UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

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

NORTHSHORE UNIVERSITY HEALTHSYSTEM'S BRIEF IN OPPOSITION TO PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

REDACTED VERSION
FOR PUBLIC FILE

June 9, 2009

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INTRODUCTION

Plaintiffs are three individuals and one employee benefit trust plan who challenge the January 1, 2000, merger between NorthShore University HealthSystem (formerly Evanston Northwestern Healthcare ("ENH")) and Highland Park Hospital. Plaintiffs propose to litigate their claims on behalf of the following class:

> All persons or entities in the United States of America and Puerto Rico, except those who solely paid fixed amount co-pays, uninsureds who did not pay their bill, Medicaid and Traditional Medicare patients, governmental entities, defendant, other providers of healthcare services, and the present and former parents, predecessors, subsidiaries and affiliates of defendant and other providers of healthcare services who purchased or paid for inpatient hospital services or hospital-based outpatient services directly from NorthShore University Healthcare (formerly known as Evanston Northwestern Healthcare), its wholly-owned hospitals, predecessors, subsidiaries, or other affiliates other than those acquired as a result of the merger with Rush North Shore Medical Center (the "Class") from at least as early as January 1, 2000 to the present (the "Class Period").

This class should not be certified. Plaintiffs' motion and supporting materials approach class certification as if this private class action were a re-run of the FTC proceeding. It is not. The FTC challenged the effect of ENH and Highland Park Hospital's merger on rates paid by *managed care organizations* ("MCOs") only for *inpatient* services from *1999-2003*. Plaintiffs' advance far broader claims and seek certification of a class that includes: (1) *all* types of private payors (individuals, self-insured entities, and MCOs); (2) who purchased either *inpatient* or *outpatient* services; (3) from *2000-2009*. Despite the substantial differences, Plaintiffs attempt to rely upon the FTC proceeding and its findings to satisfy their burden under Rule 23.

The FTC action did not address Rule 23 or its elements. Plaintiffs' nine year, all encompassing proposed class, does not satisfy the elements of Rule 23. Class certification should be denied for the following five reasons. ***First***, Plaintiffs cannot establish antitrust injury or "impact" on a classwide basis under Rule 23(b)(3). As the Third Circuit recently held, "individual injury (also known as antitrust impact) is an element of the cause of action; to prevail

on the merits, *every* class member must prove *at least some* antitrust impact resulting from the alleged violation." *In re Hydrogen Peroxide Antitrust Litig.*, 552 F.3d 305, 311-12 (3d Cir. 2008) (emphasis added).

Plaintiffs' proposed class includes numerous categories of purported class members that Plaintiffs cannot show suffered any injury or "impact" from any alleged price increase. These groups include:

- Blue Cross and any individual or entity that paid ENH based on Blue Cross rates;
- MCOs that serve as Third-Party Administrators and pass through charges to individuals or other entities; provide fully-insured products and pass through price increases; or serve as rental networks;
- MCOs, entities, or individuals that paid under an out-of-network arrangement where the price is based on usual and customary charges and not ENH's prices;
- Self-insured entities that met stop-loss thresholds regardless of any price increase;
- Individuals or entities that met their annual plan out-of-pocket maximum regardless of any price increase; or met their deductibles (and have no other cost-sharing) regardless of any price increase;
- Individuals or entities that were reimbursed for payments through supplemental insurance, secondary insurance, or other programs;
- Individuals who did not pay any above-market price because of charity care policies; had fixed payment plans; had capitated indemnity insurance; had unexhausted Healthcare Spending Accounts; and
- MCOs, entities, or individuals that paid based on chargemaster rates that did not increase.

Accordingly, Plaintiffs' inclusion of these "no impact" class members in their proposed class forecloses certification under Rule 23. *See Id.*

Moreover, Plaintiffs have not proposed—and cannot propose—a common methodology for identifying purported class members that are included within these "no impact" categories. Some of these proposed class members had no impact because any price increases were passed

on or borne by others, some have agreements which protect against price increases, other purchasers pay prices that are not correlated to ENH's prices. Because the methodology proposed by Plaintiffs does not and cannot identify these groups, it fails to meet the "rigorous analysis" requirement of Rule 23, and no class can be certified. *Id.*

Indeed, Plaintiffs wholly ignore the affidavit filed by Blue Cross Blue Shield of Illinois ("Blue Cross"), the largest member of the putative class, which unequivocally states that the merger "did not cause BCBSI any injury or damage." Despite this affidavit, Plaintiffs included Blue Cross within the purported class. Based on Blue Cross alone, more than half of the putative class was not impacted by the merger. As a result, Plaintiffs have failed their burden of proving predominance.

Second, and independent of their failure to establish impact, Plaintiffs cannot establish predominance and superiority because numerous MCOs have arbitration agreements with ENH. The prevalence of disparate contracts between various MCOs and ENH that mandate all disputes, including this one, be resolved through arbitration precludes any finding of predominance. The individual questions of law and fact that each contract raises for arbitration predominate over common issues. *See* Fed. R. Civ. P. 23(b)(3). Further, the MCOs' contracts with ENH evidence the parties intent that alternative dispute resolution ("ADR") mechanisms are preferred. Absent members of the purported class have already affirmed that this class action is not the superior method for resolving any potential claim. Hence, neither predominance nor superiority can be met, and no class can be certified.

Third, Named Plaintiffs are not adequate representatives of the proposed class as required under Rule 23. Painters Fund is a self-insured entity that has no claim because it paid for services wholly based on the "fair and reasonable" rates negotiated by Blue Cross. Blue

Cross stated that it "did not pay artificially inflated prices," thus refuting any claim to the contrary by Painters Fund. As Painters Fund cannot be a class representative, the Plaintiffs lack any representative for self-insured entities or inpatient services. No adequate class representative exists for two broad categories of Plaintiffs' proposed class.

Further, the remaining Named Plaintiffs are inadequate to represent any class including MCOs. None of the Named Plaintiffs is an insurer and cannot represent sophisticated MCOs. The interests of individual patients differ from those of the MCOs. Significant and irreconcilable conflicts exist between the purported MCO class members and proposed individual class members—not the least of which is the apparent conflict between Plaintiffs' allegations and Blue Cross' admissions. Moreover, many of the Named Plaintiffs' claims are antagonistic to other class members who benefited from quality of care improvements resulting from the merger. Because the individual Named Plaintiffs cannot fairly and adequately represent the proposed class, no class can be certified. *See* Fed. R. Civ. P. 23(a)(4).

Fourth, Plaintiffs cannot establish predominance as required by Rule 23(b)(3) because the claims of the proposed class are barred by the applicable statute of limitations. Antitrust claims are subject to a four-year statute of limitations. Claims for an unlawful merger accrue immediately when the merger is complete. The merger of ENH and Highland Park Hospital closed on January 1, 2000, therefore Plaintiffs' claims are time barred. In order to challenge this accrual date, each purported class member would need to prove that they did not have actual, imputed, or constructive knowledge of the merger, that they could not have learned of the public announcement of the merger or read the press coverage; and then establish an actual individual accrual date not expired under the four-year statute. In fact, the uncontroverted record shows that all of the claims of the MCOs, self- or fully-insured entities, the Named Plaintiffs

themselves, as well as many others within Plaintiffs' proposed class, are time barred. For example, no MCO has an actionable claim because ENH notified the MCOs in writing of ENH's intent to merge, terminate and renegotiate their contract*s before* the merger closed. This evidence demonstrates that, at best, the accrual of antitrust injury for each member of the proposed class is an individualized determination that forecloses a finding of predominance under Rule 23(b). As a result, no class can be certified.

Fifth, Plaintiffs' claims are not typical under Rule 23(a) of the broad and varied class they propose to represent. None of the Named Plaintiffs is an MCO. Named Plaintiffs are individual patients and one self-insured entity that, as previously stated, has no claim because it contracted with Blue Cross for rates, and Blue Cross admittedly suffered no injury. MCOs, unlike the Named Plaintiffs, purchase services based on complex contracts executed after bilateral negotiations with ENH. Even if the Named Plaintiffs themselves succeed in proving their claims, they will not have proved any of the claims for any category of purchasers in the proposed class. *See In re Graphics Processing Units Antitrust Litig.*, 253 F.R.D. 478, 489-90 (N.D. Cal. 2008) (finding "[t]he atypicality and detachment of the named plaintiffs' claims from those of the remaining class obstruct their ability to adequately pursue and prove the claims of the absent class members.").

For these reasons, Plaintiffs motion for class certification should be denied. [1]

[1] Due in part to the complexity of this case, ENH welcomes the opportunity for a hearing and/or oral argument on Plaintiffs' Motion if it would be of assistance to the Court. It is within the Court's discretion to grant such a hearing. *See, e.g., Vodak v. City of Chicago*, No. 03 C 2463, 2006 WL 1037151, at *1 (N.D. Ill. Apr. 17, 2006).

FACTS

A. This Case is Different than the Federal Trade Commission Proceeding.

In this case, Plaintiffs claim that the merger of ENH and Highland Park Hospital enabled anticompetitive price increases to a disparate group of private purchasers of healthcare services over a nine year period. Plaintiffs propose a heterogeneous class comprised of all private individuals and entities who directly pay for services from ENH. They approach certification as if they stood in the government's shoes (which they do not), and ignore the major differences between the FTC case and their claims on behalf of the proposed class. Unlike the FTC case, Plaintiffs' proposed class seeks to recover for *all* private purchasers of *both* inpatient and outpatient services for a *nine year* time period of 2000-2009.

The FTC alleged a significantly different case. Although it also challenged the 2000 merger with Highland Park, the FTC challenged (1) only the rates to select MCOs, (2) for just inpatient services, and (3) for a three-year period, 2000-2003. The FTC considered customers like Named Plaintiffs irrelevant—calling patients' relationships with the hospitals "a marginal issue at best."[2] It also rejected including outpatient services in its case on the basis that such services constitute a different product market. *In re Evanston Northwestern Healthcare*, Dkt. No. 9315, at 56 (F.T.C. Aug. 6, 2007) ("FTC Op."). Finally, the FTC's analysis was limited to data through 2003. Indeed, in that proceeding only four MCOs produced reliable data. One of them was Blue Cross—which has disavowed any claims in this class action. Accordingly, based

[2] *See In re Evanston Northwestern Healthcare*, No. 9315, FTC Post-Tr. Br. at 10 n.12 (June 24, 2005) ("For purposes of this case, the relevant relationship is between the hospitals and health plans because it is this competitive dynamic that sets hospital prices. In light of the evidence that health plans could not substitute ENH with hospitals located outside the ENH geographic triangle, the 'competition' among these hospitals likely relates to attracting patients, a marginal issue at best in this litigation.") (internal citations omitted).

on a proceeding that involved three years of post-merger data, from four payors, Plaintiffs propose to extend the class period an additional six years.

B. ENH and Its Customers.

ENH currently operates four hospitals in the north suburbs of Chicago. ENH merged with Highland Park Hospital on January 1, 2000. Evanston Hospital and Highland Park Hospital are 13.7 miles (27 minutes) from each other. A number of other hospitals are located closer to Evanston Hospital and Highland Park Hospital than they are to each other. *See* Chicago Area Hospital Map, Ex. A.

The categories of individuals and entities that receive and pay for services at ENH are varied and demonstrate that Plaintiffs' proposed class – which includes all these payors – should not be certified. ENH's expert, Dr. Monica Noether, details each of these payors. (Expert Report of Dr. Monica Noether, June 9, 2009 ("Noether Rep.") at App. 1 ¶¶ 6-34) (filed contemporaneously herewith). The delivery of health care services is not the simple, buyer-seller relationship that Plaintiffs pretend. For example, commercial insurance encompasses multiple benefit designs, including traditional indemnity as well as various managed care plan designs such as health maintenance organizations (HMO), preferred provider organizations (PPO); and point-of-service (POS) plans. The various plans are commonly referred to as Managed Care Organizations ("MCOs"). MCOs create networks by negotiating discounted rates with providers, such as ENH, through a complicated rate structure. The networks are created by the contracts between an MCO and ENH. The contracts are the product of lengthy bilateral negotiations.

MCOs sell their product to employers or other entities providing health insurance to employees and other individuals on a fully-insured or a self-insured (or self-funded) basis. When fully-insured, an employer pays a monthly premium to the MCO for each enrolled

employee, and the MCO pays for all covered expenses. When self-insured, the employer is charged for services under the MCO's negotiated discount rate structure, but the employer is responsible for all healthcare expenses and typically pays the MCO an administrative fee for acting as Third Party Administrator ("TPA"). Whether fully-insured or self-insured, the employer generally has a contract with an MCO.

One of ENH's customers is Blue Cross. Blue Cross is the largest commercial insurer in the Chicago area, by a wide margin. Recent estimates are that Blue Cross has 3.5 million enrollees in the Chicago area. Crain's Chicago Business: 2008 Book of Lists 131-32 (*Crain's Chi. Bus.* 2008), Ex. B. The next biggest MCO has 935,000. Redacted [redacted].[3] By definition, the largest member of Plaintiffs' proposed class is Blue Cross. During discovery in this case, Blue Cross submitted an affidavit affirmatively stating that it did not suffer "any injury or damage" and at all times paid "fair and reasonable prices" to ENH. *In re Evanston Northwestern Healthcare Anti. Litig.*, No. 07-cv-4446 (Decl. of J. Arango at ¶¶ 1, 3) (Oct. 21, 2008) [Dkt. 212], Ex. C.

Whether the MCO is large like Blue Cross, or small, a common feature of contracts with ENH are alternative dispute resolution ("ADR") mechanisms, such as mediation and arbitration. Despite the ADR provisions, Plaintiffs proposed class includes all MCOs. On June 1, soon after Plaintiffs identified the members of their purported class, ENH provided notice to Plaintiffs that any claims asserted on behalf of the following MCOs are required to be resolved pursuant to the parties' agreed ADR provisions:

[3] Approximately 50% of ENH's revenue is received from government payors such as Medicare and Medicaid. Since these governmental payors are excluded from Plaintiffs' proposed class, ENH does not discuss the complex service and payment structure under these government programs here. The expert report of Dr. Noether provides background information about government payors. *See* (Noether Rep. at App. 1 ¶¶ 18-26).

Admar Corp.
Aetna Health of Illinois Inc.
American Psych Systems Inc.
BCE Emergis Corp.
Beech Street Corp.
CCN Managed Care
ChoiceCare Network
Cigna Healthcare of Illinois Inc.
Cofinity Inc.
ComPsych Corp.
CorVel Corp.
Coventry Health and Life Insurance Co. (d/b/a Personal Care Insurance of Illinois Inc. and First Health Group Corp.)
DirectCare America Inc. (Interplan Health Group)
ForMost Inc.
Great-West Healthcare of Illinois Inc.
Health Marketing Inc.
Health Preferred of Mid-America
HealthSouth Corp.
Humana Health Plan Inc.
Magellan Health Services (formerly Medco Behavorial Care Systems Corp.)
Mental Health Care at Home (d/b/a Mental Health Case Management)
MetraComp Inc.
MultiPlan Inc.
National Provider Network Inc.
Odyssey Healthcare
One Health Plan of Illinois Inc.
Oxford Health Plans Inc.
Principal Behavioral Healthcare Inc.
Principal Health Care Inc. – PPO Greater Chicago Division
Principal Health Care of Illinois Inc. – HMO
Private Healthcare Systems Inc. (PHCS)
Three Rivers Provider Network
Unicare Life and Health Insurance Co.
United Behavioral Health Inc.
United Healthcare of Illinois Inc.
United Payor & United Providers
Wellmark HealthNetwork
York Behavioral Health Care

No MCO, since the merger in 2000, has ever sought to arbitrate or litigate the claims Plaintiffs now make on their behalf. In order to protect its contractual rights, ENH filed a motion to compel arbitration which is incorporated herein by reference. *See* (ENH's Mot. Compel Arbitration, Dkt. Nos. 270, 271, attached as Ex. D).

In addition to the arbitration provisions, the economic relationships between ENH and its individual patients further complicate this case. As more fully described in Dr. Noether's expert report, ENH provides services to patients with private insurance through MCOs; patients with private insurance through employer-based, fully-insured or self-funded plans; and patients without insurance. *See generally* (Noether Rep. at App. 1). The amounts paid to ENH by each category of patient depend on ENH's specific contract with each individual MCO, and the prices and terms of the individual patient's (or her employer's) contract with the MCO, which are set

by negotiation between the employer and an MCO. Common features of such health plans include premiums, co-payments, coinsurance, annual deductibles, out-of-pocket maximums, and non-covered services (i.e., services that are excluded from coverage).

Uninsured patients (who, by revenue, consume only a fraction of ENH's services) may be charged ENH's retail charges, but the amounts actually paid vary by case because of ENH's financial assistance and charity care policies. More often than not, these charges are never paid or paid only in small part. Redacted The wide and varied number of customers that received healthcare services at ENH, and the disparate ways they pay ENH for those services, dictate that individual issues predominate.

C. Named Plaintiffs.

Named Plaintiffs do not consist of a cross section of ENH's various customers and payors. Instead, they are one self-insured health and welfare fund and three individual patients. Painters District Council No. 30 Health & Welfare Fund ("Painters Fund"), one of the Named Plaintiffs, is a self-insured entity that has provided insurance to its members through Blue Cross at all times since the merger. Redacted Painters Fund received all the benefit of Blue Cross' "fair and reasonable prices" and, thus, has no claim. Redacted

[redacted] None of the Named Plaintiffs ever spent

a single night in the hospital at ENH. Redacted None have received any inpatient care. As shown below, the limited claims of Named Plaintiffs do not make them adequate representatives of the overly broad and divergent class proposed by Plaintiffs.

ARGUMENT

This Court should deny certification. Class certification should be granted only if Plaintiffs carry their burden of proving under a "rigorous analysis" that every element of Rule 23(a) and (b)(3) is satisfied. *Davis v. Hutchins*, 321 F.3d 641, 649 (7th Cir. 2003); *Szabo v. Bridgeport Machs., Inc.*, 249 F.3d 672, 676 (7th Cir. 2001). These elements include: (1) the proposed class is so numerous that joinder of all members is impracticable; (2) there are common questions of law or fact; (3) Named Plaintiffs' claims and defenses are typical of the rest of the class; (4) Named Plaintiffs will fairly and adequately represent the class' interests; (5) common questions of law or fact predominate over any individual questions; and (6) a class action is superior to any other method for fairly and efficiently adjudicating the controversy. *See* Fed. R. Civ. P. 23(a), (b)(3); *Williams v. Chartwell Fin. Servs., Ltd.*, 204 F.3d 748, 760 (7th Cir. 2000).

As set forth below, Plaintiffs' proposed class fails with respect to at least four of these six elements—predominance, superiority, adequacy, and typicality.[4]

I. Plaintiffs Fail To Establish Predominance Because They Cannot Demonstrate Impact On A Classwide Basis.

The proposed class is not certifiable under Rule 23(b)(3) because Plaintiffs' cannot satisfy predominance. "[W]here fact of damage cannot be established for every class member

[4] ENH does not contest numerosity. And whether Plaintiffs can establish commonality is not important because they cannot meet the higher standard for predominance. *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 623-24 (1997).

through proof common to the class, the need to establish antitrust liability for individual class members defeats Rule 23(b)(3) predominance." *Bell Atl. Corp. v. AT&T Corp.*, 339 F.3d 294, 302 (5th Cir. 2003). As shown below, Plaintiffs have not—and cannot—show predominance for three dispositive reasons.

A. Plaintiffs' proposed class includes numerous "no impact" class members.

To show predominance, Plaintiffs must establish classwide impact. Substantial types of purchasers included in Plaintiffs' proposed class suffered *zero* impact from the merger, even assuming that ENH increased prices after the merger. Classwide antitrust impact is an "element of the cause of action; to prevail on the merits, *every* class member must prove *at least some* antitrust impact resulting from the alleged violation." *In re Hydrogen Peroxide*, 552 F.3d at 311 (emphasis added).

Plaintiffs cannot make that showing here. Some proposed class members had no impact because any price increases were passed on or borne by someone other than the class member. Others had no impact because their specific agreement, plan, or contract protects against any price increases. Still other purchasers had no impact because ENH simply cannot increase any prices that those proposed class members are required to pay.

These no impact groups include:

- Blue Cross and any individual or entity that paid ENH based on Blue Cross rates;
- MCOs that serve as Third-Party Administrators and pass through charges to individuals or other entities; provide fully-insured products and pass through price increases; or serve as rental networks;
- MCOs, entities, or individuals that paid under an out-of-network arrangement where the price is based on usual and customary charges and not ENH's prices;
- Self-insured entities that met stop-loss thresholds regardless of any price increase;

- Individuals or entities that met their annual plan out-of-pocket maximum regardless of any price increase; or met their deductibles (and have no other cost-sharing) regardless of any price increase;

- Individuals or entities that were reimbursed for payments through supplemental insurance, secondary insurance, or other programs;

- Individuals who did not pay any above-market price because of charity care policies; had fixed payment plans; had capitated indemnity insurance; had unexhausted Healthcare Spending Accounts; or

- MCOs, entities, or individuals who paid based on chargemaster rates that did not increase.

As demonstrated in the examples below, and more fully detailed within the expert report of Dr. Noether, none of these purported class members has been shown to have suffered any impact. *See* (Noether Rep. at ¶¶ 9, 45-55).

1. Insurance plans that have out-of-pocket maximums have no impact.

Any class members with insurance plans that have out-of-pocket maximum components that would have been reached regardless of any price increase suffered no impact. (Noether Rep. at ¶¶ 29-30, 53, App. 1 ¶¶ 64, 66, App. 2 ¶¶ 1-4). The same would be true for class members' plans with annual deductibles and no other cost-sharing provisions. Such provisions are standard in many plans. Redacted [redacted] When an individual patient (or family) meets an annual deductible or out-of-pocket maximum, they cannot suffer any further injury after that point, because no money will come from their wallets. For example, suppose a patient has a $300 out-of-pocket maximum. In that year, she had $400 in medical expenses. Further suppose that Plaintiffs prove she was overcharged $50 that year. Her maximum would have been reached regardless; any antitrust impact was felt by the insurance company, not the patient. So even though she directly paid $300 to ENH, she was not impacted.

Annual deductibles and out-of-pocket maximums create an even greater problem: they can be spent at *any* provider, not just ENH. (Noether Rep. at App. 1 ¶ 65). Thus, for any class member whose insurance plan includes a deductible and/or out-of-pocket maximum provision, it would be necessary to investigate the total payments for the year not just to ENH, but to *all* healthcare providers. One would need to tally each individual transaction during the year to determine where each patient went for services, in order to learn if the patient felt the impact of any price increase at ENH.[5] Even if this were possible, these intense individual analyses defeat any finding of predominance as required under Rule 23. *See* (Noether Rep. at ¶ 31, App. 1 ¶ 65).[6]

2. MCOs acting as third-party administrators or rental networks have no impact.

Similarly, Plaintiffs cannot show that MCOs acting as third-party administrators ("TPAs") or rental networks for employers or self-insured entities suffered any impact. Self-insured plans typically use a TPA (or a self-insured leases an MCO's rental network). Painters Fund, for example, contracts with Blue Cross. Redacted The self-insureds enjoy the MCO's negotiated discounted rates. (Noether Rep. at ¶¶ 48, 50). The MCO directly pays the charges to ENH and the self-insured entity reimburses the MCO. Redacted The cost of the services is passed through the MCO to the self-insured

[5] Redacted

[6] As explained more fully by Dr. Noether, the data shows that patient payments decrease by a statistically significant amount as each calendar year progresses (i.e., January to December). As the months pass, the amount patients pay to any health care provider—such as ENH—decreases because they meet their deductibles or out of pocket maximums. *See* (Noether Rep. at ¶ 30, App. 2 ¶¶ 2-4).

entity. The MCO receives an administrative fee. Redacted In this scenario, the MCO is not impacted. It cannot be, since it is merely an intermediary.

Plaintiffs' proposed class includes these groups and Plaintiffs' expert does not address this issue. For if he did, he would have found that the class definition mistakenly includes thousands of transactions for which there can be no impact whatsoever.[7] This problem exists at the individual-level, too, where an individual may have supplementary or secondary insurance that reimburses any out-of-pocket amounts. In such situations, any antitrust impact would be borne by someone other than the class member. The impact of any price increases could only be measured on an individual basis, given the complexity of the payment arrangements between MCOs, self-insureds, and individuals. Since individual issues would predominate, Rule 23 cannot be met.

3. The Merger did not impact Blue Cross.

Additionally, the largest member of the proposed class also admittedly suffered no impact from the merger. Redacted Plaintiffs include Blue Cross (and the self-insureds that pay Blue Cross negotiated rates) within their proposed class despite Blue Cross' acknowledgement that its rates were *not impacted*. As soon as Blue Cross was thrust into discovery as a third-party, it took the extraordinary step of disowning this class action. Blue Cross declared:

[7] Class members who pass through their charges to another entity also raises the issue of indirect purchasers. Plaintiffs' proposed class only includes those to paid "directly" for services at ENH. However, an individual analysis is required to determine if a payment was made directly or indirectly. *See also Illinois Brick v. Illinois*, 431 U.S. 720, 728 (1977) (barring recovery for indirect purchasers). ENH reserves the right to raise the issue of indirect purchasers during any summary judgment briefing that may occur in this case.

- "From 1990 to the present, BCBSI paid Evanston Northwestern Healthcare, now known as NorthShore University HealthSystem, *fair and reasonable prices* for health care services provided by Evanston Northwestern Healthcare." Decl. of J. Arango at ¶ 1 (Oct. 21, 2008) (originally submitted in support of Dkt. No. 212) (emphasis added), Ex. C.

- "BCBSI did not pay artificially inflated prices to Evanston Northwestern Healthcare for those health care services." *Id.* at ¶ 2.

- "The conduct which Evanston Northwestern Healthcare allegedly engaged in, as stated in this case, did not cause BCBSI any injury or damage." *Id.* at ¶ 3.

- "BCBSI declines to be included as a class member in any class that may be certified in this case" *Id.* at ¶ 4.

These facts are uncontroverted. Blue Cross affirmed that it has no antitrust claim. Blue Cross' affidavit is consistent with the findings of the FTC and both sides' economists in that case. (FTC Op. at 39) (finding "little or no unexplained merger-coincident average net price increase for [Blue Cross]").

Although Plaintiffs' expert defiantly states he "will conduct an independent analysis to determine whether ENH increased its prices to BCBS," (Dranove Rep. at 5 n.21), he inexplicably failed to even read, let alone consider, the affidavit in reaching his opinion (Dranove Dep. at 14, Ex. I). The Blue Cross affidavit has been in the record since October of last year, months before his report was submitted. For this reason alone, Dr. Dranove's report lacks credibility and is unreliable. *See In re Hydrogen Peroxide*, 552 F.3d at 323-24 (finding that weighing expert testimony, including "credibility" of the experts, at the class certification stage "is not only permissible; it may be integral to the rigorous analysis Rule 23 demands.").

B. Plaintiffs' proposed methodology cannot be performed on a classwide basis.

Plaintiffs' proposed methodology is unfit to exclude any of the above mentioned purchasers who were not injured by the alleged conduct. Under Rule 23, Plaintiffs must demonstrate antitrust impact—and that means providing a sound method for doing so on a

classwide basis. *In re Hydrogen Peroxide*, 552 F.3d at 311-12 (stating that "the task for Plaintiffs at class certification is to demonstrate that the element of antitrust impact is capable of proof at trial through evidence that is common to the class rather than individual to its members."). If impact cannot be shown on a classwide basis, but rather requires individual proof, then the predominance requirement of Rule 23 is not satisfied and a class cannot be certified. *See Bell Atl. Corp.*, 339 F.3d at 302.

1. Plaintiffs' methodology cannot identify no impact groups

Separate and apart from the no impact groups identified above, which Plaintiffs have no methodology to exclude, Plaintiffs' class definition identifies some categories of purchasers that cannot have any impact: those who paid "fixed amount co-pays," "uninsureds who did not pay their bill," "Medicaid and Traditional Medicare Patients," "governmental entities" and indirect purchasers. However, Plaintiffs also are unable to identify and exclude these no impact groups on a classwide basis. The data do not report these factors, and individual patient-by-patient analyses would be required in order to exclude them.

Plaintiffs' expert hopes to look at the *individual* patient billing records to identify the proposed class members. *See* (Dranove Dep. at 27-29 (fixed co-pays), 33-34 (uninsureds that have not paid their bills), 41 (same), 42-45 (Medicaid), 46 (Medicare), 47 (governmental entities), 49 (other providers), Ex. I). While Dr. Dranove has not yet undertaken his proposed study, Dr. Noether has performed the analysis. An examination of the available data reveals it is impossible to determine reliably whether a specific payment ENH receives is a "fixed amount co-pay" or not. *See* (Noether Rep. at ¶ 82, App. 4 ¶¶ 6-13). Even if it were possible, the proof would be highly individualized. *See Allied Orthopedic Appliances, Inc. v. Tyco Healthcare Group, L.P.*, 247 F.R.D. 156, 172 (C.D. Cal. 2007) (denying class certification because proving impact and injury "will likely require highly individualized proof . . .").

Frequently, an uninsured individual may pay some, but not all, of his or her bill.[8] Plaintiffs offer no common way to include or exclude those who pay only a portion of their bills. A class member will have no impact if they paid some of their charges, but did not pay any portion that represented the anticompetitive price. Plaintiffs' expert has no systematic way to say who is in—or who is out—of the class. At best, Plaintiffs' expert hopes to analyze every patient record, one-by-one. (Dranove Dep. at 32-34, Ex. I); *see In re Graphics Processing*, 253 F.R.D. at 488-89 (finding common issues did not predominate where "plaintiffs have failed to supply a class-wide method for proving 'impact' on a class-wide basis"). Sifting through millions of billing records is simply not a "class-wide method."

2. Plaintiffs cannot imply impact on a classwide basis through averages.

Plaintiffs claim that they can *imply* classwide impact because *average prices* to some MCOs increased after the merger. To reach this inference, however, Plaintiffs' expert relies on two false assumptions: (1) that the contracts signed by MCOs use only basic methodologies and (2) that changes to chargemasters occur "across the board." Both of these assumptions are false.

Plaintiffs' expert opines that since MCO contracts use three uniform payment methodologies, impact can be inferred across the class. (Dranove Rep. at ¶ 68). But the contracts between hospitals and MCOs are not nearly as simple as Dr. Dranove believes them to be.

[8] Redacted

(Noether Rep. at ¶¶ 12, 14-33, 34-39).[9] In fact, the FTC's managed care contracting expert from the FTC proceeding contradicts that assumption.[10] As explained by Redacted

Redacted

Therefore, it is simply wrong to assume, as Plaintiffs' expert does, that an increase in average prices means an increase in *all* prices for all services across the class. (Dranove Rep. at ¶ 68). Plaintiffs' key assumption belying their inference of classwide impact is false.

Second, in order to prove impact across the class, Plaintiffs' expert presumes changes to the chargemaster occur "across-the-board." (Dranove Rep. at ¶¶ 81, 90); *see* (Dranove Dep. at 167 (admitting he did not review ENH's chargemasters), Ex. I). Dr. Noether tracked the changes to the 11,000 items in ENH's chargemasters and has disproved this operating assumption.

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[9] Dranove has not actually reviewed *any* MCO-ENH contracts. (Dranove Dep. at 81, 114, 193, Ex. I). He promises to do so. (*Id.* at 160-161).

[10] Redacted Dr. Noether also spent considerable time analyzing ENH's contracts. *See* (Noether Rep. at ¶ 6).

[11] Redacted

Redacted

Therefore, Plaintiffs' expert cannot infer impact for those class members that pay based on ENH's chargemasters.

Plaintiffs' expert concedes that his DID analysis can only show whether *average* prices have increased relative to the control group, not whether prices for individual services have increased anticompetitively. (Dranove Rep. at ¶ 15). Average price increases are not common proof that every class member was impacted. As Dr. Noether shows, even if average prices increased to the level of being an "overcharge," that does not mean that there are overcharges for every specific service purchased at ENH. (Noether Rep. at ¶¶ 11, 61-71, 75-79). This means that the DID methodology is not suitable for the task of proving injury to every member of the class. Dr. Dranove concedes this, at least implicitly, when he suggests a more individual-level analysis (which he has not yet attempted). *See* (Dranove Rep. ¶¶ 91, 95 n. 82; Dranove Dep. at 155-58, Ex. I); *see also Colomar v. Mercy Hosp., Inc.*, 242 F.R.D. 671, 677 (S.D. Fla. 2007) (denying certification of hospital class action holding "any commonality breaks down into an individualized inquiry" of the legality of "specific bills").[12]

C. Plaintiffs' proposed methodology does not satisfy the "rigorous analysis" requirement.

In addition to the flaws detailed above, Plaintiffs' proposed methodology also does not satisfy the "rigorous analysis" requirement necessary to support class certification. *Gen. Tele. Co. of Sw. v. Falcon*, 457 U.S. 147, 161 (1982); *Szabo*, 249 F.3d at 675-76; *see In re Hydrogen*

[12] Dr. Dranove first hopes he will be able to estimate a DID model for each payor, but later concedes that he may need perform a deeper model for each insurance plan (HMO, PPO, POS, etc.), then acknowledges that he may need to review each Major Disease Category, and ultimately speculates that he may even need to do an individual DRG level analysis for each payor. *See* (Dranove Dep. at 155-58, Ex. I).

Peroxide, 552 F.3d at 318. Instead of engaging in the rigorous analysis necessary to support certification of this proposed class, Plaintiffs' expert has done little more than parrot portions of the expert reports from the FTC proceedings. *See* (Dranove Dep. at 71, 85, 88-89, 112-13, 126, Ex. I) (admitting he spent only 28 hours preparing his report), Ex. I. That is not enough. *See In re Hydrogen Peroxide*, 552 F.3d at 318 (requiring a "rigorous analysis" to satisfy Rule 23).

Plaintiffs attempt to rely upon the limited analysis from the FTC case, without actually performing it themselves, and merely promise to do some analysis in the future which they hope will confirm their assumptions. Plaintiffs failure to actually perform any analysis – let alone a rigorous analysis – forecloses certification here. *See Am. Seed Co. v. Monsanto Co.*, 271 Fed. Appx. 138, 141 (3d Cir. 2008) (denying certification where plaintiffs' expert did not "independently analyze" data and documents made available during discovery).

1. Promises to perform an analysis are insufficient.

Plaintiffs and their expert hope that the data required is available or will be available in order for them to perform their proposed methodology. But this ignores the procedural posture of this case: ENH produced all available data to Plaintiffs months ago.[13] Yet Dr. Dranove failed to review it. (Dranove Dep. at 81-82, Ex. I (admitting he never examined the 2003-present data produced by ENH months before his report)). This is precisely the sort of unsupported promise foreclosed by the "rigorous analysis" requirement. "The evidence and arguments a district court considers in the class certification decision call for rigorous analysis. A party's assurance to the court that it intends or plans to meet the requirement is insufficient." *In re Hydrogen Peroxide*,

[13] On September 11 and December 11, 2008, ENH produced its complete record of patient claims data to Plaintiffs, ENHCA-011-000001 – 02 and ENHCA-029-000001 – 03. *See* Ex. K. Plaintiffs never informed ENH of any issues with their ability to review and use the data. In fact, Dr. Noether reviewed and analyzed the very same data in preparing her report.

552 F.3d at 318; *see also Am. Seed Co.*, 271 Fed. Appx. at 141 (affirming denial of class certification where expert admitted that he had "not substantiated his assumed theory by, for example, performing any analysis of the data made available to [plaintiffs] in discovery"); *In re Graphics Processing*, 253 F.R.D. at 505-06 (concluding that "plaintiffs' experts ask this Court to rely too heavily on their promises that they will be able to formulate the appropriate analysis and prove both impact and damages once they obtain the necessary data"). No class can be certified because Plaintiffs failed to perform any rigorous analysis to support their assumptions.

2. Dranove has not even attempted to demonstrate impact after 2003.

Plaintiffs' experts have not even reviewed any data for the post-2003 time period. If they had done so, they would have encountered two significant problems: (1) some types of data which Plaintiffs' expert presumes is available simply does not exist; and (2) Dr. Dranove cannot perform a reliable DID analysis without such data.

Plaintiffs' expert's proposed DID method relies on the data and copies the work performed by economists in the FTC case, but fails to account for the limitations in the data. *See* (Dranove Dep. at 126, Ex. I (admitting that he never replicated the studies)). At best, the "by payor" method used before the FTC is feasible for only the four payors that produced data (Aetna, Blue Cross, Humana, and United). None of the other payors produced workable data. This data only goes through part of 2003.

a. Data does not exist for payors, chargemasters, and other hospitals.

By far the largest of the four payors for which there is data, Blue Cross, incurred no impact whatsoever. (Decl. of J. Arango, Ex. C; FTC Op. at 39). The experience of Blue Cross rebuts Dr. Dranove's implication that he can project common impact on payors that did not produce data. There are certainly other payors like Blue Cross who suffered no impact. In

essence, Plaintiffs have data from only three purportedly-injured class members, for roughly one third of the proposed class period. From that limited data set, they hope to extrapolate impact classwide. This is plainly unreliable. (Noether Rep. at ¶¶ 72-79). The evidence from Blue Cross confirms it.

Further, chargemasters from before 2002 are not available. In any event, Plaintiffs' expert never examined the chargemasters produced by ENH. (Dranove Dep. at 167, 172, Ex. I). Not only do some of ENH's chargemasters not exist, but chargemaster data from control group hospitals has never been collected or produced. *See* (Noether Rep. at ¶ 87). These gaps in data make it impossible for Plaintiffs' expert to perform a reliable DID analysis for proposed class members that paid based on chargemasters. (*Id.*)

b. Dr. Noether demonstrates Plaintiffs' methodology will fail.

Since Plaintiffs have not yet attempted to perform their own proposed methodology, Dr. Noether tested the method and found that it fails. Reliable data from four payors was collected in the FTC case only through part of 2003. (FTC Op. at 29). The DID methodology also requires robust data from control hospitals. Plaintiffs' expert admits that the data from other hospitals necessary for a DID analysis is not available after 2003, and is unlikely to ever be available. (Dranove Dep. at 145, Ex. I).

Instead, Plaintiffs proposed to use state data on hospital discharges and the Medicare Cost Reports to construct a deflation index of hospital prices. The Medicare Cost data produce only a single discount for each year, for all services (inpatient and outpatient), and for all payors (which improperly includes Medicare and Medicaid). *See* (Noether Rep. at ¶¶ 73-76, 88). Plaintiffs' suggest that this can be used to reliably prove impact.

Dr. Noether used the ENH data to test the reliability of this method—that is, she used the state and Medicare information to create an estimate of prices, as Dr. Dranove proposes, and

compared those to the actual data available from ENH. *See* (Noether Rep. at ¶¶ 73-76). The estimated prices did not remotely match reality. In some cases, Plaintiffs' method predicts an increase, where prices actually decreased, and vice versa. Consequently, Plaintiffs have not provided a method to demonstrate impact or calculate damages for proposed class period. Accordingly, Dr. Dranove's proposed methodology is an abject failure and no class should be certified.

II. Plaintiffs Fail to Establish Predominance and Superiority Because MCOs Have Agreed to Arbitration.

Impact aside, Plaintiffs cannot establish predominance or superiority under Rule 23(b)(3) because nearly all of the MCOs have arbitration and/or alternative dispute resolution mechanisms in their contracts with ENH. For example, Aetna, United HealthCare, PHCS, and CIGNA all have mandatory arbitration clauses in their contracts with ENH.[14] The arbitration and/or ADR provisions defeat any finding of predominance. *See Christie Clinic, P.C. v. MultiPlan, Inc.*, No. 08-CV-2065, 2009 WL 175030, at *11 (C.D. Ill. Jan. 26, 2009) (holding that materially-different contract provisions, such as dispute resolution provisions "which could preclude proposed class members from participation in this litigation," defeat predominance).

[14] *See* ENH and MCO Alternative Dispute Resolution Agreements Chart, Ex. L ((Aetna) (Paragraph 8.4 provides that "any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between [Company and Hospital]. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party."); (United HealthCare) ("If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it shall thereafter be submitted to binding arbitration before a panel of three arbitrators in accordance with the Commercial Dispute Procedures of the American Arbitration Association . . ."); (PHCS) ("In the event of any problems or disputes that may arise under this Agreement, the parties to such problem or dispute will meet and seek resolution in good faith. Any controversy or claim arising out of or relating to this Agreement or the breach thereof, which is not so resolved, will be settled by binding arbitration in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration . . ."); (CIGNA) ("The proceeding shall be governed by the Rules of the American Arbitration Association then in effect, and shall be held in the jurisdiction of the Hospital's domicile.")).

The individual issues implicated by determining the extent to which each purported MCO class member has a claim that is arbitrable predominates over any common issues.

In sum, nearly forty putative class members entered into contracts with ENH which require any claims to be resolved by arbitration or ADR.[15] The MCOs and payors listed above (*supra* page 9), as well as within ENH's motion to compel arbitration (see Exhibit K), cannot remain part of this proposed class. As the current motion practice before this Court demonstrates, individual issues for each contract predominate. *See* (ENH's Mot. Compel Arbitration, Ex. D.).[16] No MCO, since the merger in 2000, has ever sought to arbitrate or litigate the claims Plaintiffs now make on their behalf. *See In re Managed Care Litig.*, 132 F.Supp. 2d 989, 999-1000 (S.D. Fla. 2000) (granting motion to compel arbitration "when such Plaintiffs have agreed to arbitrate all of their disputes with defendant"), *rev'd on other grounds*, *PacificCare Health Sys., Inc. v. Book*, 538 U.S. 401, 406-07 (2003).

Further, a finding of superiority under Rule 23 is precluded by the agreed ADR contracts. The ADR provisions eclipse Plaintiffs' contention that a class action proceeding is the superior mechanism to resolve their claims. The purported class members listed in Exhibit K and ENH already agreed that this forum is inferior to the alternative methods of dispute resolution. Federal law requires that these ADR provisions be honored; thus destroying any claim of predominance and superiority under Rule 23. *See* (ENH's Mot. Compel Arbitration, Ex. D).

A class action is not the superior method of resolving any dispute between an MCO and ENH. MCOs are multi-million (or billion) dollar corporations with substantial stakes at ENH.

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[15] *See* ENH and MCO Alternative Dispute Resolution Agreements Chart, Ex. L.

[16] The parties have filed separate motions related to the issue of arbitration. In response to ENH's motion to compel arbitration (Dkt. 270, 271), Plaintiffs have filed their own motion requesting that this Court find ENH has waived its arbitration clauses. *See* (Dkt. No. 273, 274).

The MCOs can represent themselves. *See In re Rhone-Poulenc Rorer, Inc.*, 51 F.3d 1293, 1297-1300 (7th Cir. 1995) (the existence of large individual claims undercuts the alleged superiority of the class action); *Birnberg v. Milk St. Residential Assocs. Ltd. P'ship*, Nos. 02 C 0978, 02 C 3436, 2003 WL 21267103, at *7 (N.D. Ill. May 29, 2003) (holding that class action was not superior method of adjudicating case where "existence of such large individual claims by sophisticated investors undercuts the alleged superiority of the class action"); *Liberty Mut. Ins. Co. v. Tribco Constr. Co.*, 185 F.R.D. 533, 541 (N.D. Ill. 1999) ("courts often find that class actions are not appropriate when the individual members are sophisticated and have large claims"). If an MCO believed it had a valid claim against ENH, it would have brought such a claim through litigation or arbitration long ago. As stated above, no MCO has elected to do so.

Further, the final order issued by the FTC mandates mediation and arbitration. The FTC's final order requires ENH to submit "any disputes" relating to prices and other terms of payor contract negotiations to mediation and arbitration. *In re Evanston Northwestern Healthcare*, No. 9315, at 4 (F.T.C. Apr. 28, 2008). ENH is required to abide by the terms of the FTC final order and resolve disputes with any MCOs through arbitration or mediation. In short, Plaintiffs' allegations with respect to MCOs and private payors (as well as those self-insureds who paid under such contract rates) cannot be pursued in this forum.

III. Plaintiffs Are Not Adequate Representatives Of The Proposed Class.

A. Painters Fund cannot be a class representative.

None of the Named Plaintiffs are adequate class representatives for the proposed class under Rule 23(a)(4). First and foremost, Painters Fund, the only non-individual class representative, simply has no claim relating to the merger and cannot represent the proposed class. At all times during the class period, the Painters Fund health insurance plan contracted through Blue Cross Redacted This means that Painters Fund paid the

same negotiated rates that Blue Cross said were "fair and reasonable" and "not … artificially inflated."[17] *See* Decl. of J. Arango at ¶¶ 3-4 (stating that ENH's merger with Highland Park Hospital "did not cause BCBSI any injury or damage."), Ex. C. Because the entity that sat across the table from ENH and negotiated prices on Painters Fund's behalf has declared those prices to be competitive, Painters Fund is unable to prove its claim.

This roadblock prevents Painters Fund from acting as a class representative as a matter of law. *See Robinson v. Sheriff of Cook County*, 167 F.3d 1155, 1157 (7th Cir. 1999) ("If when class certification is sought it is already apparent . . . that the class representative's claim is extremely weak, this is an independent reason to doubt the adequacy of his representation."); *see also Hardy v. City Optical Inc.*, 39 F.3d 765, 770 (7th Cir. 1994) ("plaintiff against whom the defendants have a defense not applicable to other members of the class is not a proper class representative"); *J.H. Cohn & Co. v. Am. Appraisal Assocs., Inc.*, 628 F.2d 994, 999 (7th Cir. 1980) ("[P]resence of even an arguable defense peculiar to the named plaintiff or a small subset of the plaintiff class may destroy the required typicality of the class as well as bring into question the adequacy of the named plaintiff's representation."). The largest purported class member, Blue Cross, has conceded that it, and its members, were never injured.[18] There are no other named self-insured entities in this litigation.

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[17] Redacted

[18] Further, Named Plaintiffs Redacted recently contracted with Blue Cross for health insurance. Redacted Based on Blue Cross' statements, neither of these Named Plaintiffs have a current claim.

B. Individual Named Plaintiffs cannot represent any class of inpatient claims.

Once Painters Fund is set aside, Plaintiffs lack a class representative not only for any entities that are not individual patients (including self-insured), but also for any claims related to inpatient services. None of the individual Named Plaintiffs ever spent a night at any ENH hospital; their injuries, if any, are confined to *outpatient* care. Redacted [19] They cannot represent any class member who received inpatient care. *Falcon*, 457 U.S. at 157-58; *Haroco, Inc. v. Am. Nat'l Bank & Trust Co. of Chicago*, 121 F.R.D. 664, 670 (N.D. Ill. 1988) (it is necessary that a class representative's "interest in proving his claim[s] will lead him to prove the claims of the remainder of his class") (citation omitted); *cf. Exhaust Unlimited, Inc. v. Cintas Corp.*, 223 F.R.D. 506, 511 (S.D. Ill. 2004) (denying certification where other members of the putative class paid charges in "different markets"). To the extent that the individual Named Plaintiffs hypothetically could prove any anticompetitive effect for their visits, it would be confined to the outpatient market.

C. There are irreconcilable conflicts of interest within the proposed class.

Finally, the existence of conflicts among the proposed class members makes Named Plaintiffs inadequate class representatives. There are several "inconsistencies between the interests of the named plaintiffs and the members of the proposed class such as to establish the inadequacy of the named plaintiffs as class representatives." *Cima v. WellPoint Health Networks, Inc.*, 250 F.R.D. 374, 380 (S.D. Ill. 2008). A plaintiff is considered "adequate" and

[19] Named Plaintiff Redacted has never received any inpatient services at any ENH hospital. Redacted Redacted

thus qualified to represent a class only if there are no conflicts between the class representative and the class. *See Retired Chicago Police Ass'n v. City of Chicago*, 7 F.3d 584, 598 (7th Cir. 1993) ("[a] class is not fairly and adequately represented if class members have antagonistic or conflicting claims") (citation omitted); *see also Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 625-626 (1997) (to avoid class conflicts, class "[r]epresentatives must be part of the class and possess the same interest and suffer the same injury as the class members"). In this case, the different types of purchasers' interests conflict with one another, thereby, defeating adequacy under Rule 23.

1. Plaintiffs are antagonistic to class members who benefited from the merger.

First, the evidence will show wide-ranging quality improvements throughout ENH following the merger. At least some—if not all—putative class members benefited from the pro-competitive effects of the merger. For example, after the merger, Highland Park Hospital offered new services, such as interventional cardiology, cardiac surgery, highly-specialized multidisciplinary cancer care, advanced electronic medical records, and coverage by specialized physicians called intensivists. The FTC recognized that ENH had made significant investments after the merger and improved the quality of care. *See* (FTC Op. at 48-51.)[20] Although included in Plaintiffs' proposed all-inclusive class, payors for these new services suffered no antitrust injury. *Atl. Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 334 (1990) ("[I]njury, although causally related to an antitrust violation, nevertheless will not qualify as 'antitrust injury' unless it is attributable to an anti-competitive aspect of the practice under scrutiny . . ."); *U.S. Gypsum*

[20] While the FTC categorized some of the post-merger quality improvements as not "merger-specific" and therefore not determinative under the Merger Guidelines, merger-specificity is not a relevant consideration for purposes of class certification and therefore all quality improvements are relevant to consider here. *See* (FTC Op. at 81-85). Merger-specificity is not relevant under Rule 23 because all benefits experienced by the class conflict with the allegations of antitrust injury, regardless of whether the benefits were caused by the merger.

Co. v. Ind. Gas Co., 350 F.3d 623, 627 (7th Cir. 2003) (antitrust injury must be from "those things that make the practice unlawful, such as reduced output or higher prices"). Even the Named Plaintiffs admitted that the expansion of new services where they were not previously offered is a pro-competitive effect. Redacted

The interests of class members like Named Plaintiffs—supposedly harmed by higher post-merger prices—are antagonistic to the interests of those others who received the benefit of increased quality of care or the addition of new services that were not available at Highland Park Hospital before the merger. At minimum, the Court would need to individually weigh each patients' benefit against any alleged overcharge. In effect, the Court would be required to measure health care quality against price for every patient visit. Such a class cannot be certified. *Bieneman v. City of Chicago*, 864 F.2d 463, 465 (7th Cir. 1988) (holding that class certification is inappropriate where some class members derived benefit from the same conduct alleged to be wrongful); *see Valley Drug Co. v. Geneva Pharms., Inc.*, 350 F.3d 1181, 1188-90 (11th Cir. 2003) (holding that a District Court abused its discretion by not evaluating whether Plaintiffs satisfied the adequacy of representation element "despite the fact that the most significant members of the certified class arguably experienced a net gain from the conduct alleged to be illegal by the named representatives"); *Pickett v. Iowa Beef Processors*, 209 F.3d 1276, 1280 (11th Cir. 2000) (reversing class certification where class consists of members "who benefit from the same acts alleged to be harmful to other members of the class").

2. Plaintiffs cannot represent both insurers and insureds.

Plaintiffs' heterogeneous class also neglects the inherent conflict of interest between insurer and insured. The individual Plaintiffs do not insure against any risk; they pay for portions of their charges for individual services when they need them. By contrast, insurers and

self-funded entities insure against risk across their membership. When it comes to assessment of damages, the interests of insurer and insured conflict because MCOs will want to demonstrate that they bore the brunt of any overcharge, while their own customers (individuals or self-funded entities) will want to establish that any overcharges were passed down. (Noether Rep. at ¶ 33). Named Plaintiffs cannot do both simultaneously. Wherever there is cost-sharing among purported class members, there will be conflict. Various mechanisms for cost-sharing are the norm in this market. (Noether Rep. at ¶¶ 28-29, App. 1 ¶¶ 72-82).

In addition, MCOs are sophisticated businesses motivated by generating profits. A typical patient is more motivated by receiving quality health care.[21] *See In re Graphics Processing.*, 253 F.R.D. at 490 (finding that "wholesale purchasers therefore came to the negotiating table in a fundamentally different position that the representative plaintiffs."). In this case, the different types of purchasers' interests conflict with one another, thereby, defeating adequacy under Rule 23.

IV. Plaintiffs Fail to Establish Predominance Because They Cannot Establish An Actionable Claim On A Classwide Basis.

The necessity of individualized proof to determine the applicability of ENH's statute of limitation defense precludes certification. Rule 23(b)(3) prohibits certification in cases where individual statute of limitations determinations are required. *Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.3d 331, 342 (4th Cir. 1998) (holding that "when the defendant's 'affirmative defenses (such as … the statute of limitations) may depend on facts peculiar to each plaintiff's case,' class certification is erroneous") (*quoting In re N. Dist. of Cal. Dalkon Shield*

[21] As Judge Easterbrook has observed, "[t]he HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible." *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1410 (7th Cir. 1995).

IUD Prods. Liab. Litig., 693 F.2d 847, 853 (9th Cir. 1982)); *see also Waste Mgmt. Holdings, Inc.*, 208 F.3d at 295-97 (holding that the need for individualized statute-of-limitations determinations "invariably weighs against class certification under Rule 23(b)(3)").

A. Individual issues predominate statute of limitations determinations.

The statute of limitations presents a significant problem for Plaintiffs under Rule 23(b)(3). The Court may properly consider ENH's statute of limitations defense in its certification calculus. *Waste Mgmt. Holdings, Inc. v. Mowbray*, 208 F.3d 288, 295-97 (1st Cir. 2000). The limitations period for this merger began at least at closing, January 1, 2000, and expired for all private actions four years later.[22] *See Midwestern Mach. Co. v. Nw. Airlines, Inc.*, 392 F.3d 265, 269 (8th Cir. 2004); *Concord Boat Corp. v. Brunswick Corp.*, 207 F.3d 1039, 1050 (8th Cir. 2000). As a matter of law, no member of the proposed class has an actionable claim.

Assuming, for the sake of argument, that antitrust injury from this merger may accrue at some point other than at consummation, Plaintiffs would have to submit proof that every single class member has an actionable claim. *Falcon*, 457 U.S. at 156; *see Sample v. Aldi Inc.*, 1994 WL 48780 (N.D. Ill. Feb. 15, 1994) (holding "individuals with time-barred claims may not be included within a proposed class"). The statute of limitations defense, then, rises or falls on proving an accrual date other than January 1, 2000. Such evidence is necessarily individualized. Plaintiffs' would have to prove every class member's actual, imputed, and constructive

[22] The Court's Order on ENH's motion to dismiss is not to the contrary. In that Order, the Court held that accrual was an open question because the complaint did not resolve "when a diligent inquiry would have revealed the plaintiffs' injury." *See* Dkt. No. 77 at 7-8; *see also U.S. Gypsum Co. v. Ind. Gas Co.*, 350 F.3d 623, 628 (7th Cir. 2003) (distinguishing mergers from cartels for statute of limitations purposes: "A merger may be complete at closing, but a joint venture or cartel is a continuing cooperative activity that may be discontinued, or amended, from time to time."); 2 P. Areeda & Hovenkamp, *Antitrust Law* ¶ 320c5, at 304 (explaining that "running the statute of limitation from the date the two firms come under the degree of control necessary to cause the competitive injury" is proper).

knowledge during the nine-year class period; that a diligent inquiry would not have discovered the injury, despite the public announcements and the press coverage; and then offer an individual accrual date that is not expired under the limitations period.

Even if the Court entertains such individualized evidence, the record will show that no MCO or self- or fully-insured entity has an actionable claim. Moreover, none of the Named Plaintiffs have a claim. Engaging in these individualized mini-trials defeats predominance under Rule 23(b).

B. The statute of limitations has run against all MCOs, self- and fully-insured entities.

The evidentiary record submitted with this memorandum proves that no MCO has an actionable claim. The charging allegations in the complaint are that ENH: (1) "rapidly increased" prices to most of its customers; (2) negotiated a single contract for all three hospitals; and (3) converted the payment structures under the contracts, at or "almost immediately after" the merger. (Compl. at ¶¶ 34-35 (Nov. 29, 2007)) [Dkt. 22]. With respect to the MCOs, the timing of these allegations accrued prior to and coincident with the merger. If the Court reviews documents (and testimony) from each MCO, it will find that any claims accrued at least at the time of the merger and would not be actionable.

On June 30, 1999, six months prior to the closing of the merger, ENH sent letters to all MCOs, as well as area employers and the press, announcing the merger and attaching a copy of the press release.[23] *In re Evanston Northwestern Healthcare*, No. 9315, at 14 (Oct. 17, 2005 (ALJ Op.)) ("Simultaneous with the execution of the letter of intent, Evanston and Highland Park

[23] *See, e.g.*, ENHCA-004-013384 – 92 (press release), Ex. Q; ENHCA-121-003071 – 75 (Blue Cross), Ex. R; ENHCA-123-001060 – 65 (First Health), Ex. S; ENHCA-026-018223 – 27 (HFN), Ex. T; ENHCA-002-002346 – 50 (Humana), Ex. U; ENHCA-026-009295 – 97 (United Healthcare), Ex. V.

sent a press release to area employers, elected officials, managed care companies, and the press describing the merger."). In early December 1999, ENH jointly with Highland Park Hospital sent a letter to all MCOs requiring assignment of contracts to the higher of either the Evanston Hospital or Highland Park Hospital contract rate structures. In the same letter, ENH terminated its contracts effective at midnight on December 31, 1999—in effect, instituting the contract re-negotiations precisely *coincident* with the merger.[24] The reaction from some of the MCOs further demonstrates that their claims accrued at the time of the merger. For example, in December 1999, one MCO, PHCS, advised its customers of the effect of the merger and termination and recommended other hospitals to its members. *See* ENHCA-004-014669 – 71 (Dec. 14, 1999), Ex. MM.

Evidence that MCOs' claims accrued at or before consummation also forecloses any claims of any insured class member, including self-insured or fully-insured entities. The MCOs negotiating on behalf of these class members were well aware of the alleged injury and its cause before the merger closed. The MCOs' accrual is imputed to their customers. *See* Restatement (Third) of Agency §5.03 ("[f]or purposes of a principal's legal relations with a third party, notice of a fact that an agent knows or has reason to know is imputed to the principal if knowledge of the fact is material to the agent's duties to the principal").[25] As a result, all insured members of

[24] *See, e.g.*, ENHCA-004-014667 (Blue Cross), Ex. W; ENHCA-004-014449 (CCN), Redacted

ENHCA-004-014520 (PHCS), Ex. II; Redacted

[25] *See also G.J. Leasing Co. v. Union Elec. Co.*, 54 F.3d 379, 387 (7th Cir. 1995) (claim for asbestos damage to building held time-barred because building manager was "an agent whose knowledge is attributed to [plaintiff-owner] for purposes of the statute of limitations"); *Veal v. Geraci*, 23 F.3d 722, 725 (2d Cir. 1994) (holding that the rule that statute of limitations ran against principal based on its agent's knowledge is of "general application"); *Daniel v. Cantrell*, 375 F.3d 377, 385-86 (6th Cir. 2004) (holding §1983 action time-barred based on imputation of

the purported class (self-insured or fully-insured) have no actionable claim. To rebut this proof, a putative class member could only resort to highly-individualized evidence—e.g., evidence concerning the scope of a particular agent's duties to its principal.

C. Named Plaintiffs' claims are time-barred.

Named Plaintiffs do not have actionable claims. *See Dunn v. City of Chicago*, 231 F.R.D. 367, 374 (N.D. Ill. 2005) (rejecting certification because class representative's claim was time-barred). They cannot proffer the sort of individualized evidence that might arguably survive ENH's defense. *See* (Order, May 29, 2008, Dkt. No. 77 at 13 (directing parties to conduct discovery "focused solely on the issue of the accrual date of plaintiffs' claims")). All but one knew of the merger *at or before* the time it was consummated. Redacted [redacted] Accordingly, the existence of individual issues, such as these, predominate and the proposed class cannot be certified.

attorney's knowledge to his client); *see also Curtis v. Connly*, 257 U.S. 260, 262-64 (1921) (Holmes, J.) (for statute of limitations purposes, bank charged with its officers' knowledge of suspect investments; "Notice to an officer, in the line of his duty, was notice to the bank.").

D. Any other class member would have to individually disprove imputed and constructive knowledge.

To challenge the evidence of expiration of the statute of limitations, any individual class member would have to surmount the legal principles of imputed and constructive knowledge to have an actionable claim: (1) notice to an agent is imputed to its principal, and (2) the merger and its effects were public knowledge even before closing. That hypothetical class member could only rebut them with individualized proof of unique circumstances.

Apart from imputation of the MCOs' knowledge, discussed above, the merger was extensively covered in the press.[26] Therefore, the claims of all class members who personally knew or could have known about the merger from publicity before and at the time of the merger are barred. *See* (Order, May 29, 2008, Dkt. No. 77 at 6-7) (holding that "the discovery rule holds not that a claim accrues when an injury is actually discovered but, rather, at that point in time when a diligent inquiry would have revealed an injury and its cause"); *also cf. Berry v. Valence Tech., Inc.*, 175 F.3d 699, 703 n.4 (9th Cir. 1999) ("Courts can impute knowledge of public information without inquiring into when, or whether, individual shareholders actually knew of the information in question."); *Kansas Pub. Employees Ret. Sys. v. Blackwell, Sanders, Matheny,*

[26] *See, e.g.*, Bruce Japsen, *Grant Hospital again for sale*, Chi. Trib., Jan. 23, 1999 ("As a merged entity, the Evanston Northwestern properties and Highland Park would be more centrally managed and controlled for more business initiatives…"), Ex. NN; Bruce Japsen, *Evanston Hospital parent terminates pact with 90 doctors*, Chi. Trib., Feb. 4, 1999 ("Evanston Northwestern also confirmed last month that it was in merger talks with Highland Park Hospital, which would increase its market share in the northern Chicago suburbs."), Ex. OO; Bruce Japsen, *Health-care merger heads toward approval: Deal would create Highland Park, Evanston powerhouse*, Chi. Trib., Apr. 16, 1999 ("The deal would create a powerhouse in Chicago's northern suburbs, particularly on the affluent lakefront, where commercially insured consumers abound."), Ex. PP; Mark LeBien, *Evanston Northwestern Healthcare and Highland Park Hospital Merger Advances*, Chi. Trib., June 30, 1999 ("Evanston Northwestern Healthcare and Highland Park Hospital today announced they have signed a letter of intent to merge…"), Ex. QQ; *North Shore hospitals plan to merge*, Daily Herald, July 1, 1999, Ex. RR; Karen Berkowitz, *Spaeth: Hospital merger focus is 'growth'*, Highland Park News, July 8, 1999, Ex. SS; *N. Shore Hospitals Explore Combination*, Crain's Chicago Bus., Sept. 13, 1999 (noting merger is "expected to close…later this year"), Ex. TT; *County to gain 2 open-heart surgery units*, Chi. Trib., Nov. 20, 1999 (reporting Illinois Health Facilities Planning Board had approved open-heart surgery to be implemented after the merger), Ex. UU.

Weary & Lombardi, L.C., 114 F.3d 679, 690 (8th Cir. 1997) (no need to decide whether relationship between two companies justified imputation of one's knowledge to the other, "there being sufficient proof that knowledge of these facts was public information well within the relevant period," including article in the Kansas City Business Journal). And to the extent that any class member seeks exception to this general rule, it would require individualized proof. *See McIntyre v. Household Bank*, No. 02 C 1537, 2004 WL 2958690, at *10 (N.D. Ill. Dec. 21, 2004) ("individual questions of fact and law predominate" where "whether [named plaintiff] and other class members … can overcome [defendant's] statute of limitations defense can only be determined by an individualized fact inquiry").

V. Plaintiffs Cannot Establish That Their Claims Are Typical of the Proposed Class.

Finally, Plaintiffs cannot satisfy Rule 23(a)(3) which requires that the "claims or defenses of the representative parties are typical of the claims or defenses of the class." The Supreme Court has held: "[a] class representative must be part of the class and possess the same interest and suffer the same injury as the class members." *Falcon*, 457 U.S. at 156. Named Plaintiffs fail to meet this standard.

A. There is No Class Representative for MCOs.

First, Named Plaintiffs are atypical of the class because the prices charged by ENH were not the result of bilateral negotiations between ENH and the Named Plaintiffs. The claims of the largest members of the proposed class, namely the MCOs, rely on proving that the negotiations of complex, discount rate structures and the resulting contracts were anticompetitive. *See Dieter v. Microsoft Corp.*, 436 F.3d 461, 467-68 (4th Cir. 2006) (finding atypicality because one group negotiated individual contracts). The MCOs have bargaining power when they negotiate with ENH. *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 905 (7th Cir. 1989) (explaining that "concentrated and knowledgeable buying side" makes anticompetitive conduct more difficult to

establish). MCOs have a volume of members that they can steer to (or away) from any hospital. MCOs have extensive resources. MCOs are multi-million (or billion) dollar corporations. If an MCO believed it was being injured by ENH's merger, it could have brought a lawsuit against ENH or initiated arbitration proceedings. Not a single one has done so.

Named Plaintiffs here do not remotely resemble the MCOs. Rather, the MCOs are similar to the wholesale buyers like Dell or Microsoft in the *Graphics* matter: they purchased a vast array of products on individually-negotiated terms. *In re Graphics Processing*, 253 F.R.D. at 489. The Court in *In re Graphics Processing* rejected the named plaintiffs theory of typicality because "wholesale purchasers [ ] came to the negotiating table in a fundamentally different position that the representative plaintiffs." *Id*. Here, the Named Plaintiffs did not even go to the "negotiating table" and therefore do not have claims that are typical of any MCO within their proposed class.

B. There Is No Class Representative For Self-Insured Entities.

Second, Painters Fund cannot be typical of any member of the proposed class because it has no claim, as a consequence of Blue Cross's affidavit. Redacted Without Painters Fund, there is no class representative for self-insured entities. Self-insured entities, such as employers, have no direct relationship with ENH, but contract through MCOs. Their arrangements with MCOs are complex and are negotiated between MCOs and each self-insured entity. Plaintiffs' failure to have a class representative with claims typical of an MCO or insured entity dictate that no class can be certified.

C. Named Plaintiffs Do Not Share "Essential Characteristics" of the Proposed Class.

Third, proof of Named Plaintiffs' claims would not prove the claims of any other proposed class member. Plaintiffs' claims rely on proving that the portions of the prices they

paid to ENH for specific, individual services, on specific days over the nine-year period, sometimes under their employers' insurance plans, with a specific MCO, were anticompetitive. For example, if Plaintiff Redacted proved that he was overcharged for one visit under his Redacted plan, it would not prove that Plaintiff Redacted was overcharged for any visits while he was covered by Redacted Nor would it show that Blue Cross or United Healthcare were overcharged. Even if they proved their claim, it would not necessarily prove any other class member's claim. *Retired Chicago Police Ass'n v. City of Chicago*, 7 F.3d 584, 596-97 (7th Cir. 1993) (named representatives' claims must "have the same essential characteristics as the claims of the class at large" to prove typicality); *Williams v. Ford Motor Co.*, 192 F.R.D. 580, 586 (N.D. Ill. 2000) ("If proof of [plaintiff's] claims would not necessarily prove all of the proposed class members' claims," typicality is lacking).

The prices that these Plaintiffs paid to ENH depend upon too many individualized facts to even determine if there was impact. *Puffer v. Allstate Ins. Co*., 255 F.R.D. 450, 469 (N.D. Ill. 2009) (declining to certify "[w]here, as here, a court would have to examine numerous individualized factors to determine the parameters of individual claims, the typicality requirement is not met"); *Colomar v. Mercy Hosp., Inc.*, 242 F.R.D. 671, 677 (S.D. Fla. 2007) (finding plaintiff's claim atypical of a proposed class of uninsured patients because her claim depended on fact-intensive variables that would vary among class members depending on the service received). Such facts include: the list price of the individual service purchased; whether the service was covered under the health plan; the co-payment amounts; the coinsurance amounts; whether they had reached their out-of-pocket maximum as well as annual deductibles; as well as whether ENH had improved quality of care for that service over the class period.

As in *Graphics Processing*, given the "overwhelming disparities" separating individual patients (insured or uninsured) from MCOs and self-insured entities, these Plaintiffs "simply do not have the appropriate incentive to establish antitrust violations with respect to all of the absent class members …. The atypicality and detachment of the named plaintiffs' claims from those of the remaining class obstruct their ability to adequately pursue and prove the claims of the absent class members." 253 F.R.D. at 490. For example, of the 6,200 outpatient services offered by ENH and purchased by MCOs, Redacted [redacted] For whatever similarities they may have, none of the Named Plaintiffs have the same "essential characteristics" of an MCO or self-insured entity in how they transact with ENH or how they were allegedly impacted by the merger. *See Retired Chicago Police Ass'n*, 7 F.3d at 596-97 (the typicality requirement "primarily directs the district court to focus on whether the named representatives' claims have the same essential characteristics as the claims of the class at large."). The atypicality of Plaintiffs alleged claims prevent certification in this case.

CONCLUSION

For the foregoing reasons, Plaintiffs cannot satisfy the prerequisites for class certification under Rule 23(a) and 23(b)(3), and their motion for class certification should be denied.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

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

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