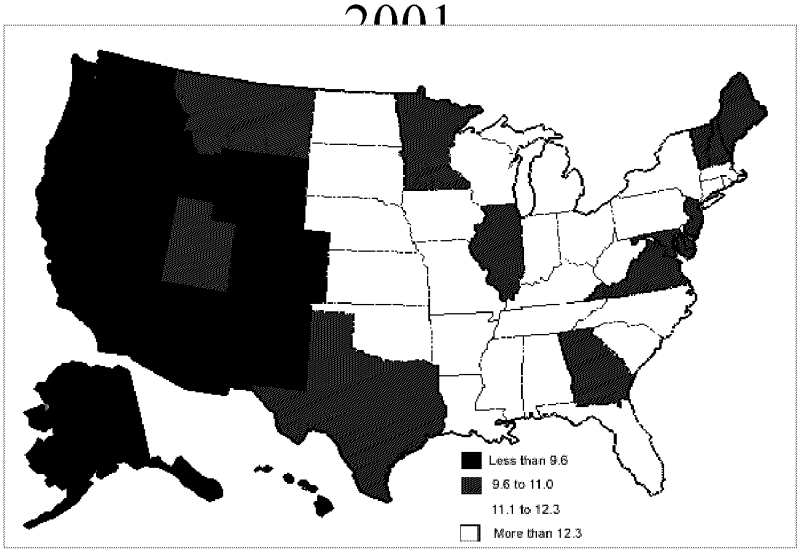
The Number of Retail Prescriptions is Rising Steadily



Source: Sondregger Research Center (University of Wisconsin) analysis of IMS Health Inc. data; American Institutes for Research (AIR) analysis of Scott-Levin data.

Trends | Cost Drivers | Employers

Americans Consumed an Average of 10.9 Prescriptions per Person in 2001

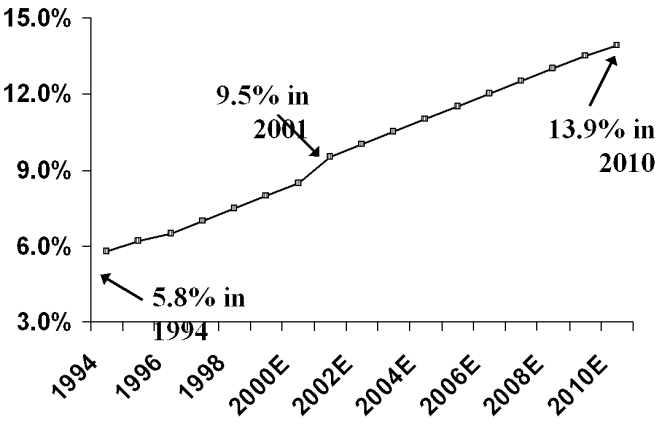


Source: Verispan Scott-Levin, as reported by The Henry J. Kaiser Family Foundation, 2003

reminder for cz: map is stored at: presdept/maps/usamap_plain.tif if needs editing

Prescription Drug Costs

Drug Spending Represents a Growing Proportion of Health Care Costs



Source: Centers for Medicare & Medicaid Services

Prescription Drug Costs

- 17.1% increase in Rx spending in 2001.
- 2001 is 4th consecutive year that increase 17% or more.
- Increases are based on:
  - 39% was the # of scripts
  - 37% was the increase in drug prices
  - 24% was the greater use of higher cost drugs

Source: The National Institute for Health Care Management Research Foundation, 2001

Three-year Drug Trend Projections

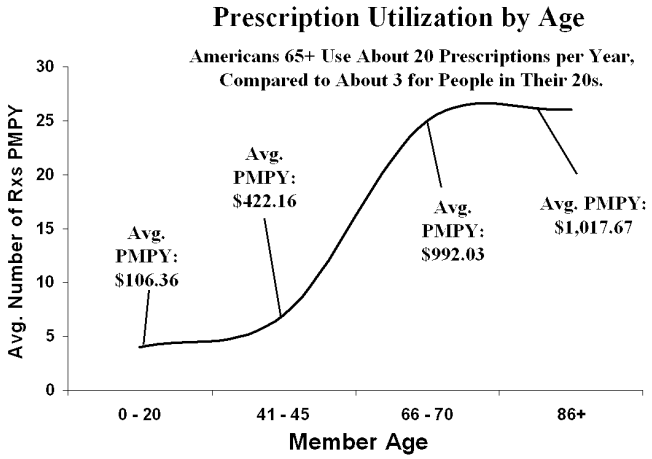
Total Average Wholesale Price per Member per Year

	2003	2004	2005
Utilization increase	6% - 8%	7% - 9%	7% - 9%
Price and mix increase	8% - 9%	7% - 9%	7% - 9%
Annual total	14% - 17%	14% - 18%	14% - 18%

Source: Medco Health data

Utilization: Change in the number of users of prescription therapy and the amount of therapy per year
Price: Change in unit cost of drugs
Mix: Change in cost due to shifting market share among drugs in the same category, often to newer, higher-cost drugs and dosage forms or higher strengths of the same drug

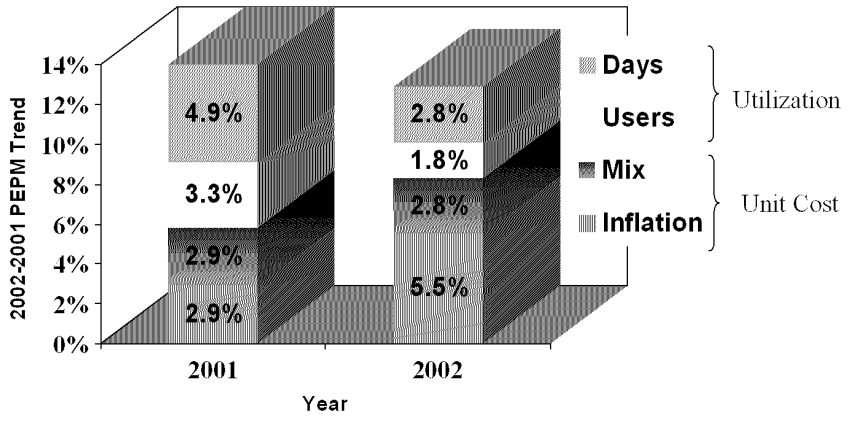
Prescription Drug Costs



Source: AdvancePCS Benefits Barometer, 2002.

Trends | Cost Drivers | Employers

Changes in Trend Drivers Over the Last Year



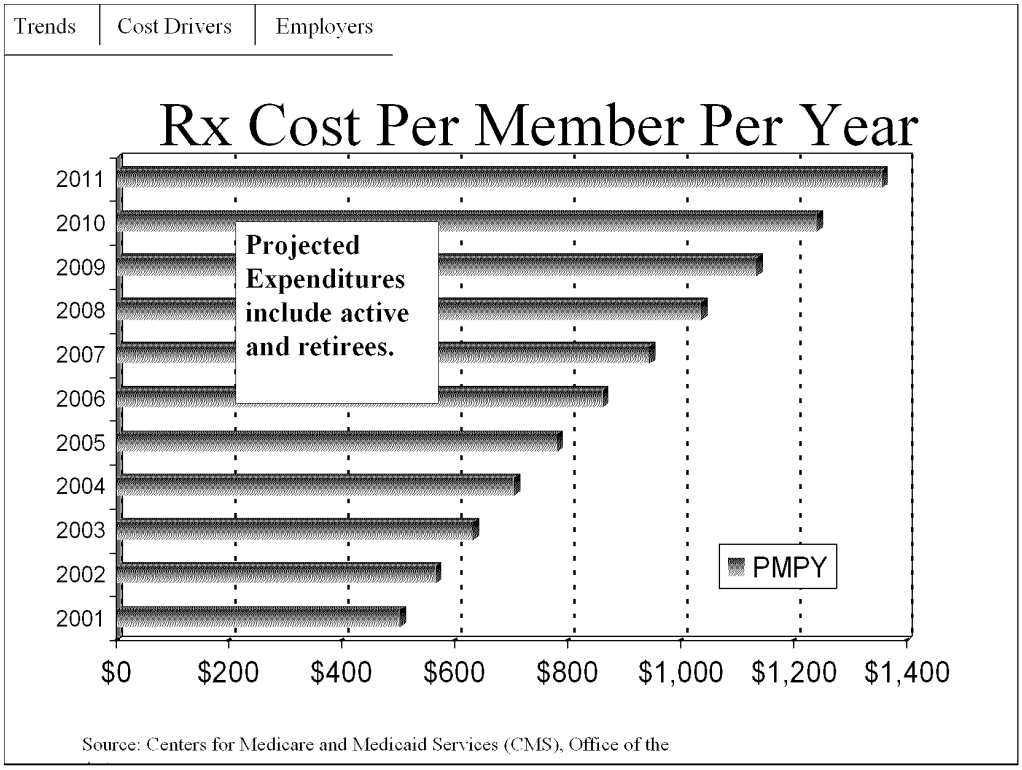
Source: Medco Health data

US Commercial Rx Costs

	PMPM*	% Change
2002	$27.79	+12.5%
2001	24.70	+18.8
2000	20.80	+27.8
1999	16.27	+25.6
1998	12.95	+12.5
1997	11.51	+3.1
1996	11.16	+5.6
1995	10.57	N/A

*$7 Generic, $15 Brand, $30 Non-Formulary Copay

Milliman 2002 HMO Intercompany Rate Survey



While specialists and an 800# are the predominant service delivery methods today, the future will be a combination of high-tech delivery via web-based self service with human touch delivered via an 800#.

Prescription Drug Costs

- 90% of Commercial HMOs managed to decrease pmpm pharmacy expense in 2002.
- Between 2001 and 2002, averaged a $3.16 pmpm drop, or 9% of Rx costs.
- One of the chief mechanisms for this reduction is consumer co-pays.

Source: InterStudy Competitive Edge 13.1 Industry Report

Trends | Cost Drivers | Employers

Rising Costs in Healthcare

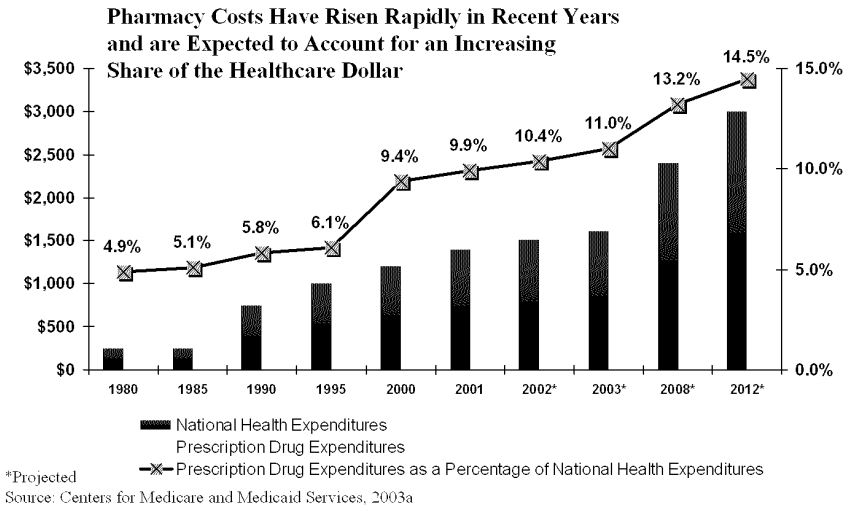
Prescription Drug Costs per Member per Year

(Wholesale Prices 1995-2004)

*Projected

Source: VHA, Inc. Health Care 2001: A Strategic Assessment of the Health Care Environment in the United States. New York, NY: Deloitte & Touche LLP.

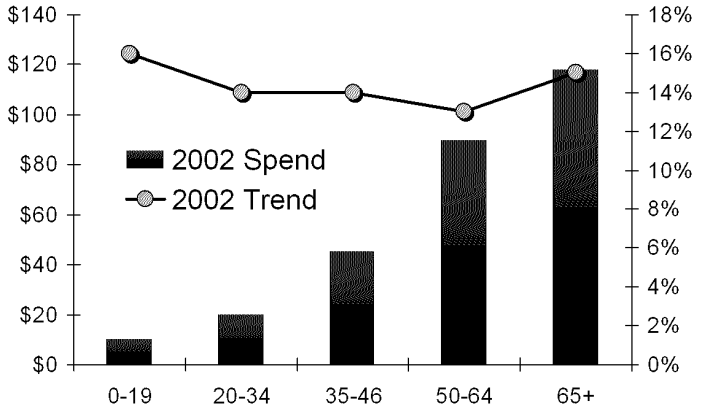
Pharmacy Costs and Growth Rate



*Projected

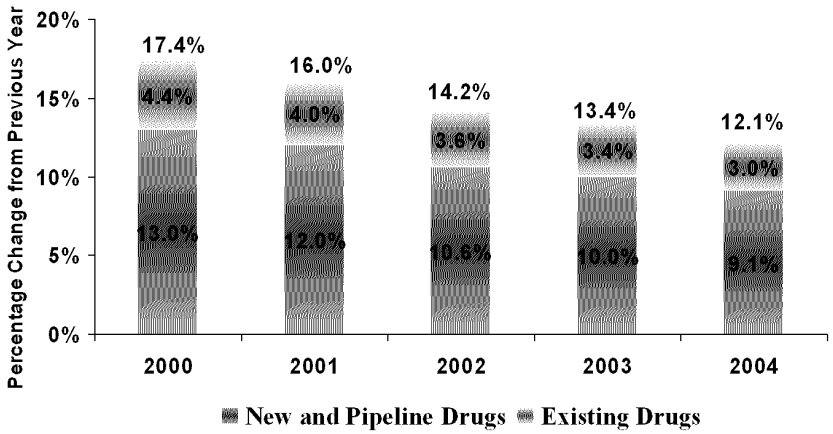
Source: Centers for Medicare and Medicaid Services, 2003a

Drug Spend and Trend by Age per Member per Month (PMPM), 2002



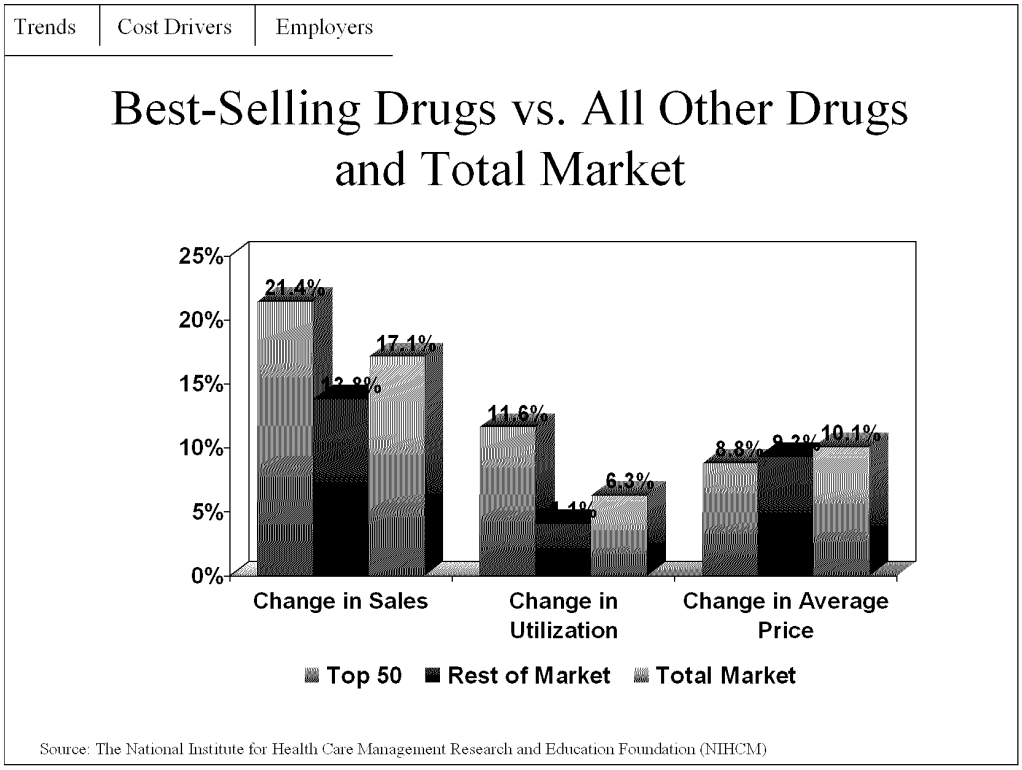
Source: Medco Health data

Drug Spending Growth*



*Extrapolated from Centers for Medicare and Medicaid Services projections, based on 75.3% growth in prescription drug expenditures due to new drugs between 1995 and 1998.

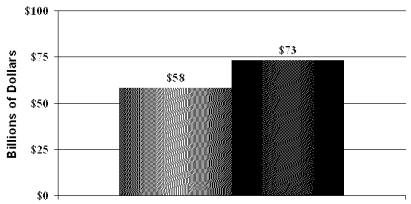
Source: Centers for Medicare and Medicaid Services; Mullins et al, 2002; Blue Cross and Blue Shield Association Analysis.



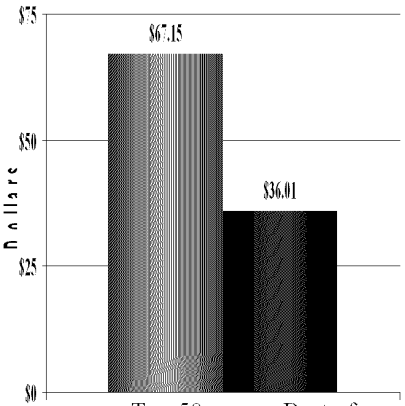
Comparison of 50 Best-Selling Drugs to All Other Drugs and Total Market

Trends | Cost Drivers | Employers

Challenge: Use of Higher Cost Drugs



Top 50 Sales | Rest of Market Sales

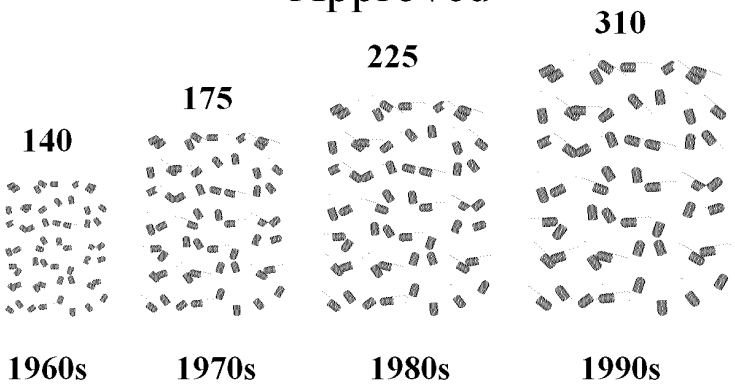


Top 50 Average Price | Rest of Market Average Price

Source: National Institute for Health Care Management: Prescription Drug Expenditures in 2000.

Drivers: New Medications Keep Coming

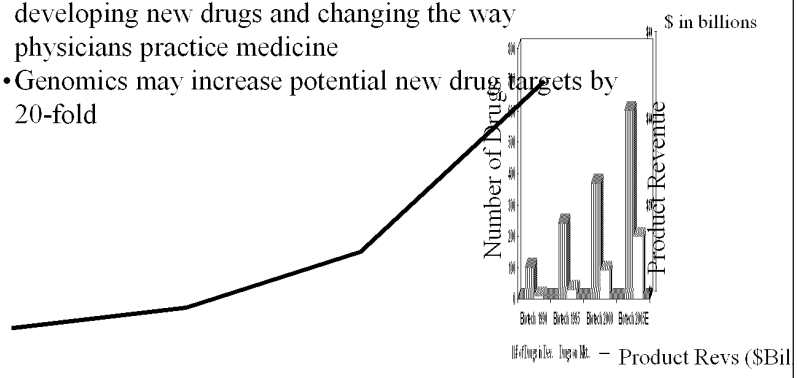
Number of New Molecular Entities Approved



Source: U.S. Food and Drug Administration, 1999.

Biotech Revolution

- Biotechnology companies are a dominant force in developing new drugs and changing the way physicians practice medicine
- Genomics may increase potential new drug targets by 20-fold

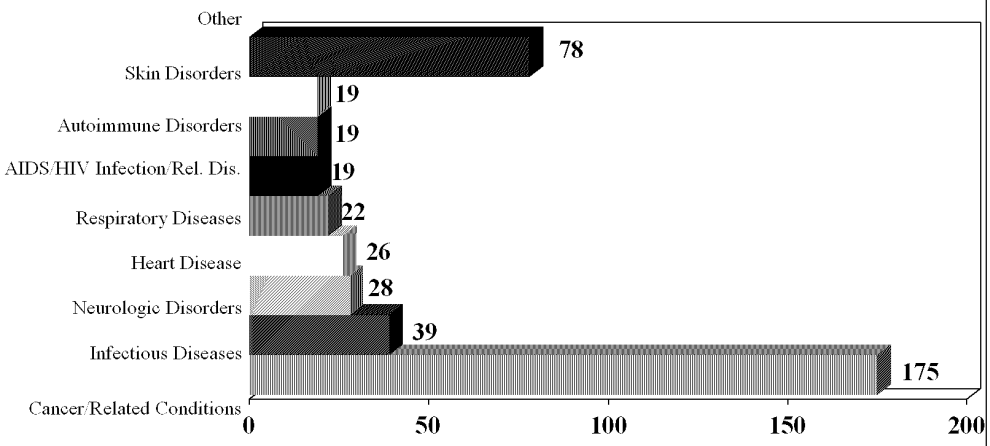


Source: Wall Street Journal research data and estimates, 2002

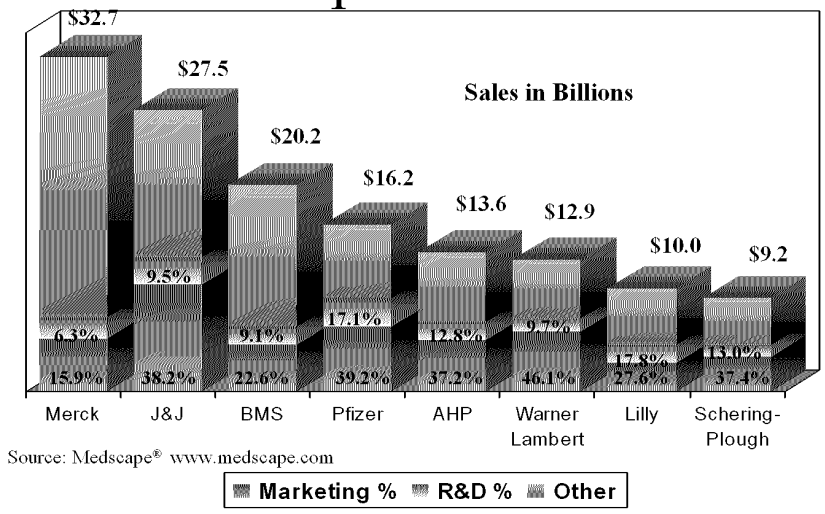
Trends | Cost Drivers | Employers

The Impact of Biotech Development

Number of Drugs in the Development Pipeline

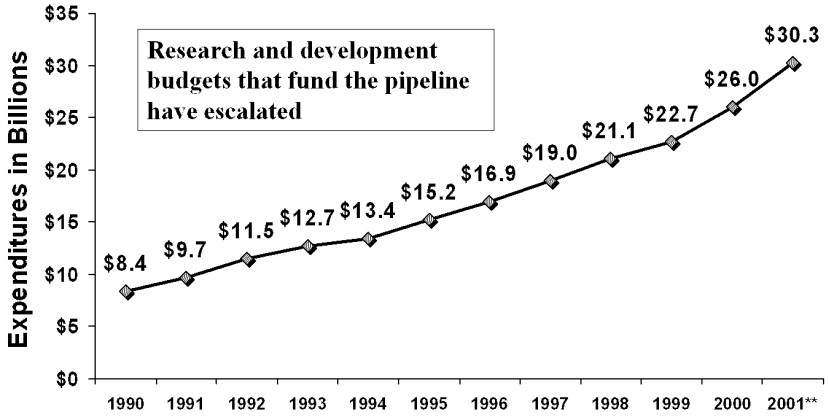


Pharmacy Marketing and R&D Expenses



Trends | Cost Drivers | Employers

R&D Expenditures*



*Data fro PhRMA member companies
**Projected
Source: Pharmaceutical Research and Manufacturers of America, 2001

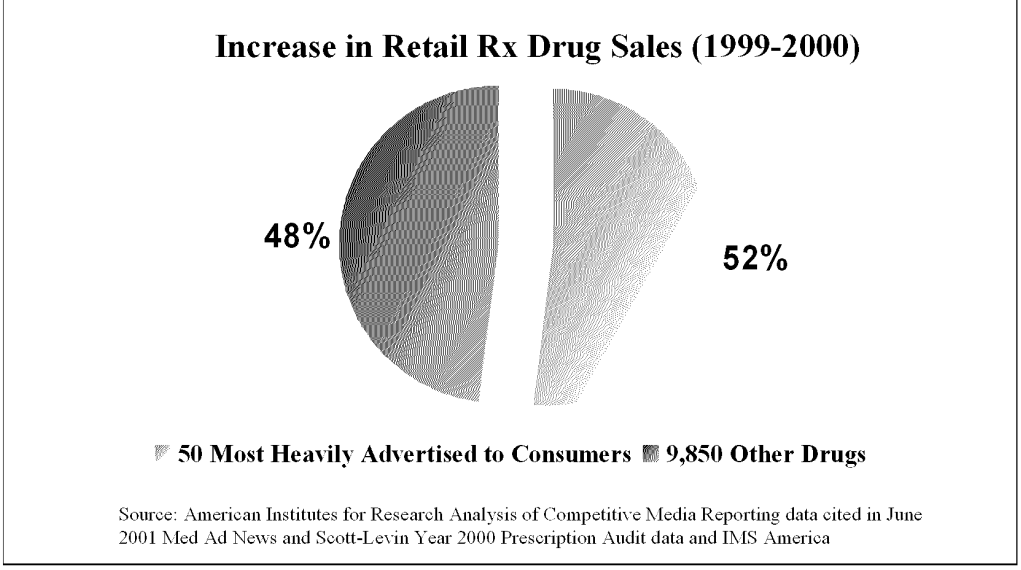
Pharmaceutical R&D Expenses

Company	R&D Expense[1] (in millions)	% of Revenue Spent on R&D[1]
Millenium Pharmaceuticals	$478.9	154%
GlobeSpanVirata	$157.2	67%
Ciena	$239.6	66%
Cirrus Logic	$158.4	51%
Broadcom	$454.4	45%
Cypress Semi	$295.7	37%
Lattice Semi	$81.4	36%
Adaptec	$133.4	33%
Biogen	$360.1	32%
MarvellTech	$130.5	30%

1 – most recent 12 months of reported revenue; includes only companies with revenue of $200 million or more

Sources: *USA Today* research, Multex

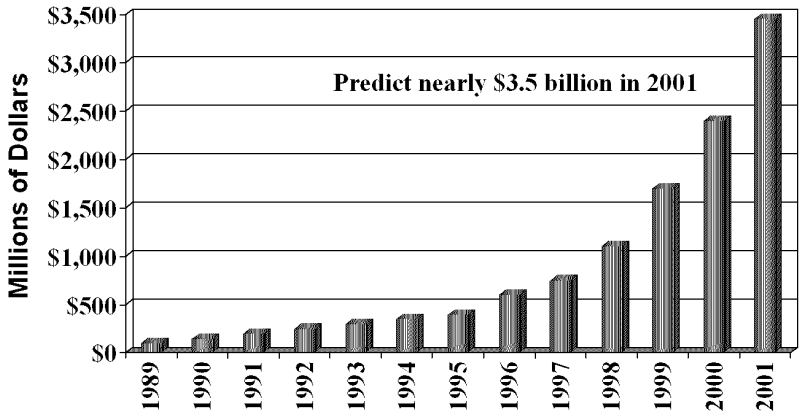
Effects of DTC Advertising



Source: American Institutes for Research Analysis of Competitive Media Reporting data cited in June 2001 Med Ad News and Scott-Levin Year 2000 Prescription Audit data and IMS America

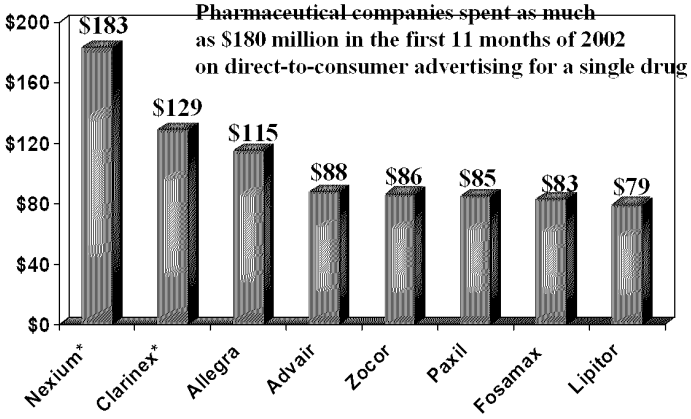
Spending on mass media advertising of prescription drugs rose 35% from 1996 to 2000 – from $791 million to $2.5 billion

Direct-to-Consumer Advertising



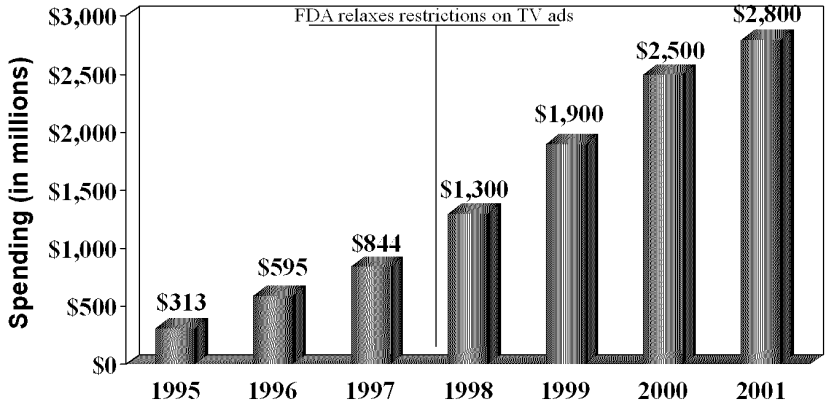
Source: Competitive Media Reporting and IMS America Ltd.

Spending on Direct-to-Consumer Advertising, January-November 2002



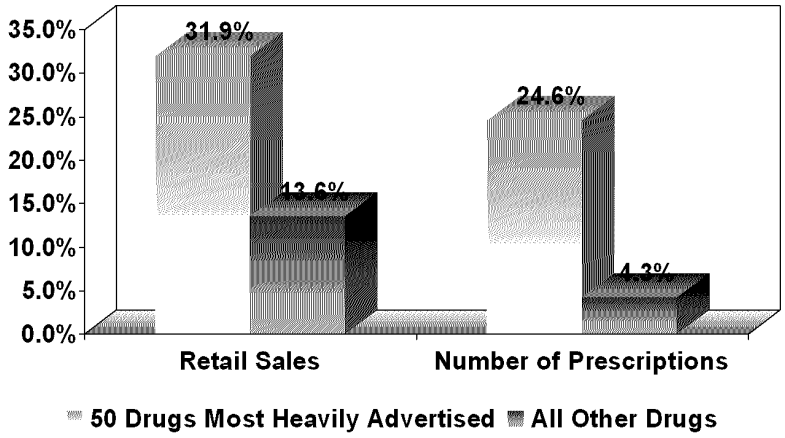
*These drugs have been promoted to replace very similar drugs (Prilosec and Claritin) that have recently lost patent protection.
Source: CMR/TNS Media intelligence and Publishers Information Bureau, 2003.

DTC Promotional Spending from 1995 through 2001



Source: IMS Health, Inc., as published in *The New York Times*, June 13, 2002

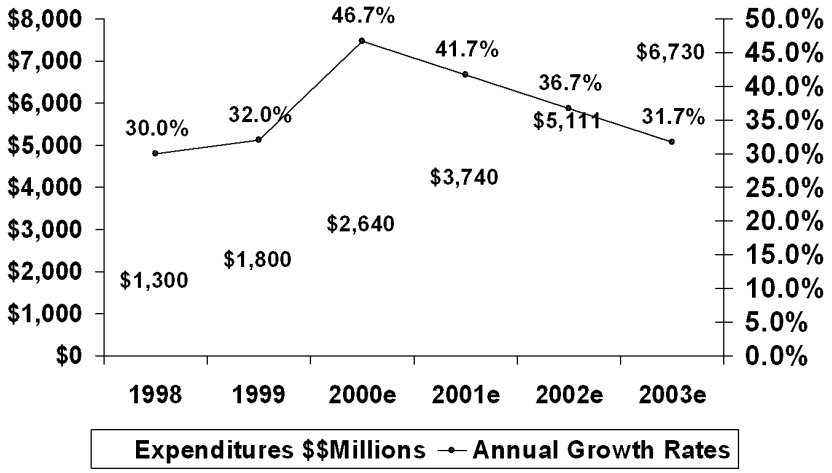
Direct to Consumer Advertising Affect on Rx



Source: American Institutes for Research Analysis of Competitive Media Reporting data cited in June 2001 Med Ad News and Scott-Levin Year 2000 Prescription Audit data

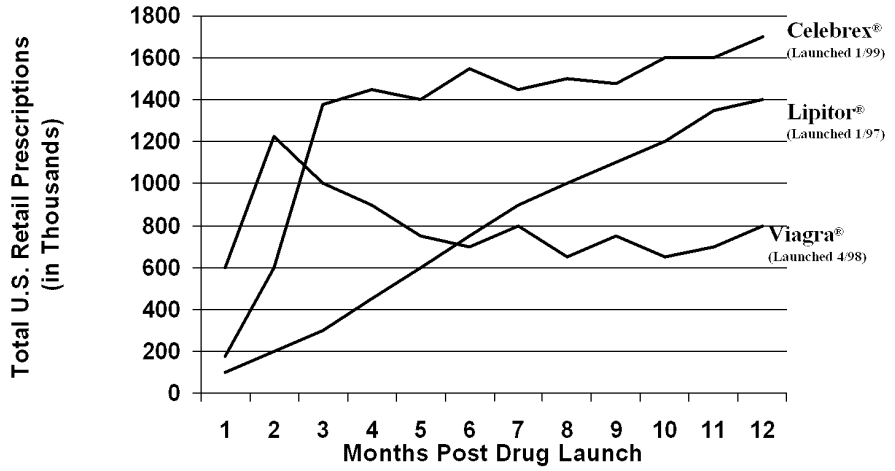
Trends | Cost Drivers | Employers

Direct to Consumer Advertising



Trends | Cost Drivers | Employers

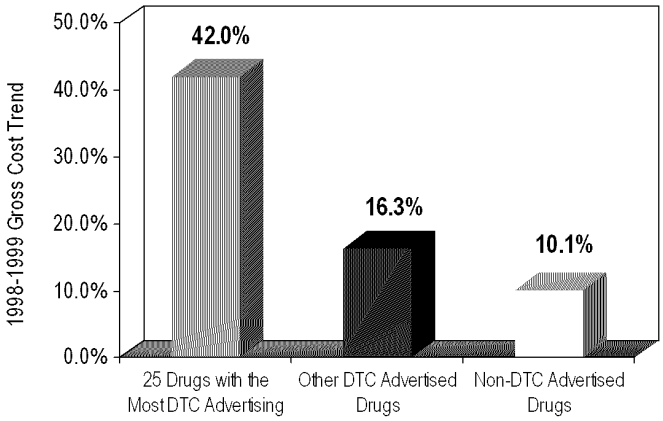
Blockbuster Drug Sales Comparison



Source: IMS Health, National Prescription Audit Plus

Monthly U.S. Retail Prescriptions from Month of Launch

Effect on Direct to Consumer Advertising on Rate of Rx Cost Increases



Source: Merck-Medco 2001 Drug Trend

Increase in Retail Drug Spending, 2000-2001

- Increased spending on small number of individual drugs and categories of drugs
  - 50.6% occurred in nine categories
    - depression, high cholesterol, diabetes, arthritis, high blood pressure, pain, allergies, ulcers and other GI ailments
  - Antidepressants top-selling category
    - $12.5 billion in retail sales, up 20.2%
  - 50.5% of increase were sales for 27 individual drugs including:
    - Lipitor, Imitrex, Fluoxetine, Zocor, Vioxx, Nexium, Advair, Protonix, OxyContin, Zyprexa, Celexa, Actos, Celebrex, Prevacid

Source: The National Institute for Health Care Management Research and Education Foundation (NIHCM)

Factors Contributing to 17.1% Increase in Retail Prescription Drug Spending, 2000-2001

•$22.5 billion in 2001 largely attributable to increased spending on relatively small number of individual drugs and categories of drugs

- •50.6% occurred in nine categories of drugs – depression, high cholesterol, diabetes, arthritis, high blood pressure, pain, allergies, ulcers and other GI ailments
- •Antidepressants top-selling category, with $12.5 billion in retail sales, up 20.2%
- •50.5% of increase were sales for 27 individual drugs including:
  - •Lipitor, Imitrex, Fluoxetine, Zocor, Vioxx, Nexium, Advair, Protonix, OxyContin, Zyprexa, Celexa, Actos, Celebrex, Prevacid

Retail Drug Expenditures by Therapeutic Category

Rank	Type of Drug	2001 Sales (millions)	2001 Average Price per Prescription	Percent Change in Sales 2000-2001
1	Antidepressant	$12,540.6	$73.16	20.2%
2	Antiulcerant	$10,812.0	$109.04	14.4%
3	Cholesterol Reducer	$10,066.1	$88.41	22.2%
4	Broad Antibiotic	$8,493.9	$35.43	8.8%
5	Antiarthritic	$7,155.8	$64.37	15.6%

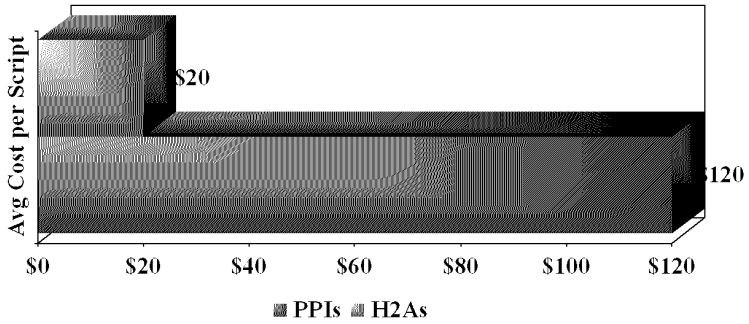
Source: American Institutes for Research (AIR) analysis of Scott-Levin data

Top 5 Drugs Ranked

Rank	Name of Drug	Type of Drug	2001 Sales (millions)	2001 Average Price per Prescription	Percent Change in Sales 2000-2001
1	Lipitor	Cholesterol Reducer	$4,571.5	$84.96	22.3%
2	Prilosec	Antiulcerant	$3,999.0	$143.68	-2.5%
3	Prevacid	Antiulcerant	$3,195.8	$133.20	12.8%
4	Zocor	Cholesterol Reducer	$2,739.2	$120.82	24.1%
5	Celebrex	Antiarthritic	$2,387.2	$97.32	18.4%

Source: American Institutes for Research (AIR) analysis of Scott-Levin data

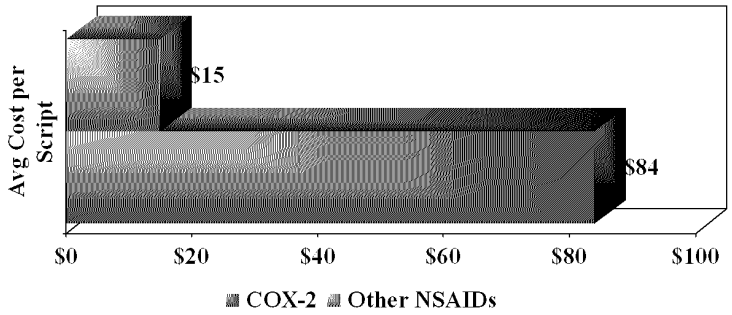
Gastrointestinal Medication



- Histamine-2 Receptor Antagonists (H2As)
  - –cimetidine, rantidine, famotidine, Axid
- Proton Pump Inhibitors (PPIs)
  - –Prevacid, Protonix, Prilosec, Nexium, Aciphex

Source: CIGNA Healthcare, Clinical Pharmacy Program Update, 2002-2003

Nonsteroidal Anti-inflammatory Medication

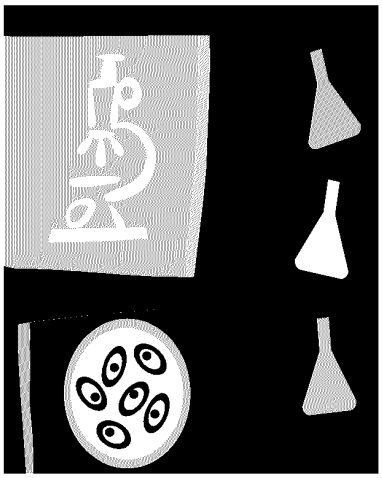


- COX-2
  - –Celebrex, Vioxx, Bextra
- Other Nonsteroidal Anti-inflammatory
  - –Traditional agents for arthritis, headache, pain, etc

Source: CIGNA Healthcare, Clinical Pharmacy Program Update, 2002-2003

New Cholesterol Guidelines

- Revised guidelines
- More prescriptions
- Reduction in health care costs



Source: AdvancePCS Fall 2001

The National Institutes of Health recently revised its clinical guidelines for the prevention and management of high cholesterol.

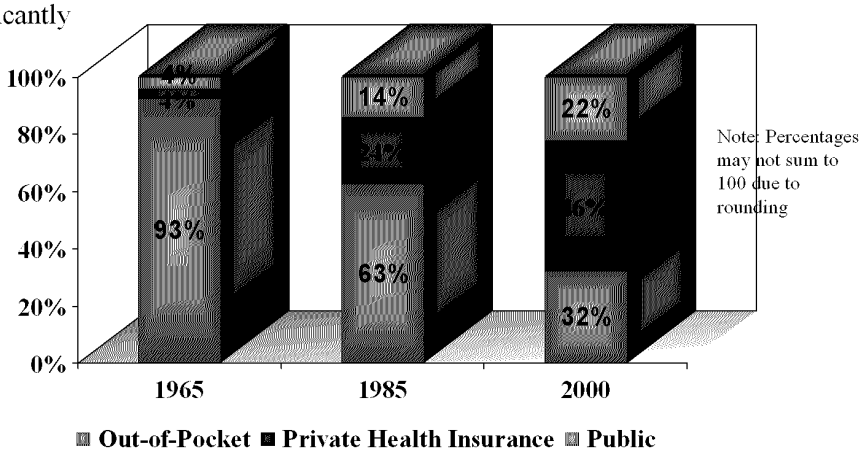
Guideline changes include reduced threshold levels at which cholesterol should be treated.

With the new guidelines, we expect more patients will have prescriptions for cholesterol-lowering drugs. This will expand the number of Americans receiving treatemnt from 13 million to 56 million, tripling drug sales to nearly $30 billion a year.

Although we expect overall drug spend for statins to rise with increased utilization, we also anticipate an overall reduction in health care costs from earlier detection and treatment, resulting in a decline in hospitalizations and emergency room and office visits.

Spending for Rx Drugs by Source of Funds, 1965-2000

The share of drug spending covered by public and private sources has grown significantly

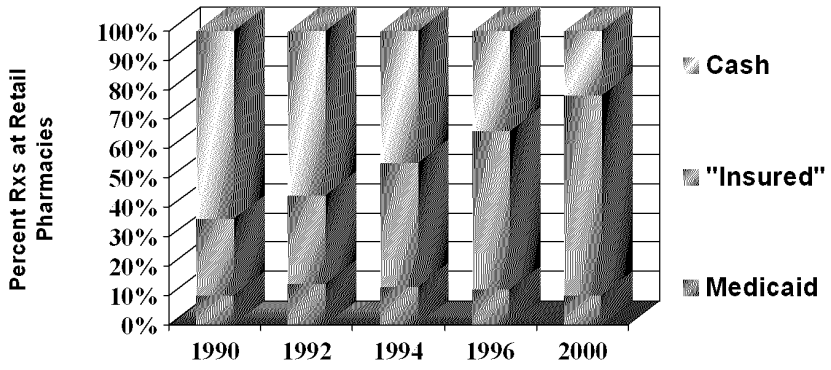


Note: Percentages may not sum to 100 due to rounding

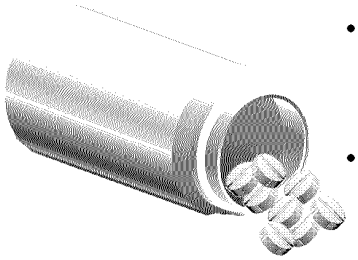
Source: CMS, Office of the Actuary, National Health Statistics Group

Trends | Cost Drivers | Employers

Rx Challenge: Who is Paying?



Out-of-Pocket Costs Drop



- Americans will pay for just a fourth of their prescription drugs out of their own pockets this year
- Most are paid for by insurance or state and federal programs

1970	82%
1980	66%
1990	48%
2001[1]	25%

1 – Projection

Source: Health Care Financing Administration

Government Mandates

- There are over 1,400 separate health care mandates at the state and federal levels. Some of the better known federal mandates are:
  - ERISA
  - COBRA
  - HIPAA
  - Mental Health Parity Act
  - Newborn and Mothers Healthcare Prevention Act
  - WHCRA
- It is estimated that mandates add 8-22% to the cost of health care

Government Mandates – Cost Shifting

Two Bed Hospital

	Year One	Year Two	Increase
Cost/Bed Day	**$100**	**$110**	**10.0%**
Government Paid	**$90**	**$93**	**3.3%**
Cost to Private Pay	**$110**	**$127**	**15.5%**

Now let's return to our cost increase slide and I'll talk about some other reasons for health care cost increases.

Technological Advances

As a result of advances in technology and greater expectations of patients, providers are stepping up their use of costly diagnostic and clinical procedures, such as bypass operations, which are now widely accepted. Large claims are also on the rise. Exotic procedures such as intestinal transplants, and the great advances in helping premature babies survive contribute to costs. Technological advances are helping to improve lives and save lives. Most people would not want to halt or slow these advances. Therefore, we need to accept that increased cost comes along with these advances.

Market Pressures

Looking at nationwide market pressures, it is apparent that there are more and more hospitals and insurance plans which are becoming for profit. Once a company becomes for profit, there is naturally pressure on the organization to make a profit. Insurance companies and HMOs are pulling out of areas where they cannot make enough money, and they are discontinuing plans where costs are too high. There are also more companies and hospital chains merging. This leads to fewer companies competing for business, and when that happens, costs go up.

Uninsured People

Surveys have shown that there are approximately 44 million uninsured people in the United States. An even higher number are probably under-insured. The number of uninsured people may seem unrelated to the health insurance premiums here at OSI, but they are. Think about it. People who are uninsured still require medical care, but often they will wait to get that care until there is a crisis. Hospitals and doctors provide the treatment, and the costs get passed along to everyone who pays privately or through insurance. People like you, and others with private employer-sponsored health insurance are helping to pay for the uninsured.

Government Mandates

Government mandates add to the cost of your insurance. Mandates are issued at both the federal and state level. Examples of these at the federal level are COBRA, HIPAA, WHCRA, and the Mental Health Parity Act. For example, the Women's Health and Cancer Rights Act finally forced insurance plans to cover surgery and hospitalization for breast reconstruction following mastectomy. For a woman faced with a mastectomy, being covered for reconstructive surgery is extremely important. All you need to do is imagine yourself, your wife or your mother needing the reconstructive surgery, and you will probably agree it's a good law. However, providing coverage for breast reconstruction comes with a price. As consumers of medical care, we need to be willing to accept that if we want the government to push insurers to offer more benefits, we must be equally willing to help pay for those increased benefits.

What Can Employers Do?

What's Wrong with the Current Picture?

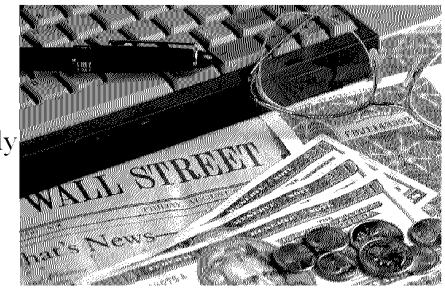
- The consumer is insulated from the cost of services
  - Why care when you don't pay for it?
- Current co-pay levels are meaningless – it costs more to go to a movie than a doctor

"Nobody spends someone else's money as carefully as they spend their own."

– Milton Friedman

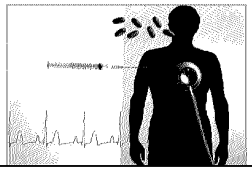
Keys to Success in Managing Health Care Costs

- **Understand:**
  - Market direction,
  - Human Resources
  - Healthcare
  - Business direction, and
  - Adjust strategy accordingly
- **Know what drives:**
  - Employee behavior,
  - Satisfaction, and
  - Financial efficiency.



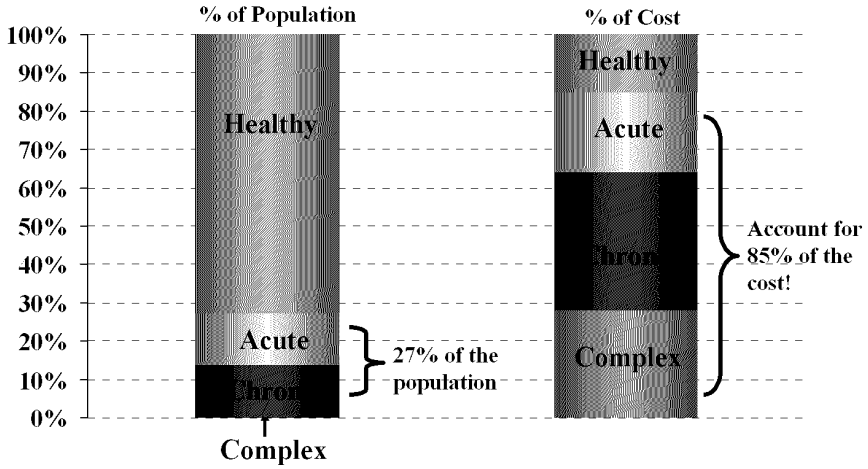
Why Hasn't Managed Care Worked?

- Little or no "managed" care
- Reliance on price discounts
- Unmet expectations for:
  - Keeping people healthy
  - Helping people manage their health
  - Helping people navigate the healthcare system



Trends | Cost Drivers | Employers

Focus on Cost Drivers



What If You Started Managing Controllable Costs?

Savings Expectations - 2004

UM/Case Management	1%	–	1.5%
Disease Management	1%	–	1.5%
Health Promotion	1%	–	1.5%
Prescription Drugs	1%	–	1.0%
Stop Loss	.25%	–	5%
Direct Savings	**4.25%**	**–**	**6%**
Worker Productivity	.75%	–	1%
Total Savings	**5%**	**–**	**7%**

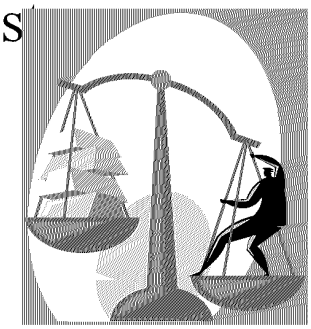
Improvement!

Six Macro-Messages for Employers

- Health care is **a rapidly changing, confusing and complex issue** and it will continue to cost more
- **Technology is rapidly changing** all facets of care delivery and administration
- **Consumers are disengaged** from the health care purchasing process. Employers' actions **will encourage employees to be consumers**
- The **Point of Care** is when consumers need information and are ready to take action with the appropriate information
- Consumerism is **evolving along many paths**
- It will happen one member at a time

Source: Watson Wyatt Worldwide

What Employers Can Do to Manage Cos



- Tactical Solutions
  - Cost shifting
- Product Based
  - Consumer-directed health plans
  - High performance networks
- Strategic
  - Health improvement/management programs
  - Consumerism

Source: 2002 Mercer National Survey of Employer-Sponsored Health Plans

Four Key Steps in Shaping Your Strategy

- Step 1: Establish guiding principles
  - Understand and support the business strategy
  - Establish financial/cost controls objectives
  - Deliver benefits efficiently and effectively (e.g., in/out)
- Step 2: Benchmark your health & welfare
  - Analyze and adjust costs for design, demos, geography
  - Benchmark adjusted cots to competitors
  - Compare value
  - Review health plan vendors against the marketplace

Four Key Steps in Shaping Your Strategy

- Step 3: Determine the implications of your choices against your guiding principles
  - Structure (number/types of plans)
  - Plan design
  - Care management
  - Pricing/employee contributions
  - Vendor management
  - Employee education/communication
- Step 4: Set the strategy

Employer Cost Saving Options

- Benchmark and identify your specific cost drivers.
- Work with medical care providers to actively address inefficiencies of medical delivery system.
- Increase access to quality health care education designed around your cost drivers.
- Provide self-care information and resources to employees.

Employer Cost Saving Options

- Set coverage features to monetarily incent employees to seek high quality/low cost providers and alternatives.
  - Use increased quality of data to make educated plan design decisions.
- Increase employee cost share in relation to intensity.
- Preventative incentives and wellness programs.
- Migrate to a Defined Contribution philosophy.
- Engage employees by implementing consumer driven health plans.

Engaging the Plan Member and Improving Health are Vital

Employees think the cost of an office visit **is the $10 copay**...Drugs cost **$10** too...employers are faced with **shifting cost or cutting benefits** to employees...**Retirees** are **especially at risk...**

Americans for the first time are **in a state of declining health**... **Obesity has increased 61%** in a 10-year time period... The **prevalence of diabetes has increased 49%** between 1990 and 2000...**60% of Americans do not get enough physical activity** to make a difference in their health...

The average American will spend a total of **13 years in less than optimal health** because of chronic or acute limitations**...70% of the causes of disease and death** are related to modifiable lifestyle behaviors...**Employers pay the price** for the employees' **personal lifestyle decisions.**

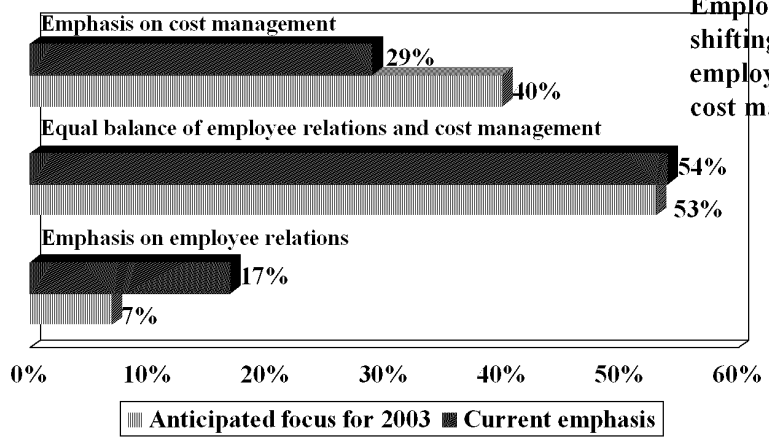
Source: Watson Wyatt Worldwide

Private Sector Strategies

- Increase employee cost sharing
  - Higher deductibles, copayments, out-of-pocket limits
  - Greater employee premium share
- Contracting/Management of networks
  - Prescription drug management strategies
  - Tiered/limited provider networks
  - Disease management
  - Community based Care Management
- Health reimbursement accounts
  - Retiree medical savings accounts
  - Consumer-driven healthcare

Trends | Cost Drivers | Employers

The Changing Face of Healthcare: Balancing Employer and Employee Need



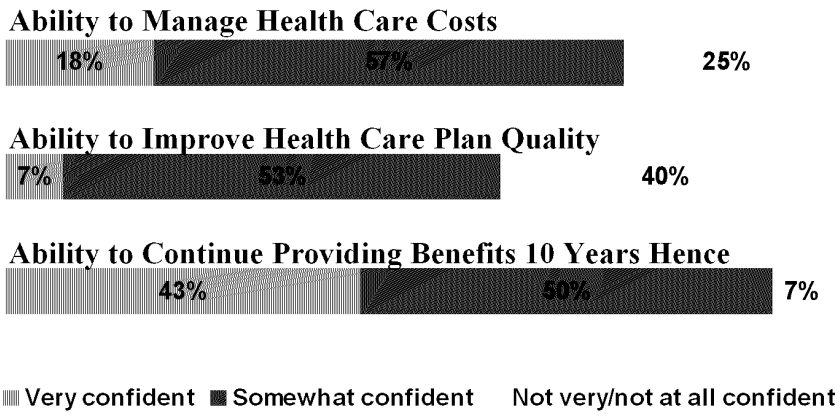
Employer emphasis is shifting from employee relations to cost management

...with the economy limping along and unemployment up, corporations are turning their focus to slashing labor costs.

WSJ 11/26/02

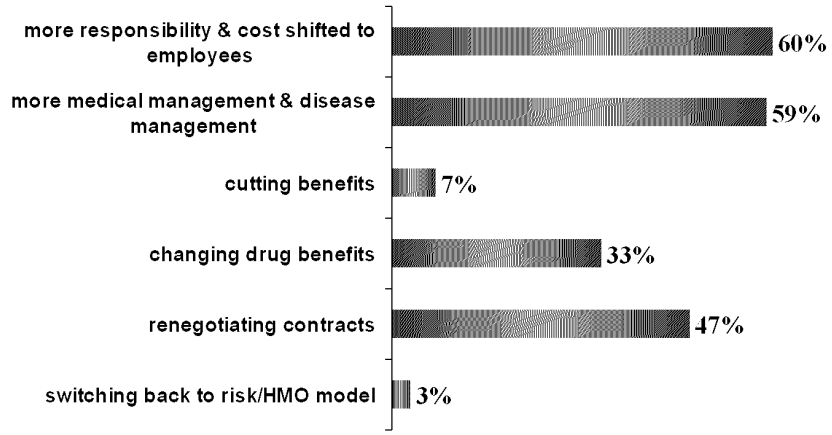
Source: Towers Perrin 2003 Health Care Cost Survey

Employer Confidence Levels



Source: Watson Wyatt Worldwide

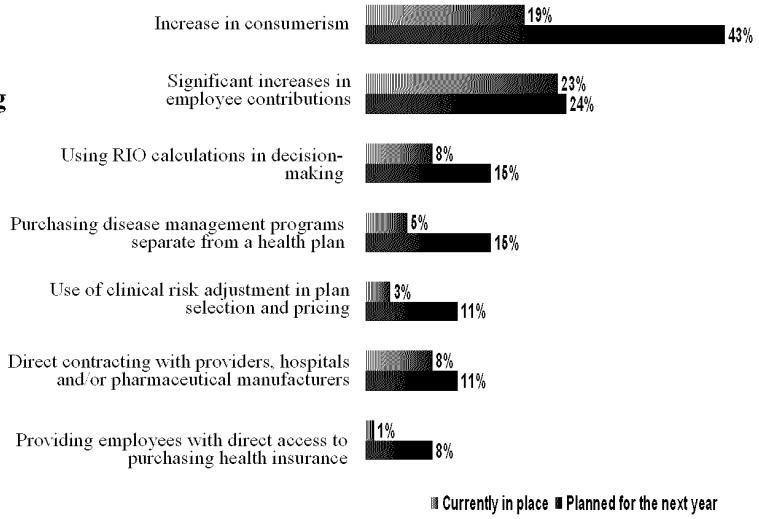
What Steps is Your Organization Taking to Reduce Healthcare Costs?



Source: 2002 Capitation Survey, National Health Information, L.L.C., www.nhionline.net

Leading-Edge Strategies

Leading-Edge Strategies are Supplementing Traditional Methods



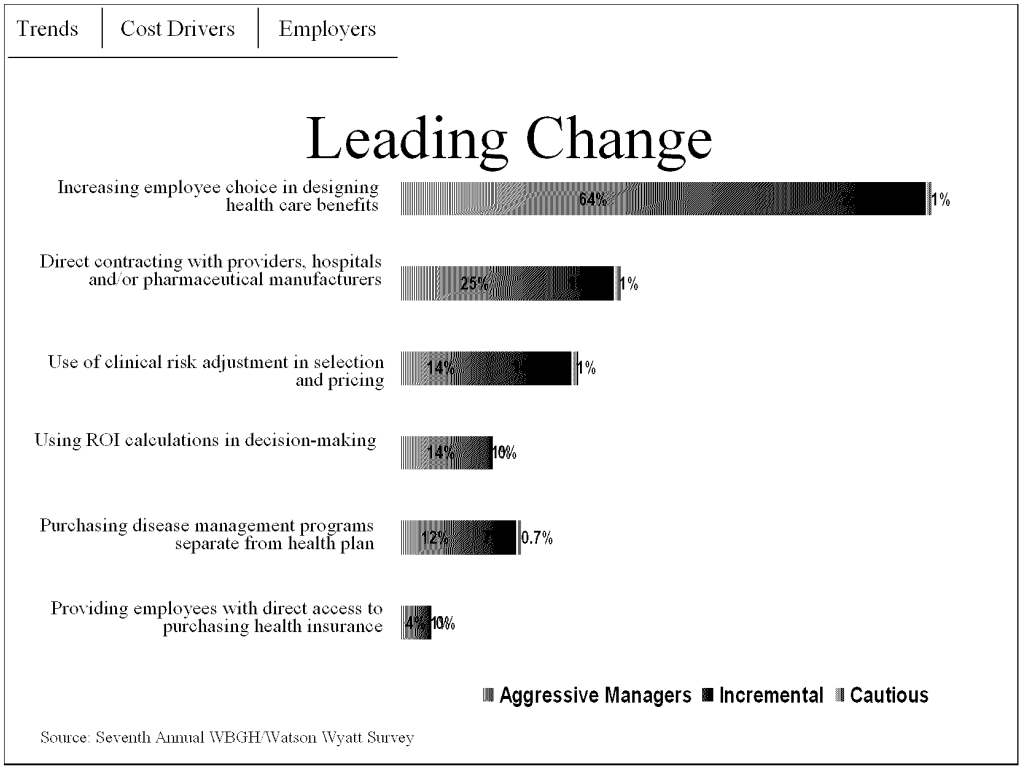
Source: Seventh Annual WBGH/Watson Wyatt Survey

Winning companies do not save money just by picking a particular plan model.

Respondents reported that cost differences between plan models narrowed considerably.

Instead, companies are adopting a wide variety of leading-edge strategies, including:

- consumerism and
- purchasing disease management programs separate from a health plan and use of clinical risk adjustment in plan selection and pricing



Doing nothing and remaining cautious will likely mean that health care costs will double by 2007 — clearly an unacceptable alternative.

In fact, aggressive managers have the best chance of reducing their health care cots by carefully adjusting the mix of strategies they have adopted.

Trends | Cost Drivers | Employers

Approaches to Control the Cost of Health Care Benefits

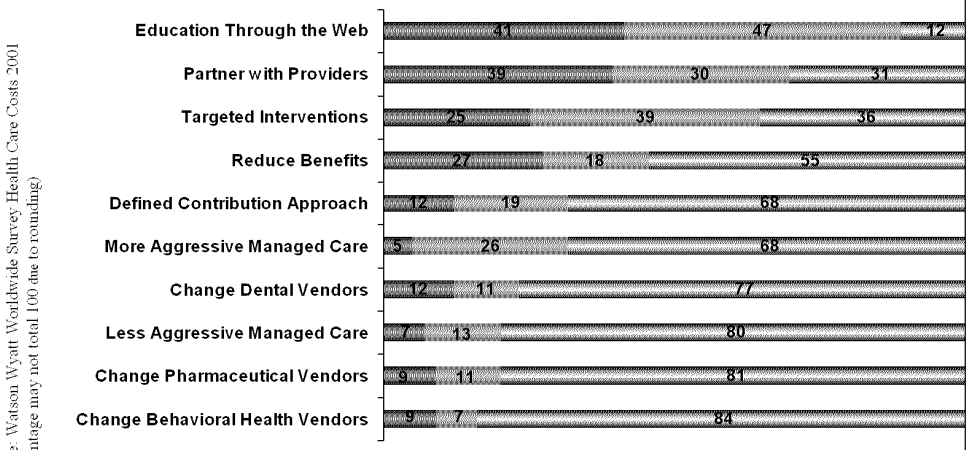
Source: "Towers Perrin Survey Finds Employers Committed to Playing an Active Role in Health Care Despite Concerns About Rising Costs," www.towers.com, May 1, 2001. p.11.

Employers surveyed by Towers Perrin implemented or are considering implementing the following approaches to health care cost control

Trends | Cost Drivers | Employers

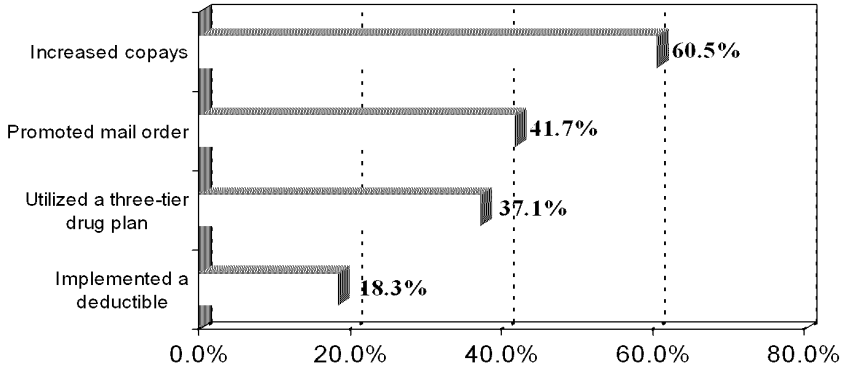
Cost Sharing Survey Results

Survey Question: In the next 12 months, what actions do you anticipate taking to manage health care costs?



Source: Watson Wyatt Worldwide Survey Health Care Costs 2001
(Percentage may not total 100 due to rounding)

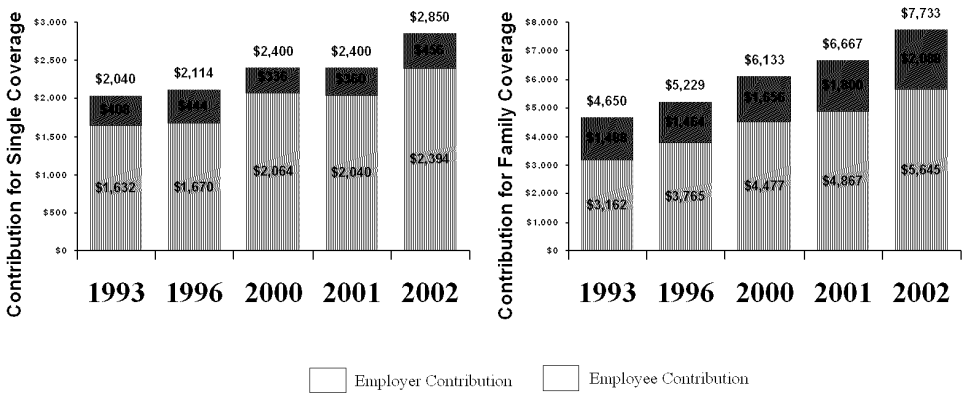
Employers' Responses to Rx Increases



Source: CMI Consulting Group, Jan 2003

Trends | Cost Drivers | Employers

Average Annual Premium Contribution



Source: The Henry J. Kaiser Family Foundation/Health Research and Educational Trust, 2002

Large Employers More Likely to Raise Contributions, Cost-Shift, Next Year

Will increase employee contribution percentage next year	For 2003	For 2002
Small employers	24%	18%
Large employers	49%	40%
Will increase cost-sharing* next year	**For 2003**	**For 2002**
Small employers	19%	15%
Large employers	44%	34%

*by raising deductibles, copays/coinsurance, or out-of-pocket maximums

Source: 2002 Mercer National Survey of Employer-Sponsored Health Plans

Employee/Retiree Cost Sharing

- Employers are still shouldering the lion's share of costs
  - However, fully 50% of respondents increased employees' share by raising contributions at a greater rate than premium increases

	Single Coverage *% of total cost*		Family Coverage *% of total cost*	
	2002	**2003**	**2002**	**2003**
Active employees	18.7%	19.3%	21.7%	22.2%
Retirees under age 65	43.9%	42.8%	44.2%	43.0%
Retirees age 65 and older	43.6%	44.7%	42.8%	44.0%

Source: Towers Perrin 2003 Health Care Cost Survey

"Best In Class" Care Management

- Current Care Management often falls short because of:
  - Missed case management opportunities
  - Inadequate physician advisor intervention
  - Poorly executed policies/procedures
  - Lack of impact documentation
  - Nurse staff with low impact expectations
  - Numerous other deficiencies

"Best In Class" Care Management

- Evaluate the market for exceptional ***full service*** vendors
  - Traditional UR/CM
  - Disease management
  - Care Management
- Attributes of selected vendors
  - Proven industry leader
  - Competitive program design and staffing
  - Handles acute, episodic, chronic and catastrophic illness
  - Ability to leverage technology
  - Attractive pricing
  - Ability to exceed client expectations

Disease Management

- Reasons for disease management:
  - 27% individuals spend 85% dollars
  - 33% expenses for preventable conditions
  - 50-60% hospital admissions due to chronic conditions

This is where the money is!

Disease Management

- Target conditions for self-care efforts
- Avoid complications from chronic illness
- Patient empowerment
- Coordinate interventions and communication
- Support the physician/patient and plan of care
- Use evidence-based guidelines
- Evaluate clinical, humanistic, and economic outcomes

Source: Disease Management Association of America, 2001

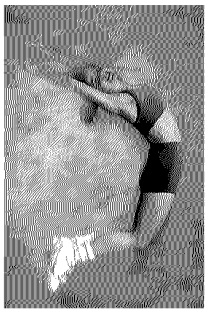
Health Promotion/Disease Prevention

50% of all disease, injury and prema death is preventable

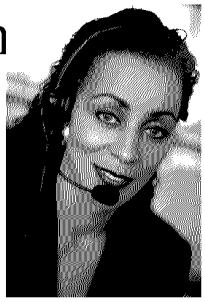
- Excess risk factors:
  - Account for 25% medical costs
  - Lead to higher absenteeism/lower productivity
- Lifestyle triggers of preventable disease:
  - Tobacco
  - Poor diet
  - Obesity
  - Stress
  - Lack of exercise

Health Promotion/Disease Prevention

- Health promotion/disease prevention includes:
  - Focus on cost-effective interventions
  - Web-based services
  - Tele-coaching
  - Print options



Health Promotion/Disease Prevention

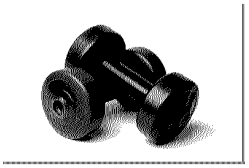


Why it works now:

- Annual HRAs
- Tailored findings
- Tailored interventions
- Medical self-care
- Website
- Self-directed change
- High risk intervention
- Integrated programming
- Targeted interventions
- Benefit-based financial incentives
- Tele-coaching

Health Promotion/Disease Prevention

- Health promotion/disease prevention lessons learned:
  - Comprehensive and integrated approach
  - Across the life span and the full continuum of care performance
  - Address direct and indirect costs
  - ROI real



Concluding Takeaways

- The managed care marketplace has changed
- Care management has center stage
- Analyze experience and quantify savings
- Customize care management to employees' risk profiles
- Reduce benefits when above market
- Restructure contributions to reflect plan values
  - Higher coverage for centers of excellence
  - Incentives for participation in disease management

Trends | Cost Drivers | Employers

Concluding Takeaways

Healthier People

Improved Lifestyle

Right Care, Right Setting

Better Employees

Direct $$ Savings
- Medical Plan
- Disability Plan
- Workers' Comp

Indirect Savings
- Absenteeism
- Presenteeism
- Overtime
- Recruitment
- Retention

Intangible Savings
- Morale
- Satisfaction
- Attitude

Exhibit 13


LEXITAS™

[redacted]

Q How long does it typically take to build a new network?

A It's going to depend on the -- whether we have relationships in that geography today, but at least 18 months, closer to 2 years to build from beginning to end.

Q And would you say that building a new network is a resource-intensive process?

A Yes, it is.

[redacted]

[redacted]

[redacted]

Q Any reason to think this isn't a true and correct copy of that agreement from 2003 with the Mayo Health System?

A That portion looks to be what that is, yes. No reason to believe it's not.

Q So if we turn to page 10 of the PDF, this is CIGNA3706.

And there's a provision there, Section G, Representations, and the portion I want to focus on is this Section 5, and that begins with a sentence that says that "Cigna makes no representations or guarantees concerning the number of Participants it can or will refer to MHS Providers under this Agreement."

Do you see that language?

A I do.

Q And that's similar language to what we had reviewed earlier in the deposition today with Aurora's contract from 2003 as well, correct?

MS. WALLIN: Object to form.

A It is.

Q The second sentence of Section 5 there under -- or the second paragraph, excuse me, of G5 there under "Representations," it says that "Cigna shall not modify or offer benefit plans to Participants residing in Wisconsin in a manner that tiers Providers based on differences in Coinsurance percentages, Copayment amounts, or any other financial incentives that might prompt a Participant to select particular Participating Providers instead of MHS and MHS Providers."

Do you see that language?

A I do.

Q Do you have an understanding as to what that portion of the contract is accomplishing?

A It's anti-tiering language that is based on financial incentives only.

Q So this is anti-tiering language that exists, not in Aurora's contract, but Cigna's agreement with Mayo, is that correct?

A That's correct.

Q So there's at least one other health system that we've seen here in Wisconsin where there was tiering-related restrictions?

A In Wisconsin, yes.

[redacted]

Exhibit 18


LEXITAS™

the -- you know, there's -- all kinds of factors would go into it.

Q. How long would you say it typically takes to build a new network, from idea to it getting offered?

A. Depends on the amount of resources.

Q. Could you give me a rough ballpark based on the resources that are usually available?

A. We built a network in Illinois this past year. It took about 12 months to build a statewide network in 102 counties.

Q. Is that typical or is that on the faster end?

A. That's probably about right when you're talking about a statewide contract.

Q. So you mentioned resources. Is it fair to say that building a new network is a pretty resource-intensive process?

A. It is.

Q. What kind of resources are required?

A. In addition to contractors, we need the support of a legal team to review.

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, Plaintiffs, v. ADVOCATE AURORA HEALTH, INC. and AURORA HEALTH CARE, INC., Defendants.	Case No. 2:22-cv-610 **REDACTED PUBLIC VERSION**

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION TO EXCLUDE OPINIONS OFFERED BY MR. JONATHAN ORSZAG

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I. INTRODUCTION

For nearly two decades, Defendants Advocate Aurora Health, Inc., and Aurora Health Care, Inc. (collectively "AAH"), imposed anticompetitive contractual restraints on Wisconsin health plans (the "Challenged Conduct" or the "All Plans" provision). Plaintiffs are two employers, Uriel Pharmacy and Hometown Pharmacy, that offer health benefits to their employees through self-funded plans. They allege that AAH's restraints enabled its Wisconsin hospital system ("AAH-Wisconsin") to charge supracompetitive prices to Wisconsin employers, unions, insurers, and patients.

Plaintiffs retained expert economist Dr. Jeffrey Leitzinger to quantify the resulting harms, which take the form of overcharges to insurers and health plans whose members received care from AAH-Wisconsin. Dr. Leitzinger designed a multivariate regression model that compares AAH-Wisconsin's prices to those of AAH's hospital system in [redacted]—a similar system under the same corporate ownership that [redacted]—while controlling for other factors that might affect their prices. Based on his regression model and the discovery record, Dr. Leitzinger concludes that AAH's anticompetitive conduct inflated its Wisconsin prices by [redacted]%. Dr. Leitzinger also ran a second regression comparing AAH-Wisconsin's prices to those of the most comparable hospital system in Eastern Wisconsin (Ascension) and found similar results.

AAH does not deny that it imposed the challenged restraints on Wisconsin health plans and does not offer its own competing overcharge model. Instead, it retained Mr. Jonathan Orszag merely to criticize Dr. Leitzinger's regression model, seeking to deprive Plaintiffs of their damages expert and avoid accountability on the merits. Orszag's critiques are uniformly unpersuasive, as Plaintiffs will show at later stages of this case. But certain of Orszag's opinions are so untethered from the facts, the data, and accepted methodologies that they fail to satisfy even the liberal

standards for admission under *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). Under *Daubert*, courts play a gatekeeping role, and "the key to the gate is … the soundness and care with which the expert arrived at [his] opinion." *Schultz v. Akzo Nobel Paints, LLC*, 721 F.3d 426, 431 (7th Cir. 2013). Here, as he has done repeatedly throughout his career—courts have excluded five of his opinions in just the past five years[1]—Orszag failed to exercise the required level of care.

First, Orszag claims that Dr. Leitzinger failed to account for the supposed fact that [redacted], before the Challenged Conduct began. Even setting aside that any price differences 25 years ago would say little about prices today, this opinion is inadmissible on two independent grounds. The data Orszag relies on is not reliable. [redacted] Even taken at face value, moreover, the data say nothing about [redacted] or even hospital prices more broadly [redacted] There is "simply too great an analytical gap," *GE v. Joiner*, 522 U.S. 136, 146 (1997), between a high-

[1] *Skillz Platform Inc. v. Papaya Gaming, Ltd.*, 2026 WL 395430, at *2-*4 (S.D.N.Y. Feb. 12, 2026); *Applied Med. Res. Corp. v. Medtronic, Inc.*, 2025 WL 4052504, at *7 (C.D. Cal. Apr. 11, 2025); *Jones v. Varsity Brands, LLC*, 2024 WL 457173, at *2-*4 (W.D. Tenn. Feb. 6, 2024); *In re: EpiPen (Epinephrine Injection, USP) Mktg., Sales Pracs. & Antitrust Litig.*, 2022 WL 226130, at *11 (D. Kan. Jan. 26, 2022); *Academy of Allergy & Asthma in Primary Care v. Superior Healthplan, Inc.*, No. SA-17-CA-1122-FB, ECF 280 at 1-2 (Mar. 30, 2021); *see also In re Elec. Books Antitrust Litig.*, 2014 WL 1282298, at *14-*20 (S.D.N.Y. Mar. 28, 2014).

level statistic about employer healthcare spending across two broad regions and Orszag's conclusions about two specific hospital systems' prices. Orszag never even addressed that gap, let alone bridged it.

Second, Orszag contends that Dr. Leitzinger's model [redacted]. This opinion is inadmissible because Orszag skipped three foundational steps for a valid placebo test. A "placebo" test without a placebo is meaningless, but Orszag never even checked whether the hospitals he used were valid placebos. In fact, the record shows they were not: [redacted] Orszag also acknowledged that a valid placebo test requires the placebo hospitals to be sufficiently comparable to [redacted] and he identified several metrics an economist should compare before using a placebo. Remarkably, however, Orszag did not consider *any* of those metrics for *any* of his placebo hospitals. His failure to do so makes it impossible to know whether his results show anything meaningful or are simply the consequence of applying a model to hospitals it was never designed to analyze. Lastly, Orszag did not have sufficient data. Instead of gathering his own data, Orszag used Dr. Leitzinger's—but Dr. Leitzinger collected data from the largest payors in Eastern Wisconsin and [redacted], not [redacted] where Orszag's placebo hospitals operate.

Third, Orszag purports to run a "before" and "after" test using a "difference-in-differences" (DID) model, which he says [redacted] Once again, however, Orszag failed to verify the predicates for his methodology. Orszag admitted at his deposition that [redacted]—and when Dr. Leitzinger replicated the test Orszag [redacted]

[redacted]. Orszag's shifting explanations, the inconsistency between his testimony and his report, and the statistical realities reveal the unreliability of his test. In addition, Orszag improperly assumed that the "All Plans" provision's effect on prices [redacted] That assumption is not just unverified; it directly contradicts the record evidence and accepted economic principles. His "after" period was not an "after" period at all, stripping his test of any meaning.

Orszag's carelessness manifests throughout his entire report. While many of Orszag's shortcomings go to the weight of his opinions rather than their admissibility, the opinions discussed in this motion are so unreliable, and characterized by such lack of rigor, that they should be excluded in their entirety.

II. BACKGROUND

A. Factual and Procedural History

Plaintiffs filed their complaint on May 24, 2022, alleging that AAH abused its market dominance to engage in anticompetitive conduct and overcharge Class members (self-funded employer health plans and commercial insurers) for healthcare services. The principal restraint at issue is the "All Plans" restraint, which blocked the mechanisms through which price competition normally takes place in this industry. The "All Plans" provision [redacted] It also [redacted] AAH's wrongful conduct reduced competition and allowed it to charge supracompetitive

prices for years [redacted]

Plaintiffs disclosed reports from three experts. Dr. David Dranove[2] performs structural econometric analyses and opines that [redacted] in the Eastern Wisconsin market. Ex. 2, Expert Report of David Dranove, Ph.D. (Nov. 21, 2025) ("DR1") ¶ 28. Dr. Patrick Romano[3] opines that [redacted]. Ex. 3, Expert Report of Dr. Patrick S. Romano, M.D., M.P.H. (Nov. 21, 2025) ("RR1") ¶ 105. He further opines that the "All Plans" language was "[redacted]." Dr. Jeffrey Leitzinger[4] performs a statistical

[2] Dr. Dranove is the Walter J. McNerney Distinguished Professor of Health Industry Management and Professor of Management and Strategy at the Kellogg School of Management at Northwestern University, where he also serves as Faculty Director of Ph.D. Programs. Ex. 2, DR1 ¶ 1. He specializes in industrial organization and healthcare markets, with over 100 published research articles and eight books, including the textbook *Economics of Strategy* used by leading business schools worldwide. *Id.* ¶ 3. In 2022, Dr. Dranove received the Victor Fuchs Award for Lifetime Contributions to the Field of Health Economics, and in 2024, he was elected to the National Academy of Medicine for his contributions to understanding healthcare market dynamics. *Id.* ¶ 6. Dr. Dranove has three decades of experience in economic analysis for litigation and regulatory actions, including testifying for the U.S. Department of Justice in its lawsuit to block the Anthem-Cigna merger. *Id.* ¶ 4.

[3] Dr. Romano is a Professor of Medicine and Pediatrics at the University of California Davis (UC Davis) School of Medicine. Ex. 3, RR1 ¶¶ 1, 3. He has authored over 240 peer-reviewed publications, 15 book chapters, and over 80 other publications on a wide range of healthcare issues, with a particular focus on health care quality measures and comparing health system performance. *Id.* ¶ 2. As a result of his expertise in healthcare quality evaluation, he leads several applied research projects on health care quality, serves in numerous consulting and technical assistance roles, and has held advisory positions with several organizations. *Id.* ¶¶ 2-6. He has extensive experience evaluating the quality implications of hospital mergers and other anticompetitive conduct, both in the litigation context and on a consulting basis. *Id.* ¶ 10.

[4] Dr. Leitzinger is the founder and Managing Director of Econ One Research, Inc., an economic research and consulting firm. Ex. 4, LR1 ¶ 1. He holds doctoral degree in economics from the University of California, Los Angeles. *Id.* During his 45-year professional career, antitrust

regression analysis of millions of insurance claims and concludes that the Challenged Conduct raised AAH-Wisconsin's prices by [redacted] percent. Ex. 4, Expert Report of Jeffrey J. Leitzinger, Ph.D. (Nov. 21, 2025) ("LR1") ¶ 9 & Ex. 4. Because the opinions at issue in this motion all relate to Dr. Leitzinger's analysis, a more detailed description of his work is provided here.

To measure overcharges, Dr. Leitzinger used a "yardstick" regression that compares AAH-Wisconsin's prices to the prices charged for the same services during the same time period by two comparator (or "yardstick") providers. His primary yardstick is AAH's own hospital system [redacted] his second yardstick is the Ascension hospital system in Wisconsin. Ex. 4, LR1 ¶¶ 26-45. Dr. Leitzinger's regression model includes several control variables designed to isolate the effects of the Challenged Conduct on AAH-Wisconsin's prices. Ex. 4, LR1 ¶ 26; *see id.* ¶¶ 36-37 (listing 15 such variables). For example, Dr. Leitzinger controls for demographic characteristics in the service area, the type of facility where a service was provided, labor costs, provider concentration, and Network Vendors' market shares. *Id.* ¶¶ 36-37. Dr. Leitzinger also explains that his selection of [redacted] as his yardstick automatically controlled for the many factors that AAH-Wisconsin and [redacted] already had in common:

> I had the fortuitous circumstance of two hospital systems, AAH Wisconsin [redacted] and [redacted], both serving large metropolitan areas [redacted] and both were in the same corporate family. Testimony and other evidence indicates [redacted]. From an overcharge estimation standpoint, the situation was ideal…. Much of what might normally have required multiple external control variables was dealt with simply by using [redacted] for the control experience.

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economics has been the principal focus of his work, including frequent analysis of damages and impact in both individual and class action antitrust litigation. *Id.* ¶ 2. Dr. Leitzinger has testified as an expert economist in state and federal courts, before regulatory commissions, and in international treaty arbitrations, and has previously analyzed anticompetitive conduct in numerous cases involving healthcare markets, including as the testifying expert in the similar *UEBT v. Sutter* case. *Id.*

Ex. 5, Rebuttal Report of Jeffrey J. Leitzinger, Ph.D. (Mar. 23, 2026) ("LR2") ¶¶ 82-83.

With respect to hospital quality specifically, Dr. Leitzinger accounted for quality through his selection of [redacted]—a hospital system of similar quality to AAH-Wisconsin—as the yardstick. Specifically, Dr. Leitzinger noted [redacted].

Dr. Leitzinger's analysis finds that the Challenged Conduct allowed AAH to overcharge Class members in Eastern Wisconsin by [redacted]%. Ex. 4, LR1 ¶ 40. His results were statistically significant at the 99 percent confidence level and "consistent with Plaintiffs' claims about overcharges stemming from the Challenged Conduct." *Id.*[5]

Dr. Leitzinger's second yardstick analysis used Ascension as the yardstick. *Id.* ¶ 45. [redacted], Dr. Leitzinger selected Ascension as an appropriate yardstick because it shared "several common factors" with AAH-Wisconsin. Specifically, he determined that Ascension [redacted]

[5] Orszag contends that Dr. Leitzinger used the wrong data field when analyzing one Network Vendor's Illinois data. *See* Ex. 5, LR2 ¶ 7. Dr. Leitzinger does not find Orszag's position persuasive, *see id.* ¶ 14, but shows that even when using Orszag's preferred data treatment, his regression model shows substantial overcharges that are statistically significant at the 99 percent confidence level, *id.* ¶ 7.

[redacted] Ex. 5, LR2 ¶ 91. These common factors allowed him to apply the same model to a different hospital system without "the need for additional control variables that would have been needed" if he used other, less similar hospitals. *Id.* The Ascension regression corroborated the results of Dr. Leitzinger's primary regression, showing a substantial overcharge that is statistically significant at the 99 percent confidence level. Ex. 4, LR1 at Ex. 6, ¶ 40.

B. Orszag's Opinions

AAH proffered the opinion of Mr. Jonathan Orszag, tasking him with critiquing Dr. Dranove and Dr. Leitzinger. *See* Ex. 1, Expert Report of Jonathan Orszag ("Ex. 1, OR1") ¶ 9 ("[redacted]."). As relevant to this motion, Orszag opines that Dr. Leitzinger's yardstick regression [redacted]. Orszag's critiques are unpersuasive, as Dr. Leitzinger fully details in his Rebuttal Report, and as Plaintiffs will show at trial. *See* Ex. 5, LR2 ¶¶ 5-134; *see also, e.g.*, *Manpower, Inc. v. Ins. Co. of Pa.*, 732 F.3d 796, 808 (7th Cir. 2013) ("[A]rguments about how the selection of data inputs affect the merits of the conclusions produced by an accepted methodology should normally be left to the jury."). Three of Orszag's opinions, however, fail to meet even the liberal standards for admissibility and should be excluded entirely.

First, Orszag opines [redacted] Ex. 1, OR1 ¶ 84. Orszag's opinion [redacted]

[redacted]

Second, Orszag opines that Dr. Leitzinger's regression model [redacted] Ex. 1, OR1 ¶ 97, 99. In contrast to Dr. Leitzinger's detailed explanation of why it was appropriate to use the Ascension system as a corroborating yardstick, *see supra*, Orszag's report [redacted] and did not analyze whether he had sufficient data to run the tests at all.

Third, Orszag purports to run a "difference-in-differences" ("DID") test comparing "before" and "after" periods. He claims [redacted] Ex. 1, OR1 ¶ 12. Orszag's report, however, does not discuss whether the required preconditions for a DID analysis were satisfied, including [redacted] The record evidence, in fact, shows otherwise.

III. ARGUMENT

Under the Federal Rules of Evidence and *Daubert*, a district court must make a preliminary determination that an expert's testimony is reliable. *ATA Airlines, Inc. v. Fed. Exp. Corp.*, 665 F.3d 882, 896 (7th Cir. 2011). While the threshold for admissibility is not particularly high, courts must ensure that the expert's "testimony is based on sufficient facts or data" and "reflects a reliable application of the principles and methods to the facts of the case." Fed. R. Evid. 702. Although this "places the judge in the role of gatekeeper for expert testimony, the key to the gate is not the ultimate correctness of the expert's conclusions." *Schultz*, 721 F.3d at 431. Instead, the "key to the gate" is "the soundness and care with which the expert arrived at her opinion." *Id.* AAH, as the party proffering Orszag's testimony, "bears the burden of demonstrating that the [his] testimony satisfies the [*Daubert*] standard by a preponderance of the evidence." *Krik v. Exxon Mobil Corp.*, 870 F.3d 669, 673 (7th Cir. 2017).

These standards apply regardless of whether an expert is offering affirmative testimony or only rebutting another party's expert. Even as to rebuttal experts, defendants "do[] not have the right … to call an expert economist to present opinions unless those opinions are the product of the expert's rigorous application of economic methods." *In re Elec. Books*, 2014 WL 1282298, at *20; *see also, e.g.*, *Funderburk v. S.C. Elec. & Gas Co.*, 395 F. Supp. 3d 695, 716 (D.S.C. 2019) ("[A] rebuttal expert is still subject to the scrutiny of *Daubert* and must offer both relevant and reliable opinions."). Even rebuttal experts must "employ[] in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field." *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152 (1999).

A. Orszag's Opinion About Historical Price Differences [redacted] Is Unreliable.

An expert opinion passes muster only if the expert "consulted reliable sources and provided reasoned explanations connecting the source material to his conclusions." *Lees v. Carthage Coll.*, 714 F.3d 516, 524 n.3 (7th Cir. 2013); *Weir v. Crown Equip. Corp.*, 217 F.3d 453, 465 (7th Cir. 2000) ("For testimony based on reports to be admissible, the reports themselves must be reliable sources of information."). Experts must "connect the dots" from the studies to their ultimate conclusions, *C.W. v. Textron, Inc.*, 807 F.3d 827, 837 (7th Cir. 2015), and may not offer opinions that are "connected to existing data only by the *ipse dixit* of the expert." *Joiner*, 522 U.S. at 146; *see also Wasson v. Peabody Coal Co.*, 542 F.3d 1172 (7th Cir. 2008). In *Joiner*, for instance, an expert was excluded because he extrapolated from animal studies to a conclusion about cancer in humans without explaining how or why it was scientifically valid to make that inferential leap. *Joiner*, 522 U.S. at 144-46.

Orszag has been excluded before for making such unexplained inferential leaps. In *Applied Medical*, for example, Orszag opined about the percent of the market that Medtronic's conduct foreclosed. 2025 WL 4052504, at *7. Orszag's conclusions relied critically on a "figure from a Medtronic's Quarterly Business Review slide deck," but the court held that he had no basis to extrapolate from the figure on the slide deck to his foreclosure analysis. Because he "provide[d] no explanation for the methodology used" to conclude that the figure was relevant, and instead offered only his "*ipse dixit* conclusion," the court found "Orszag's foreclosure figure fundamentally unreliable." *Id.* Similarly, in *In re Elec. Books*, certain of Orszag's opinions were excluded because instead of "undertak[ing] an examination of [the] market and perform[ing] a study, … [h]e simply took a single, general remark about Amazon's goals from an Amazon executive and extrapolated from that." 2014 WL 1282298, at *17.

1. Orszag Fails To Connect His Sources To His Conclusion.

AAH cannot satisfy its burden to show that Orszag's opinion about historical price differences [redacted] satisfies *Daubert*'s requirements. Orszag seeks to offer an opinion comparing [redacted] Unlike Dr. Leitzinger, *see* Ex. 4, LR1 ¶ 32, he did not use [redacted] Nor did he use data on hospital prices from third-party entities like RAND, as Prof. Dranove did, *see* Ex. 2, DR1 ¶¶ 152-54. [redacted]. *See* Ex. 7, AAHEDWI01645637 at 662-63, 665. Even setting aside that those studies are unreliable, *see infra* Part I.B, they do not measure what Orszag needed them to measure: [redacted][6] [redacted] *See* Ex. 5, LR2 ¶¶ 17-20 ([redacted]); *see id.* ¶ 19 (noting that employer healthcare spending is driven by factors unrelated to provider prices, including "the amount of services consumed, … the frequency and seriousness of health problems, the plan coverage terms, and a host of items beyond health care service charges.").

Orszag never explained how or why he could extrapolate from [redacted] He did no statistical work to bridge the gap. He simply

[6] [redacted]

[redacted] and asserted his conclusion, never "connect[ing] the dots between the … studies … and the opinions that he offered." *Textron*, 807 F.3d at 832; *see* Ex. 1, OR1 ¶ 84. "This is a *Joiner* problem," *Textron*, 807 F.3d at 832, as there is far "too great an analytical gap between" what these slides say and the conclusion Orszag draws from them, *Joiner*, 522 U.S. at 146.

It is no wonder Orszag failed to provide an explanation: [redacted]. Ex. 8, Deposition of Jonathan Orszag ("Orszag Tr.") at 99:16-17 ("[redacted]"); *id.* at 115:3-5 ("[redacted]"); *id.* at 117:22-24 ("[redacted]"). Orszag thus [redacted]:

- "[redacted]." *Id.* at 105:11-14.
- "[redacted]." *Id.* at 116:6-7.
- "[redacted]." *Id.* at 101:18-19.
- "[redacted]." *Id.* at 102:2-4.
- [redacted]." *Id.* at 102:21-24.
- "[redacted]." *Id.* at 109:11-15.
- "[redacted]." *Id.* at 108:17-20.

- "[redacted]." *Id.* at 119:12-16.
- "[redacted]." *Id.* at 115:8-9.
- "[redacted]." *Id.* at 110:6-7.
- "[redacted]." *Id.* at 110:17-18.
- "[redacted] *Id.* at 120:17-19.
- "[redacted]." *Id.* at 118:21-23.
- "[redacted]." *Id.* at 115:13-15.
- "[redacted]." *Id.* at 118:15-18.

Without any of this basic knowledge, Orszag could not reliably draw inferences from the studies to his conclusions about [redacted] For example, Orszag admitted that he [redacted]. *Id.* at 114:6-10 ("[redacted]."); *see also id.* at 113:2-7 ("[redacted]."); *id.* at 116:20-22 ("[redacted]."). Drawing inferences with [redacted] is precisely what *Joiner* prohibits, and a conclusion "connected to existing data only by the *ipse dixit* of the expert" is not admissible expert testimony. *Joiner*, 522 U.S. at 146;

see also Autotech Tech. Ltd. P'ship v. Automationdirect.com, 471 F.3d 745, 749 (7th Cir. 2006) (excluding expert who opined on a software program without examining the program).

Orszag has been excluded on nearly identical grounds before. In *Applied Medical*, Orszag sought to opine on the percentage of the market the defendant's conduct foreclosed. 2025 WL 4052504, at *7. Like here, he eschewed rigorous analysis of foreclosure in favor of [redacted] And like here, Orszag "provide[d] no explanation for the methodology used to reach the conclusion" [redacted]—could be reliably used to estimate market foreclosure. *Id.* Because he failed to connect the dots from [redacted] to the opinion he offered, Orszag's "methodology-free conclusion" was excluded. *Id.*; *see also In re Elec. Books*, 2014 WL 1282298, at *17 ("Orszag therefore has no basis for the central assumption in his string of assumptions."). The same result is warranted here.

2. <u>Orszag's Opinion Is Not Based On Reliable Sources.</u>

[redacted] is enough to warrant exclusion. *Joiner*, 522 U.S. at 146. But Orszag's opinion fails for the independent reason that [redacted]. AAH and Orszag have effectively conceded as much.

First, AAH itself [redacted]. Expert opinions are inadmissible if they rely on studies "riddled with design flaws" and the expert does not do even the "minimal amount of identifying or controlling for error." *Gilbert v. Lands' End, Inc.*, 158 F.4th 839, 850 (7th Cir. 2025). The Mercer Study fits that description precisely—[redacted]. [redacted] Ex. 9,

AAHEDWI01501491 at 491, "[redacted]," Ex. 10, AAHEDWI01587785 at 788, used a "[redacted]," *id.*, and fails to reflect that "[redacted]" for employer healthcare costs, *id.* at 787. AAH's own documents referred to [redacted]—the very figures Orszag now relies on for his opinion in this case—as "[redacted]," Ex. 11, AAHEDWI00311317 an "[redacted]," Ex. 10, AAHEDWI01587785 at 786, and a "[redacted]," *id.* at 787. AAH cannot satisfy its burden to show [redacted].

Second, Orszag's deposition made clear that [redacted] Expert opinions that so uncritically rely on dubious sources are inadmissible. In *Fail-Safe, LLC v. A.O. Smith Corp.*, 744 F. Supp.2d 870 (E.D. Wis. 2010), for example, an expert's opinion was excluded because it was founded on a statistic he "adopt[ed] wholesale from a single, undated … PowerPoint slide" that he did not scrutinize. *Id.* at 887. The court deemed his use of that data "extremely suspect, as was [his] scrutiny of that data." *Id.* Orszag's [redacted] is just as suspect, and just as inadmissible. While econometric experts are free to consult a variety of sources in forming their opinions, a reliable analysis would not rest *exclusively* on [redacted]. Accordingly, Orszag's opinion fails Rule 703's reliability requirement. *See Smith v. Ford Motor Co.*, 215 F.3d 713, 718 (7th Cir. 2000) ("[T]he district court functions as a gatekeeper whose role is to keep experts within

their proper scope, lest apparently scientific testimony carry more weight with the jury than it deserves.").

* * *

Finally, the absurdity of Orszag's overall position warrants emphasis. Orszag claims, on the one hand, that he can reliably opine about [redacted], including one that [redacted]." Yet while swearing to the reliability of his own "methodology-free conclusion," *Applied Med.*, 2025 WL 4052504, at *7, Orszag claims that Dr. Leitzinger's multivariate regression model—which analyzes millions of lines of actual claims data from AAH-Wisconsin and [redacted], controls for numerous important variables, and is so statistically robust that it explains 93% of the variation in prices—cannot reliably compare AAH-Wisconsin's and [redacted] prices. That is simply not credible. An expert who holds his own work to no standard while demanding impossible standards of others is not offering reliable analysis—he is offering advocacy, and advocacy dressed up as expertise is precisely what Rule 702 exists to exclude.

B. <u>Orszag's Opinion About "False Positives" is Unreliable.</u>

Even when an expert uses an accepted methodology, he must demonstrate that the conditions that make the methodology work are actually present. Fed. R. Evid. 702(d) (expert opinion must "reflect[] a reliable application of the principles and methods to the facts of the case"); *Krik*, 870 F.3d at 674 ("[A] trial judge must make a preliminary assessment that the testimony's underlying reasoning or methodology is … properly applied to the facts at issue."). Here, Orszag's purported "placebo test" is inadmissible because he failed to evaluate, much less demonstrate, that the preconditions for a valid placebo test were satisfied. A placebo test that is

run without first confirming the conditions that give its results meaning is not a reliable application of the method.

A placebo test is an econometric technique used to check whether a regression model is working correctly. The idea is that a regression model should usually find no overcharge when applied to a group of "placebo" hospitals known to be unaffected by any of the Challenged Conduct. Ex. 5, LR2 ¶ 73 (citing P.J. Gertler, et al., *Impact Evaluation in Practice*, World Bank Group and Inter-American Development Bank (2d ed. 2016) at 332). If a sufficient number of placebo tests show overcharges at appropriate placebo hospitals, that may be a reason the model's results are due less weight. But this test only works if the right kinds of hospitals are chosen as the placebos. Specifically, the placebo hospitals must be ones where you would genuinely expect no overcharge to appear—ones that (1) were not affected by the Challenged Conduct and (2) are similar enough to the hospitals in the original analysis that the model's existing controls are sufficient to account for any pricing differences between them. *See* A.C. Eggers, et al., *Placebo tests for causal inference*, American Journal of Political Science 68(3) (2024), at 1106 to 1121. If those conditions are not met, a finding of an "overcharge" at the placebo hospital proves nothing—it may simply reflect that an invalid placebo hospital was chosen, not that the model is wrong. *Id.*; *see also* Ex. 5, LR2 ¶¶ 74-75.

Orszag committed three fundamental errors in purporting to run a placebo test: (1) he ignored record evidence that his placebo hospitals were engaged in or affected by the Challenged Conduct; (2) he failed to consider, let alone show, that his placebo hospitals were sufficiently comparable to [redacted] for the placebo test to be valid; and (3) he failed to ensure that he had sufficient data about his placebo hospitals.

First, Orszag failed to ensure that his placebo hospitals were not "[redacted]." Ex. 5, LR2 ¶ 75. As Dr. Leitzinger explains, if the placebo hospitals are engaged in or affected by the Challenged Conduct, "any positive result would not be a 'false' one" but rather an accurate detection of the presence of Challenged Conduct. *Id.* Orszag acknowledged as much: he [redacted].[7] Ex. 1, OR1 ¶ 97 n.145. In short, a placebo test without an actual placebo is meaningless.

Despite relying on record evidence [redacted], Orszag ignored record evidence that [redacted] As to [redacted], Network Vendors testified that [redacted] *See* Ex. 5, LR2 ¶¶ 94-96. Ex. 12, [redacted]); Ex. 13, Deposition of Eric Stotlar (Cigna) ("Stotlar Tr.") at 166:3-168:6 [redacted]); *see also* Ex. 14, [redacted], yet Orszag's report reflects no awareness of it—he either failed to review this evidence or chose

[7] "Umbrella effects arise when anticompetitive restraints imposed by a dominant market actor diminish the incentives for other market participants to lower their own prices, thereby interfering with the competitive forces that would normally drive price reductions. As a result, prices across the market are likely to remain elevated under the 'umbrella' of the antitrust violator." Ex. 4, LR1 ¶ 43 n.71; *see also Olean Wholesale Grocery Coop., Inc. v. Bumble Bee Foods LLC*, 31 F.4th 651, 675 (9th Cir. 2022) (en banc) ("[Umbrella effects] refers to an economic observation that when many suppliers engage in a conspiracy to raise prices, non-conspirators may raise their prices to supra-competitive levels.").

to ignore it. Orszag's omission is even more glaring given that [redacted]. *See* Ex. 1, OR1 ¶¶ 65 n.97, 97 n.145. Orszag also admitted that he did not "[redacted]" with [redacted]. Ex. 8, Orszag Tr. at 164:10-166:20. Because Orszag cannot show that [redacted] was a valid placebo, his "placebo" results for [redacted] have no value.

A similar problem taints Orszag's selection of [redacted] and [redacted], which both operate substantially within [redacted] service area—meaning that their prices are likely impacted by the umbrella effects of [redacted]. Ex. 5, LR2 ¶¶ 97-98. [redacted] also has facilities within the service area of [redacted], another hospital system that Orszag acknowledges was alleged to engage in similar conduct. *See* Ex. 5, LR2 ¶ 97; Ex. 1, OR1 ¶ 97 n. 145. But while Orszag rejected the [redacted] as a placebo because of the potential for umbrella effects, *see* Ex. 1, OR1 ¶ 97 n.145, he included [redacted] and [redacted] even though they faced the same problem. He never explained why umbrella effects disqualified [redacted] but not two hospitals operating in [redacted] and [redacted] backyard. Because these two "placebo" hospitals' prices may have been affected by conduct like that alleged here, Orszag cannot show that they are valid placebos either.

Second, Orszag failed to ensure that his placebo hospitals were sufficiently comparable to [redacted] As Dr. Leitzinger explains, "a placebo test is informative only if the yardstick group and the placebo group are sufficiently comparable such that, when the challenged conduct is absent, the estimated effect should be zero." Ex. 5, LR2 ¶ 75; *see also* American Bar Association (ABA) Section of Antitrust Law, *Proving Antitrust Damages: Legal and Economic Issues* (3d. ed. 2017), at 93 ("The yardstick employed must be comparable."). Without that assurance, a positive result "does not demonstrate that the model is producing a false positive," but may show only that "the comparator is not a proper yardstick." Ex. 5, LR2 ¶ 75.

Orszag agreed with this point, testifying that [redacted]. Ex. 8, Orszag Tr. at 170:24-175:14. Orszag made the same point in the similar *Sidibe v. Sutter Health* case, where he stated that "[c]omparisons across hospitals that vary significantly in size and sophistication likely reveal price differences that have nothing to do with the challenged conduct." Ex. 15, Corrected Expert Report Declaration of Dr. Robert T. Willig[8] In Support of Defs.' Opp. to Class Cert., *Sidibe v. Sutter Health* ("Sutter Report"), No. 12-cv-4854 (N.D. Cal. Nov. 8, 2018), at ¶ 197. Orszag thus acknowledged here that before choosing a hospital as a placebo, an economist should consider [redacted] *Id.* at 173:3-9.

Orszag failed to follow his own standard. [redacted] Ex. 1, OR1 ¶ 97. [redacted] *See* Ex. 8, Orszag Tr. at 173:3-9. [redacted]." Ex. 5, LR2 ¶ 80. As Orszag himself acknowledged in *Sutter*, the results may reflect "price differences that have nothing to do with the challenged conduct." Ex. 15, Sutter Report, at ¶ 197;

[8] In *Sidibe*, Dr. Willig fell ill after submitting his report. Orszag then took over as the defense expert and expressly adopted Dr. Willig's opinions.

see Brown v. Burlington N. Santa Fe Ry. Co., 765 F.3d 765, 773 (7th Cir. 2014) (testimony unreliable where expert "deviated from his own stated" methodology).

Orszag's fly-by-night selection of placebos stands in stark contrast to Dr. Leitzinger's selection of [redacted] as a corroborating hospital for his analysis. As described *supra*, Dr. Leitzinger did not select [redacted] until he analyzed its characteristics and concluded that it was similar to the AAH systems on numerous relevant dimensions: [redacted] Ex. 4, LR1 ¶ 43; Ex. 5, LR2 ¶ 91. Orszag did not conduct any analysis of this kind—he neither employed any analytically rigorous method to ensure these hospitals were sufficiently comparable to [redacted] "nor explained why he hadn't." *Zenith Elecs. Corp. v. WH-TV Broad. Corp.*, 395 F.3d 416, 419 (7th Cir. 2005). He simply cannot say whether this fundamental precondition to a placebo test is satisfied.

Faced with this contradiction, Orszag tried to backtrack. He suddenly claimed [redacted] because he was [redacted] Ex. 8, Orszag Tr. 177:24-178:2. But that argument is circular. The whole point of a placebo test is to check whether the model finds an overcharge *where no overcharge should exist*. As the literature makes clear and [redacted] (and years earlier in the *Sutter* case), a placebo test can do that only if the placebo hospital is comparable enough to the original hospitals that the model would be expected to show no overcharge. Orszag skipped that step entirely, which means his placebo test cannot tell the difference between a flaw in Dr. Leitzinger's model and a flaw in his own choice of hospitals. *See, e.g.*, Eggers, *supra*, at 1108 (explaining that the "placebo analysis

[must] mirror[] the original research design closely enough to reproduce a possible violation of the core assumptions").

Nor can Orszag escape by arguing that Dr. Leitzinger's model should have automatically controlled for any differences between the placebo hospitals and [redacted] Dr. Leitzinger designed his model specifically to compare AAH-Wisconsin and [redacted]—two hospital systems in the same corporate family, [redacted] Ex. 5, LR2 ¶ 82. Because those two hospital systems were so similar, Dr. Leitzinger did not need to build in explicit controls for many characteristics they already shared. Ex. 5, LR2 ¶¶ 75, 79-83, 85-89; *see supra*. When Orszag swapped in [redacted] for AAH-Wisconsin, those commonalities disappeared. His "placebo" test then lumped all of those uncontrolled differences into the "overcharge" figure, making it impossible to know whether the "positive" results reveal anything about Dr. Leitzinger's model or are simply the predictable consequence of applying that model to hospitals it was never designed to analyze. *See* Ex. 5, LR2 ¶¶ 80, 86-88.

Third, Orszag failed to ensure that he had sufficient data to run the placebo tests. *See* Fed. R. Evid. 702(b) (expert testimony must be "based on sufficient facts or data"). Courts reject expert opinions for failing to ensure that the data used is "appropriately representative of the larger entity or population being measured." *Allgood v. Gen. Motors Corp.*, 2006 WL 2669337, at *11 (S.D. Ind. Sept. 18, 2006); *see also, e.g.*, *ATA Airlines*, 665 F.3d at 895 (finding expert unreliable where model used sample that was "less representative of the population being sampled"); *Farmer v. DirectSat USA, LLC*, 2013 WL 1195651, at *6-7 (N.D. Ill. Mar. 22, 2013) (excluding testimony where expert "conducts no analysis to … demonstrate the appropriateness of extrapolating results" from a limited data set). Orszag himself acknowledged that "[redacted]

[redacted]." Orszag Tr. 89:23-25; *see id.* at 90:1-2 ("[redacted]").

Orszag made no effort to satisfy his own standard. Instead of collecting any data of his own, he relied exclusively on Dr. Leitzinger's data. *See* Orszag Tr. at 183:24 ("[redacted]"). That shortcut created a major problem: Dr. Leitzinger collected data from the largest Network Vendors in Eastern Wisconsin and [redacted] (AAH-Wisconsin's and [redacted] service areas), but Orszag's placebo hospitals operate almost entirely elsewhere—[redacted]. *See* Ex. 1, OR1 ¶ 97; *see* Ex. 8, Orszag Tr. 178:7-8 ("[redacted]"). Orszag thus had no data from the many Network Vendors with a substantial presence in the service areas for [redacted] but not in Eastern Wisconsin. For example, [redacted] does not have a significant presence in Eastern Wisconsin but is a very substantial payor to [redacted], accounting for "[redacted]." Ex. 16, Expert Reply Report of David Dranove, Ph.D ("DR2") at ¶ 136 n.206. Yet at his deposition, [redacted] *See* Ex. 8, Orszag Tr. at 181:8-182:4 ("[redacted]").[9]

[redacted], Orszag failed to investigate this issue. Despite testifying [redacted], Ex. 8, Orszag Tr. at 90:1-2, he [redacted], *see* Ex. 8, Orszag Tr. at 179:17-180:25. [redacted]

[9] Other payors with a substantial presence in Western Wisconsin and not in the dataset Orszag used include Group Health Cooperative of Eau Claire, Group Health Cooperative of South Central Wisconsin, and Dean Health.

[redacted], *see id.* at 181:1-7, [redacted]. He thus had no basis to conclude that the data he used for his placebo hospitals was representative of anything. [redacted] An expert who [redacted] cannot satisfy Rule 702's requirement that his testimony be "based on sufficient facts or data," Fed. R. Evid. 702(b), or that it reflects data "appropriately representative of the larger entity or population being measured," *Allgood*, 2006 WL 2669337, at *11.

C. Orszag's "Difference-in-Differences" Opinion is Unreliable.

Orszag also misapplied another methodology, once again failing to ensure that necessary predicates were satisfied. Orszag purports to "[redacted]." Ex. 1, OR1 ¶¶ 103, 109. He uses [redacted] as his control group. *Id.* ¶ 110. The idea behind Orszag's DID model is to study whether AAH-Wisconsin's rates decreased relative to [redacted]" Ex. 1, OR1 ¶ 102.

For a DID test to be valid in this context, two conditions must be satisfied—and neither was satisfied here.

First, a DID analysis is valid only if it satisfies the "parallel trends" condition. As both experts agree, and the literature reflects, one of the "foundational condition[s] for the causal validity of a DID model is that outside of the treatment period, price trends for the treatment and

control groups should be similar." Ex. 5, LR2 ¶ 36 (citing Joshua Angrist, *Mostly Harmless Econometrics: An Empiricist's Companion*, Princeton University Press (2009), at 218-220). If the treatment and control groups were not moving in parallel prior to the treatment period, "the DID results are likely biased." Ex. 5, LR2 ¶ 37. [redacted] Orszag Tr. at 364:1-25.

Orszag's DID failed to satisfy this foundational condition, and he did not have his story straight. Orszag's report [redacted] *See* Ex. 5, LR2 ¶ 38. He claimed at his deposition that [redacted] Orszag Tr. at 368:12-19. That was not true: [redacted]. *See* Ex. 5, LR2 ¶ 38. [redacted] Ex. 8, Orszag Tr. at 365:6-9.[10] [redacted]. *See* Ex. 5, LR2 ¶ 39. [redacted] *Id.*; *see id.* ¶¶ 40-43. Because

[10] Orszag testified that [redacted]. *See* Ex. 8, Orszag Tr. at 365:8-12 ([redacted]). He did not cite any authority [redacted] and the academic literature is to the contrary. *See* Ex. 5, LR2 ¶ 42 ("[T]he literature discussing these tests states that researchers should be comparing the trends for a period that is long enough to show underlying trends, as far back as possible." (citing sources)).

this foundational requirement for a DID test was violated, and in any event because Orszag failed to satisfy his burden to show that it was satisfied, this opinion must be excluded.

Second, Orszag's DID rests on the incorrect assumption that [redacted] Indeed, Orszag admitted at his deposition that [redacted]

Orszag did not provide any evidence to support this critical predicate for his DID analysis—he just assumed it was true. His willingness to assume convenient facts without evidentiary support is not new. In *In re Electronic Books*, 2014 WL 1282298, Orszag's opinion was excluded because he assumed a specific useful life for Amazon's Kindle devices with "no evidence" to support that figure—and when a different assumption was substituted, his entire damages offset calculation "would be wiped out." *Id.* at *18. Similarly, in *Jones v. Varsity Brands*, 2024 WL 457173, a court excluded Orszag's opinions because instead of "apply[ing] any economic modeling, regression, statistical, or econometric analysis," he simply asserted facts without support. *Id.* at *4. Here, Orszag's assumption that the All Plans provisions' price effects [redacted] is precisely that kind of unsupported assertion.

Not only does Orszag's analysis rest entirely on an unexamined assumption, but the assumption was untrue, contradicted by record evidence and economic realities. [redacted] Ex. 1, OR1 ¶ 112 [redacted]

[redacted]. *See* Ex. 16, DR2 ¶ 196 n.311. More important, removing the All Plans provision does not itself affect prices; prices would not change until after a new round of price negotiations outside the shadow of the All Plans provision. Orszag claims that [redacted] but the evidence shows otherwise. Orszag states that [redacted] Ex. 1, OR1 ¶ 113 n.155, but in reality, [redacted] Ex. 16, DR2 ¶ 197 & n.316. [redacted] *Id.* (quoting Ex. 17, AAHEDWI02143440 at 442) [redacted]

Orszag's assumption [redacted] also fails to account for basic market dynamics. [redacted], the "All Plans" provision [redacted]. *See* Ex. 5, LR2 ¶ 34; Ex. 2, DR1 ¶ 194 n. 348. [redacted] and more time still "for Network Vendors to use the leverage from selective contracting to negotiate prices for new networks or renegotiate existing contracts."

Ex. 2, DR1 ¶ 194 n. 348; *see also id.* (detailing "economic research show[ing] that anticompetitive conduct can result in lingering price effects that can last for years.").

The record evidence bears this out: [redacted] Network Vendor executives testified that building a new network can take at least one or two years. *See* Ex. 13, Stotlar Tr. (Cigna) at 40:13-23; Ex. 18, Deposition of Paul Maxwell (Humana) at 37:3-17; [redacted]

Orszag's decision to treat [redacted]—made without investigating whether the competitive price effects had fully materialized or confronting the record evidence saying otherwise—renders his DID analysis unreliable. A "before" and "after" test without an "after" period offers nothing of value.

IV. CONCLUSION

Defendants do "not have the right … to call an expert economist to present opinions unless those opinions are the product of the expert's rigorous application of economic methods." *In re Elec. Books Antitrust Litig.*, 2014 WL 1282298, at *20. The opinions highlighted in this motion are not the product of a rigorous economics, but of unexamined assumptions and unwarranted shortcuts. Plaintiffs' motion should be granted.

Dated: June 2, 2026

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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/ Michael Lieberman
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