UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, et al., *Plaintiffs*, v. ANTHEM, INC. and CIGNA CORP., *Defendants*.	Case No. 1:16-cv-01493 (ABJ)

NOTICE OF FILING REDACTED DOCUMENT

Plaintiffs file the attached public version of their Motion *in Limine* to exclude expert opinion testimony in Senator Benjamin Nelson's declaration and testimony from Defendants' experts relying upon that declaration, and associated exhibits (ECF #211). This public version includes redactions, which are necessary to comply with court orders regarding confidentiality of party and non-party material.

Dated: November 7, 2016

Respectfully submitted,

/s/ Jon B. Jacobs

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CERTIFICATE OF SERVICE

I certify that on November 7, 2016, a true and correct copy of the foregoing document was served upon the parties of record via the Court's CM/ECF system.

Dated: November 7, 2016

/s/ Jon B. Jacobs

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, et al., *Plaintiffs*, v. ANTHEM, INC. and CIGNA CORP., *Defendants*.	Case No. 1:16-cv-01493 (ABJ) (Public, Redacted Version)

PLAINTIFFS' MOTION *IN LIMINE* TO EXCLUDE EXPERT OPINION TESTIMONY IN SENATOR BENJAMIN NELSON'S DECLARATION AND TESTIMONY FROM DEFENDANTS' EXPERTS RELYING UPON THAT DECLARATION

Plaintiffs respectfully request that the Court exclude from evidence improper opinion testimony in former U.S. Senator Benjamin Nelson's declaration and the testimony of Defendants' experts, Dr. Mark Israel and Dr. Robert Willig, that relies on that declaration. Although Defendants explicitly identified Senator Nelson as a fact witness (preventing discovery into his expertise), they submitted a declaration from him that improperly includes expert opinion testimony, on which both Dr. Israel's and Dr. Willig's expert reports improperly rely, in violation of the Federal Rules of Evidence. Admitting this improper testimony, whether through expert reports or live testimony at trial, would allow Defendants to offer an expert in "lay witness clothing" and thus evade the evidentiary requirements for expert witnesses.

BACKGROUND

Senator Benjamin Nelson of Nebraska has spent over fifty years working in, and on matters related to, state insurance regulation. Declaration of Senator Benjamin Nelson (Oct. 6, 2016) at ¶¶ 1–5. He's worked in Nebraska's Department of Insurance; in private practice (as Vice

President and General Counsel, and then CEO, of the Central National Insurance Group of Omaha); as the Governor of Nebraska (during which he was "actively involved with the Nebraska State Insurance Director"); as a U.S. Senator (during which he "was the point person on state insurance regulatory issues" and "played a key role in securing state oversight on the Patient Protection and Affordable Care Act"), and at the National Association of Insurance Commissioners (first as the Chief of Staff and Executive Vice President, and then, two decades later, as its CEO). *Id.* ¶¶ 2–5. By any measure, he is correct to describe himself as having a "unique combination of executive, legislative, and state insurance regulatory expertise." *Id.* ¶ 5.

Perhaps given this expertise, Defendants initially listed Senator Nelson on their preliminary list of expert witnesses. *See* Ex. A. But rather than produce Senator Nelson's testimony as an expert report, Defendants instead converted the testimony into a fact declaration and attached it to the report of one of Defendants' expert witnesses, Dr. Mark Israel. Senator Nelson's declaration includes opinion statements about federal and state regulation of healthcare products that draw upon his specialized and extensive knowledge of these subjects, and both Dr. Israel and another of Defendants' expert witnesses, Dr. Robert Willig, cite this testimony in their reports.

After Defendants submitted this declaration, in a hearing on October 18, 2016, Plaintiffs raised the question whether Senator Nelson was a fact witness or an expert witness. Defendants informed both Plaintiffs and this Court that Senator Nelson (in addition to another individual, Shubham Singhal) was a fact witness, not an expert:

> THE COURT: So the individuals who gave those declarations are not going to be witnesses?
>
> MR. CURRAN: Well, they're not experts. . . . As Your Honor knows, it's not unusual for experts to rely upon declarations and statements of fact witnesses and so forth. These are not expert witnesses who are submitting these declarations. . . .

> THE COURT: But you're telling me right now that whether they testify or not, you do not intend to elicit opinions from the two people from whom there are declarations?
>
> MR. CURRAN: That's right. They're fact witnesses, not experts.

Tr. at 25:7–26:6, Oct. 18, 2016, *United States v. Anthem, Inc., et al*, No. 16-cv-1493 (D.D.C.).

Given this representation, the Court made clear that it is

> attuned to the idea that you can't get somebody else's expert opinion in through another expert who said, well, I read it and I relied on it and so that affects my opinion, because then the underlying expert hasn't been proffered as an expert, hasn't been available for cross-examination of his opinions, etcetera.

Id. at 30:25–31:5.[1]

ARGUMENT

Senator Nelson's declaration introduces expert opinion testimony under the guise of fact witness testimony, in violation of Federal Rule of Evidence 701. The Court should not permit Defendants to make an end-run around the rules distinguishing expert opinion from fact testimony, and should exclude from evidence both Senator Nelson's improper opinion testimony and those portions of Dr. Israel's and Dr. Willig's reports relying upon those opinions, and preclude Defendants' experts from relying upon them at trial.

I. The expert opinions in Senator Nelson's declaration should be excluded from evidence.

Federal Rule of Evidence 701 bars fact witnesses from offering opinion testimony unless it is "(a) rationally based on the witness's perception, (b) helpful to clearly understanding the witness's testimony or to determining a fact in issue, and (c) not based on scientific, technical, or other specialized knowledge within the scope of Rule 702."

[1] In a motion filed contemporaneously with this one, Plaintiffs are separately seeking to strike portions of Mr. Singhal's declaration on similar grounds.

This rule ensures that the evidentiary requirements for expert witnesses in Federal Rule of Evidence 702 will not be "evaded through the simple expedient of proffering an expert in lay witness clothing." *United States v. Wilson*, 605 F.3d 985, 1025 (D.C. Cir. 2010) (citing Fed. R. Evid. 701 Adv. Comm. Notes to 2000 Amendments). The "distinction between lay and expert witness testimony is that lay testimony results from a process of reasoning familiar in everyday life, while expert testimony results from a process of reasoning which can be mastered only be specialists in the field." *United States v. Yanez Sosa,* 513 F.3d. 194, 200 (5th Cir. 2008) (quoting Fed. R. Evid. 701 Adv. Comm. Notes) (internal quotation marks omitted). "Unlike experts, lay witnesses must base their testimony on their experiential 'perception' and not on 'scientific, technical, or other specialized knowledge within the scope of Rule 702.'" *Wilson,* 605 F.3d at 1025 (citing Fed. R. Evid. 701(a), (c)). "A lay witness who is not qualified as an expert may not give opinions that are based on his or her specialized knowledge, even if those opinions were also based on his or her personal knowledge." *Armenian Assembly of Am., Inc. v. Cafesjian*, 746 F. Supp. 2d 55, 65 (D.D.C. 2010). "Rather, a lay opinion must be the product of reasoning processes familiar to the average person in everyday life." *United States v. Garcia,* 413 F.3d 201, 215 (2d Cir. 2005) (citing Fed. R. Evid. 701 Adv. Comm. Notes to 2000 Amendments).

Most of the "facts" presented in Senator Nelson's declaration are opinion statements drawing on his specialized knowledge of complex issues of healthcare regulation, including state-based mechanisms of insurance regulation, local market conditions, and interpretations of insurance law and regulations. For example, his declaration includes the following opinions or legal conclusions (among many others):

- "States should continue to maintain primacy over health insurance regulation because states are best suited to respond to local market conditions and have the mechanisms in place to do so." Nelson Decl. at ¶ 8.

- "Policyholders desire the benefits of competition, yet unrestrained competition has and could lead to insurer insolvencies." *Id.* at ¶ 10.

- "Insurer licensing is one of the primary requirements states use to regulate insurers." *Id.* at ¶ 17.

- "I see the UCAA as facilitating entry across states because the hard work is done with the submission for approval to the initial state and the uniformity among states reduces barriers than a wholly new entrant to any state. . . viewing competition at a single point in time is not an accurate depiction of the dynamic and storied health insurance market." *Id.* at ¶ 18.

Such statements are based on scientific, technical, or other specialized knowledge within the scope of Rule 702, and thus their inclusion in the declaration of a fact witness violates Rule 701, rendering them inadmissible. *See, e.g.*, *Mason v. Brigham Young University*, 2008 WL 444538 at *2 (D. Utah Feb. 14, 2008) (finding a fact witness's lay opinions contained in his declaration "not admissible under Rule 701").

Plaintiffs attach as Exhibit B to this motion Senator Nelson's declaration, which includes each of the statements that constitutes improper opinion testimony by a fact expert. We ask that the Court exclude all of these statements in Exhibit B from evidence as improper opinion testimony under the Federal Rules of Evidence.

II. The testimony of Dr. Mark Israel and Dr. Robert Willig that relies on Senator Nelson's inadmissible opinion testimony should also be excluded from evidence.

Under Federal Rule of Evidence 703, an expert "may base an opinion on facts or data in the case that the expert has been made aware of or personally observed." Fed. R. Evid. 703. The purpose of Rule 701's "no specialized knowledge" requirement "is to prevent a party from conflating expert and lay opinion testimony thereby conferring an aura of expertise on a witness without satisfying the reliability standard for expert testimony set forth in Rule 702 and the pre-trial disclosure requirements set forth in Fed. R. Crim. P. 16 and Fed. R. Civ. P. 26." *Garcia*, 413 F.3d at 215.

Dr. Israel's report cites to Senator Nelson's declaration generally and includes it as one of the materials he relied upon. Expert Report of Mark A. Israel, Ph.D ¶ 37 n.39, Appendix C. Dr. Willig cites to Senator Nelson's declaration in several places. Expert Report of Robert D. Willig, Ph.D. ¶ 18 n.28, ¶ 27 n.39, ¶ 28 (quoting from Sen. Nelson's declaration). Defendants may call Dr. Israel and Dr. Willig to provide additional testimony at trial.

By definition, Senator Nelson's improper opinion testimony does not constitute "facts or data" an expert can base his or her opinion on under Rule 703. Thus, Plaintiffs also move to exclude from evidence those portions of Dr. Israel's and Dr. Willig's reports relying upon these opinions and to preclude Defendants' experts from relying upon them at trial.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court exclude from evidence both Senator Nelson's improper opinion testimony and those portions of Dr. Israel's and Dr. Willig's reports relying upon these opinions, and preclude Defendants' experts from relying upon them at trial.

Dated: November 7, 2016

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on November 7, 2016, a true and correct copy of the foregoing was served upon all parties of record via the Court's CM/ECF system.

Dated: November 7, 2016

/s/ Jon B. Jacobs

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Exhibit A

United States, et al. v. Anthem, Inc. and Cigna Corp.

Case No. 1:16-cv-01493 (ABJ)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, *et al.*, *Plaintiffs*, v. ANTHEM, INC. and CIGNA CORP., *Defendants*.	Case No. 1:16-cv-01493-ABJ

DEFENDANTS' EXPERT WITNESS DESIGNATION

In accordance with the Final Case Management Order filed August 31, 2016 (ECF 91), Anthem, Inc. and Cigna Corp. ("Defendants") hereby designate the expert witnesses that they may call live at trial during Defendants' case-in-chief and defense case. This designation reflects the early stage of discovery in this case, including the fact that Plaintiffs thus far have not completed their document productions or responded to all interrogatories, have not identified any market shares or bases for evaluating markets and competitive effects, and have provided limited responsive discovery, including no responsive discovery from the Department of Health and Human Services. Defendants reserve the right to designate additional expert witnesses following a review of those materials and responses. Defendants also reserve the right to designate additional expert witnesses following 30(b)(6) depositions of Plaintiffs' witnesses or following Plaintiffs' identification of feature markets, which Plaintiffs have so far refused to identify. Defendants further reserve all rights to amend or supplement the designations below and later provide a final expert designation list consistent with the Case Management Order, including in

response to the Case Management Order's exchange of expert reports and rebuttal and supplemental expert reports.

Defendants do not expect to call all of these witnesses live at trial, but expect to winnow the list down as discovery progresses in this action.

1. Mark A. Israel, Ph.D.
Compass Lexecon
1101 K Street NW, 8th Floor
Washington, DC 20005

Dr. Israel may be offered as an expert economist to testify to topics, including but not limited to, the competitive effects of the merger including merger efficiencies. His analysis may include merger simulation for the proposed merger, the complaint's alternative allegations of a purported national market or 14-state market definition, and the procompetitive effects of the transaction.

2. Robert D. Willig, Ph.D.
Compass Lexecon
220 Ridgeview Road
Princeton, NJ 08540

Dr. Willig may be offered as an expert economist to testify to topics, including but not limited to, Plaintiffs' purported claims of the existence of 35 CBSA and micro "markets" listed in the complaint, the absence of any negative competitive effects, and entry and expansion.

3. Lona Fowdur, Ph.D.
Economists Incorporated
2121 K Street, NW
Suite 1100
Washington, DC 20037

Dr. Fowdur may be offered as an expert economist to testify to topics, including but not limited to, an analysis of local marketplace conditions, local marketplace statistics, local market definition, and the presence, expansion, entry, and competitive impact of marketplace participants.

4. Bruce Richards
[redacted]

Mr. Richards may be offered as an expert actuary in the health insurance industry, including but not limited to, providing testimony on the role of pricing and claims

analysis and purchasing strategies used by customers and their actuarial advisers to evaluate geographic and product options and solutions that reduce their healthcare costs, on the geographic scope of the customer's analysis, on the closeness of competitive options, including non-carrier solutions, in terms of anticipated claims costs, and commercial rates in relation to government-based reimbursement rates.

5. Mark Stern [redacted]

Mr. Stern may be offered as an industry expert on the perspective of a broker-consultant and customers, including but not limited to, Mr. Stern's analysis evaluating the purported "national" and alternative 14-state market identified in the complaint, customer and broker-consultant negotiating strategy to reduce costs, considerations in evaluating bids, evaluating alternatives to carrier-based products, and the considerations of employers when evaluating innovation as it relates to the purchase of solutions for healthcare coverage for employees.

6. Jerry Frye [redacted]

Mr. Frye may be offered as an industry expert regarding provider strategies, incentives, and tools used as an alternative to the traditional carrier model, which the complaint purports to characterize as the only solution to employers' healthcare needs. Mr. Frye may testify on topics that, include but are not limited to, the development and implementation of provider-sponsored health plans and other forms of vertical integration and partnering, relevant healthcare innovations, the role of third party administrators, and the component costs of healthcare as factors driving the wide range of viable alternative solutions not acknowledged by Plaintiffs in the complaint.

7. Sen. Benjamin Nelson [redacted]

Senator Nelson, the former CEO of the National Association of Insurance Commissioners, may be offered as an expert on state and federal insurance regulation, providing testimony on topics that, include but are not limited to, the nature and scope of industry regulation, the mechanisms and resources used at the state and federal level to regulate and monitor rates, products, and marketplace conduct for insurers, and the role of industry regulation as a means for protecting consumers and facilitating entry.

8. Jeanne Bell
Hager Strategic
1764 Litchfield Turnpike, Suite 200
Woodbridge, CT 06525

Ms. Bell may be offered as an industry expert on alternative solutions employers use, including but not limited to, the role of private healthcare exchanges and benefits administration outsourcing. Ms. Bell's analysis and testimony may include the strategies employers and broker-consultants employ for creating competitive solutions and reducing healthcare costs, and the role of and commoditizing effect that these alternative solutions have on competition to provide healthcare solutions.

9. Colm O'Muircheartaigh, Ph.D.
1155 E. 60th Street
Suite 153
Chicago, IL 60637

Dr. O'Muircheartaigh may be offered as an expert on surveys, with his analysis and testimony including, but not limited to, the surveys, if any, relied upon by Plaintiffs or Plaintiffs' experts, including those of the various medical associations, such as identified by Plaintiffs in their interrogatory responses.

Dated: September 23, 2016
Washington, D.C.

/s/ *Christopher M. Curran*

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CERTIFICATE OF SERVICE

I hereby certify that on September 23, 2016, a true and correct copy of the foregoing Defendants' Expert Witness Designation was served via e-mail, pursuant to Paragraph 18 of the Case Management Order (Dkt. 91), upon all counsel of record.

/s/ *Heather M. Burke*

Exhibit B

United States, et al. v. Anthem, Inc. and Cigna Corp.

Case No. 1:16-cv-01493 (ABJ)

APPENDIX J: DECLARATION OF SENATOR BENJAMIN NELSON

DECLARATION OF SENATOR BENJAMIN NELSON

I, **Benjamin Nelson**, declare as follows:

1. I began my career in state insurance regulation over fifty years ago when I started working with the Nebraska Department of Insurance as Supervisor of Claims and Inquiries. I later served as Compliance Director responsible for insurance industry compliance with Nebraska Insurance laws and regulations. In 1975, the Governor of Nebraska appointed me as Director of Insurance for Nebraska. After this, I served as Vice President and General Counsel and then as CEO of the Central National Insurance Group of Omaha.

2. In 1982, I was selected as Chief of Staff and Executive Vice President of the National Association of Insurance Commissioners ("NAIC"). The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the fifty states, D.C., and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC members, together with the central resources of the NAIC, form a nation-wide system of state-based insurance regulation in the United States. In 1985, I left the NAIC to campaign for Governor of Nebraska.

3. In 1990, I was elected Governor of Nebraska and in 1994 was reelected to a second term. As Governor, I was actively involved with the Nebraska State Insurance Director, a member I appointed to my cabinet, on numerous insurance regulatory matters. After my Governorship, from 1999 to 2000, I returned to practice law at Lamson, Dugan & Murray LLP while campaigning for Senate.

4. From 2001 to 2013, I served two terms representing the state of Nebraska in the U.S. Senate. In the U.S. Senate, I was the point person on state insurance regulatory issues. As a result, I played a key role in securing state oversight on the Patient Protection and Affordable Care Act in 2010 ("ACA"). In 2009, the Senate's forty Republicans unanimously opposed the Senate's version of the ACA. To end a Republican filibuster and pass the measure, the Democrats needed the votes of all 58 of their senators, plus those of two independents who caucused with their party. A Democrat, I cast the 60th and final vote for cloture, paving the way for passage of the ACA.

5. After retiring from the Senate, the NAIC contacted me and appointed me to serve as CEO of the NAIC from 2013 to 2015 based on my unique combination of executive, legislative, and state insurance regulatory experience.

6. Currently, I sit on the Board of Advisors of Behlen Manufacturing Corporation, a closely held global manufacturer headquartered in Nebraska. I am also a founding board member of the National Strategic Research Institute, a United States Strategic Command sponsored University Affiliated Research Center at the University of Nebraska focused on combating and responding to national security threats.

7. I earned a Bachelor of Arts degree in 1963, a Master of Arts degree in 1965, and a Juris Doctor degree in 1970, all from the University of Nebraska. I received the 2011 Distinguished Alumni Award from the University of Nebraska College of Law and an honorary doctor of letters from the University of Nebraska in 2013.

I. States are Best Suited to Address Local Market Conditions.

8. States should continue to maintain primacy over health insurance regulation because states are best suited to respond to local market conditions and have the mechanisms in place to do so. There is a long history of state regulation of the business of insurance that originated in the 1820s.

9. The U.S. Congress has recognized that the states—not the federal government—are closer to consumers and providers, and are therefore better equipped to regulate the business of insurance. This is further supported by the enactment of the McCarran-Ferguson Act in 1945, which preserves the states' authority to regulate the business of insurance by exempting it from most federal regulation.

10. As states, Congress, and the Supreme Court have recognized, the purpose of state regulation of health insurance is to protect consumers. Policyholders desire the benefits of competition, yet unrestrained competition has and could lead to insurer insolvencies. State regulation of insurance balances this intrinsic tension and therefore has two main components: (i) solvency regulation to guarantee that insurers are financially capable of fulfilling their contracts with consumers and (ii) market conduct regulation to ensure policyholders are treated fairly and to promote competition among insurance companies. Through state insurance regulations, states safeguard consumers from unfair or egregious insurance costs while guaranteeing that rates allow insurance companies to remain solvent.

11. To implement these solvency and market conduct regulations, each state has an insurance body responsible for oversight and enforcement. Each state has a commissioner, superintendent, or director of insurance, which is either an elected or appointed position, who has the power to administer and enforce insurance laws, to issue guidelines and regulations, and to serve as a forum for insurance dispute settlements. State insurance regulators can sanction insurers for noncompliance with state insurance laws by levying fines, revoking or suspending licenses, or imposing other civil or criminal penalties.

12. The NAIC plays a vital role in promulgating state insurance model acts, which states have increasingly adopted in substantially similar form. By providing model laws, the NAIC facilitates coordination, consistency, and resource-sharing between states. States, however, are able to maintain diverse sets of laws by shaping regulations to meet the statewide needs of consumers. States have been and continue to be innovators in developing unique solutions to address local conditions.

13. Under the NAIC's accreditation standards, known as the Financial Regulation Standards and Accreditation Program, states must maintain and demonstrate adequate statutory and administrative authority to regulate insurer solvency. All fifty states and the District of Columbia have adopted a variation of the NAIC's accreditation standards. The NAIC Accreditation Program assures that small states and large states can equally regulate domestic insurers and that all states continue to meet baseline, high quality financial solvency and market conduct oversight standards.

14. Although certain activities of health insurers are now subject to complementary regulation under the ACA, the ACA also reinforced the importance of state insurance regulation by delegating the chief oversight responsibility to the states and providing states "more extensive

scrutiny or powers to disapprove proposed rate increases."[1] For example, in September 2011, the Department of Health and Human Services ("HHS") announced a state-based rate review program in which states must conduct reviews of rates above a certain threshold.[2] As part of the ACA, states are also eligible to receive grants to aid with rate review activities.[3] In addition, the ACA reintroduced the imposition of the "medical loss ratio," which limits the amount health insurers can profit from consumer health premiums. Essentially, the ACA provides a regulatory baseline upon which states can expand—most states always mandate more, depending on the health care market conditions in their respective state.[4]

II. State-Based Mechanisms of Insurance Regulation Have Evolved to Develop Unique Solutions to Address Local Conditions

15. Health insurance, including rates, is highly regulated. It is more regulated than many other types of businesses and state laws targeting the business of insurance exist across a spectrum of state statutes. As a result, insurance regulation exists in the following categories: (i) insurer licensing; (ii) product design regulations (iii) rate regulations, (iv) medical loss ratios; (v) market conduct regulations, including unfair trade practices and unfair claims settlement laws; (vi) solvency regulations; and (vii) network adequacy regulations which govern how insurance products are offered and how insurance is delivered.

16. State regulation has responded to an evolving and vigorous insurance industry. States employ over 13,000 state insurance regulatory personnel—individuals who are closely attuned to consumers, providers, insurers, and statewide dynamics—to develop and enforce insurance regulations. State insurance regulators are so close to their marketplace that they know what is happening with insurers and the market availability of health plans. This "ear to the ground" enables insurance regulators to identify market conditions and developments on an ongoing basis. Thus, state regulators are best suited to predict and detect changes and adapt and develop solutions.

A. Insurer Licensing

17. Insurer licensing is one of the primary requirements states use to regulate insurers. All insurers must comply with state licensing requirements prior to selling an insurance product within a state. It is important to note that there are no insurer licensing requirements below the statewide level (i.e., county or city), thus state regulators are the first and only gatekeepers to the entry of new insurance companies and products in a state. Insurer licensing regulations typically mandate that insurers comply with financial standards, minimum capital and surplus requirements, and adequate reserves. These regulations allow insurers to enter a state

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[1] NCSL, *State Approval of Health Insurance Rate Increases*, July 18, 2016, *available at* http://www.ncsl.org/research/health/health-insurance-rate-approval-disapproval.aspx.

[2] *Id.*

[3] *Id.* ("These funds will help states strengthen their oversight capabilities and will allow states that do not currently review rates to establish a program.")

[4] *See* Brendan S. Maher and Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL'Y REV. 275, 297 (2013) (highlighting that states can expand the regulatory framework offered by the ACA).

immediately across local geographies and across product lines once an insurer licensed within a state.

18. Moreover, the NAIC created the Uniform Certificate of Authority Application ("UCAA"), which makes available to states a licensing system that allows insurers to file the same licensing application to operate in numerous states. These regulations enable an insurer to expand quickly across state lines insofar as the insurer meets the capital, financial, and market requirements of the additional state. I see the UCAA as facilitating entry across states because the hard work is done with the submission for approval to the initial state and the uniformity among states reduces barriers than a wholly new entrant to any state. This is demonstrated in the active entry and exit of competitors in any given state, which also means that viewing competition at a single point in time is not an accurate depiction of the dynamic and storied health insurance market.

19. As part of state licensing procedures, insurers must file annual statements and financial reports with state officials, which allow regulators to continually monitor insurers operating within the state. Failure to comply with these requirements triggers a state's insurance enforcement mechanisms, which can ultimately result in a state insurance regulator revoking an insurer's license.

20. Increasingly, third-party administrators are managing the claims processing component of health insurance in direct competition with insurance carriers. These third-party administrators, which primarily serve large-group consumers, such as those that Anthem serves, are not subject to the same licensing regulations with which insurers must comply before entering a state. Although third-party administrators compete head-to-head with health insurance companies for this business, third-party administrators face far fewer hurdles for entry and expansion into states than do traditional insurance companies. While states can enforce licensing regulations against health insurers, these same powers do not broadly exist for third-party administrators thereby facilitating their unfettered participation in many states.

B. Product Design Regulations

21. States also regulate health insurers by monitoring the types of services and health plans insurers offer consumers. State regulators examine whether a health plan contract meets the types of health services and plan requirements defined in state laws through an evaluation of an insurer's policy form filings, which must be approved. Regulators often review an insurer's premium rates and policy forms simultaneously.

22. In the 1990s, the NAIC developed the System for Electronic Rate and Form Filing ("SERFF"). The SERFF is an effort to "streamline the product filing process" by developing uniform product naming conventions.[5] Many states have adopted the SERFF system within their states with slight variations to conform to state regulations. Through the SERFF, the NAIC facilitates uniform procedures yet allows states to maintain diverse regulatory schemes that include state-specific requirements.

[5] NAIC, SERFF, *available at* http://www.serff.com/about.htm.

C. Rate Regulations

23. In addition to policy form approval as mentioned above, an insurer must obtain premium rate approval of some form in most states. State rate regulations are at the core of insurance laws because of the tension between ensuring adequate premiums and promoting fair competition. Since the 1850s, state insurance laws have granted state insurance commissioners the power to regulate insurance rates.

24. States typically regulate rates through one of the following systems: prior-approval, file and use, use and file, flex rating, modified prior approval, community rating systems or by regulating rates for vulnerable consumers that could be subject to excessive costs or limited access to health plans.

- In states with a **prior-approval process**, rates must be submitted for approval before they may be used. Many states have a "deemer" option where a rate is considered approved and effective if the state does not rule on the filing within a certain time period.

- Insurers in states with **file and use** requirements must file rates before they may be used, but the rates do not need to be approved before use. Rather, the state retains the power to disapprove the rate after filing. The rates could be disapproved as unreasonable if they are excessive, inadequate, unjustified, or unfairly discriminatory.

- **Use and file** requirements allow an insurer to use rates immediately, provided they are filed within a short time period after they become effective. As with file and use, states with use and file regimes can disapprove rates after filing. Rates could be disapproved if the premiums are not reasonable, or if the rates are excessive, inadequate, or unfairly discriminatory.

- In **flex rating** states, an insurer may be required to make a rate filing for a rate change under a certain percentage (either up or down), and which may be filed for informational purposes and not subject to approval. The director of insurance may still retain power to determine whether the filing is compliant and can issue an appropriate compliance order.[6]

- Some states employ **community or adjusted community ratings**. States which feature community ratings systems prohibit the use of a person's health or number of claims in setting premiums. Limits may also be placed on other factors to consider in adjusting premiums, including age or geography. Many states also maintain laws to protect consumers from excessive rates.

25. States often most rigorously examine small-group and individual health plans. Under state regulations, small-group plans refer to plans that cover two to fifty employees or, in some cases, two to 100 employees, whereas individual plans are those that individuals can purchase directly from insurers and not through an employer. States, aware that insurers may have incentives to set high rates for these purchasers, often force insurers to spread the health risks across a broader group of policyholders to allow access to consumers without the high

[6] *See, e.g.*, ALASKA STAT. § 21.39.210(e) (2015); S.C. CODE ANN. § 38-73-220(C) (2016).

costs. Implicit in these regulations is the belief that large-groups are more than capable of obtaining fair rates through many mechanisms available to them such as through brokers, agents, and direct contracting, whereas individuals and small-groups are not.

26. As seen in the chart below, nine of the ten states in the Complaint require prior large-group rate review and/or approval by the state insurance regulator. Six states, Colorado, Connecticut, Georgia, Indiana, New Hampshire, and New York, require prior approval for large-group rates, and three states, California, Maine, and Virginia, require prior filing before use of large-group rates.

State Rate Review Requirements for the Ten States Alleged in Justice Department's Complaint

State	Requirement for Individual	Requirement for Small Group	Requirement for Large-Group
California	***File and Use***	***File and Use***	***File and Use***
Colorado	***Approval Authority***	***Approval Authority***	***Approval Authority***
Connecticut	***Approval Authority***	***Approval Authority***	***Approval Authority***[7]
Georgia	***Approval Authority***	***Approval Authority***	***Approval Authority***
Indiana	***Approval Authority***	***Approval Authority***	***Approval Authority***
Maine	***Approval Authority***	***Approval Authority***	***File and Use***
Missouri	***File and Use***	***File and Use***	***No Rate Review***
New Hampshire	***Approval Authority***	***Approval Authority***	***Approval Authority***
New York	***Approval Authority***	***Approval Authority***	***Approval Authority***
Virginia	***Approval Authority***	***Approval Authority***	***File and Use***

27. States have effectively balanced the needs of consumers and the needs of insurance companies to create a viable system of insurance rates and payments for the last 160 years. Through the various forms of rate regulations, states guarantee that insurance companies do not unfairly raise rates, price discriminate among consumers, and maintain below competitive prices.

28. Medical loss ratios are another important tool for states to regulate insurance rates and pricing. A medical loss ratio is the amount of premium that health insurers use to pay for medical claims costs and benefits versus administrative processing or other non-medical costs.[8] By establishing a minimum medical loss ratio, a state limits the portion of premium used for administration, marketing, and profits and ensures that health insurers return a percentage of premiums to consumers through medical care reimbursements.[9] Although medical loss ratio policies were common in state regulations prior to the enactment of the ACA, the ACA

[7] HMOs are statutorily required to obtain approval for rates, and in practice, all insurance products' rates must be filed for approval like HMOs.

[8] NCSL, *Medical Loss Ratios for Health Insurance* (Nov. 2015), *available at* http://www.ncsl.org/research/health/health-insurance-medical-loss-ratios.aspx.

[9] *See e.g.*, Joshua Ackerman, *The Unintended Federalism Consequences of the Affordable Care Act's Insurance Market Reforms*, 34 PACE L. REV. 273, 292 (2014).

mandated that all states enact such rules. Under ACA rules, health insurers must spend at least 80% of premiums from small-group and individual plans on medical claims and benefits.[10] For large-groups, health insurers must spend at least 85% of premiums on medical claims and benefits.[11] Any premium above the remaining 15% or 20% is reimbursed back to the customer. As a result of the ACA, medical loss ratio regulations leave little room for an insurer to make a profit.

29. As noted above, the ACA is a minimum starting point for states to operate. Most often, states have expanded the minimum standards required under the ACA and have creatively developed additional requirements and regulations to address state market conditions.

D. Market Conduct Regulations

30. States have also enacted market conduct regulations, which promote fair and reasonable insurance prices, products, and trade practices. These market conduct regulations include rules governing the terms with which insurers can make plans available to employers and individual consumers. These types of regulations also include rules regarding the means through which insurance carriers market health plans to consumers, pay claims, terminate coverage, or determine a policyholder's eligibility.

31. Through market conduct regulations, states exercise significant power to safeguard access to health plans and thrust the regulation of insurance into a public benefit. Most market conduct regulation violations result in claims disputes. Thus, two common forms of market conduct regulations which govern claims disputes include unfair trade practices laws and unfair claims settlement practices laws.

i. State Regulators Protect Against Unfair Trade Practices

32. The NAIC introduced an Unfair Trade Practices Model Act in 1945. Forty-five states have adopted the Model Act in a substantially similar manner as the Model Act[12] to ensure that consumers are protected from (i) misrepresentation and false advertising of insurance policies; (ii) unfair discrimination in premiums, policy terms and conditions or policy benefits; (iii) boycott, coercion and intimidation; (iv) redlining; (v) discrimination based on race, color, creed or national origin, sex or marital status; and (vi) rebating.[13] If an insurer violates such laws, an insurance regulator will impose monetary and/or other penalties against the insurer, such as suspension, and can also seek a court judgment requiring the insurer to cease and desist from engaging in the prohibited acts. The ten states in the Complaint have adopted and enacted into law the NAIC's Unfair Trade Practice Model Act with slight variations, including: added protections against different types of discrimination; removal of the protection of immunity from prosecution in exchange for testimony or evidence; and added privacy protections.

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[10] *See* The Henry J. Kaiser Family Foundation, Explaining Health Care Reform: Medical Loss Ratio (MLR) (Feb. 29, 2012), *available at* http://kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/.

[11] *Id.*

[12] NAIC, Unfair Trade Practices Model Act (last revised in 2011).

[13] *Id.*

ii. State Regulators Protect Against Unfair Claims Settlement Practices

33. Like the Unfair Trade Practices Model Act, the NAIC has also introduced the Unfair Claims Settlement Practices Model Act which regulates how insurers conduct and manage claims. Forty-six states have adopted and enacted into law the Model Act in a substantially similar manner[14] which authorizes a state's insurance department to enforce the Act's provisions through investigations and sanctions.[15] The practices that the Act regulates include: (i) misrepresentation of insurance policy provisions; (ii) failing to adopt and implement reasonable standards for the prompt investigation of claims; (iii) failing to acknowledge or to act with reasonable promptness when claims are presented; and (iv) refusing to pay claims without an investigation. The Model Act has been materially adopted by the ten states in the Complaint, with some alterations which include lowering the hurdle of insurer culpability and notification requirements to insureds of insurer's potentially misleading arbitration practices.

E. Solvency Regulation

34. Preventing insurer insolvency was a central component of early forms of insurance laws. As referenced above, as part of licensing regulations, insurers must maintain certain statutory capital requirements. Typically, solvency regulations require that an insurer domiciled in that state maintain specific amounts of fixed and risk-based capital ("RBC"). All fifty states and the District of Columbia have adopted either the NAIC's Risk Based Capital for Insurers Model Act or maintain a related law or regulation. By maintaining risk-based capital requirements, states guarantee that insurers maintain a minimum amount of capital to support the insurer's business and the insurer's risk pool.

35. Through solvency regulations, states can direct insurers to take preventive and corrective measures that vary depending on the capital deficiency indicated by the RBC result. These preventive or remedial measures can help insurers avoid insolvency before it occurs. While the desire for increased competition has eased certain solvency restrictions and allowed for easier admission into certain states, state solvency regulations continue to guarantee that insurers can fulfill their commitments to policyholders.

F. Network Adequacy Regulations

36. States can also regulate health plan coverage by regulating the means through which health services are delivered. Through network adequacy regulations, states regulate the level of accessible providers and facilities able to serve a given population. These network adequacy regulations limit the extent to which a health insurer can negotiate with providers. Typically, states establish a minimum adequacy standard that requires plans to maintain a "robust," "adequate," or "sufficient" network of providers.[16] States monitor network adequacy

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[14] *Id*.

[15] *Id*.

[16] *See* NCQA, *Network Adequacy & Exchanges* 2 (2013), *available at* https://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf; NCSL, *State Laws Related to Access to Healthcare Providers Network Adequacy* (Nov. 2015), *available at* http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx (identifying network adequacy laws in California, Connecticut, Hawaii, Washington, and the District of Columbia).

when insurers apply for a license or certification with state authorities or through public comments about the lack of access to providers.[17]

37. California insurance law, for example, requires the insurance department to monitor health insurers' provider networks "to ensure . . . an adequate number of accessible facilities within each service area."[18] Colorado is more specific in requiring insurers to "maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible[.]"[19] New Hampshire adds an additional element by requiring "a network sufficient in numbers, types, and geographic location[.]"[20] States have adopted network adequacy regulations and tailored it to the needs of their particular state. Regardless of how states stylize these provisions, network adequacy rules help ensure that covered persons are able to access a dependable network.

38. The NAIC maintains its own network adequacy guidelines, the Health Benefit Plan Network Access and Adequacy Model Act. Most states that have implemented network adequacy rules have actively sought to implement unique statutory schemes that resemble the NAIC standards but make key distinctions as health care is unique in each state. All ten states identified in the Complaint have statutory network adequacy requirements. Most of these ten states have gone above and beyond the NAIC in clarifying and elaborating on network rules and adopting them to the needs of their state. For example, states in the Complaint have established special rules on network notice requirements,[21] out-of-network reimbursements,[22] retroactive denials of claims,[23] access to emergency and urgent care services,[24] protections against arbitrary contract terminations[25] and more structured referrals to specialists (among other areas).[26]

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[17] *Id.*

[18] CAL. WELF. & INST. CODE § 14182(c)(2).

[19] COLO. REV. STAT. § 10-16-704(1).

[20] N.H. REV. STAT. ANN. § 420-J:7.

[21] COLO. REV. STAT. §§ 10-16-704(2)(b), (d) (requiring carriers to use a conspicuous format in policy materials and marketing materials, and include the counties in which they do not contract with any providers).

[22] COLO. REV. STAT. §§ 10-16-704(2)(c), (i) (special payment rules in cases of a covered person being required to travel a reasonable distance for care from a participating provider, and instead the covered person knowingly seeks services from a non-participating provider).

[23] N.H. REV. STAT. ANN. § 420-J:8-b (prohibiting retroactive denials of claims unless i. the carrier provides written justification, and ii. the time between the payment and challenged claim is not greater than 18 months, with exceptions).

[24] ME. CODE R. § 02-031-850(7)(B)(4) (requiring "service[] at all times" for "urgent services," in addition to "emergency services" provided for in the NAIC network adequacy rules).

[25] MO. REV. STAT. § 354.609(5) (prohibiting carriers from terminating contracts in cases in which a health care provider advocates for certain employees, files complaints against a health carrier, appeals a decision of a health carrier, and other reasons).

[26] N.Y. INS. LAW §§ 4804(c)-(d) (requiring that an insurer maintain a procedure to make standing referrals to an insured person who needs ongoing care for life threatening conditions, instead of the NAIC's suggestion to "establish reasonable procedures" for continued care).

39. The ACA further implements network adequacy standards for qualified health plans listed on public exchanges.[27] As a result, in 2014, nearly all states implemented rules to monitor the sufficiency of an insurance carrier's provider networks through qualitative measures.[28] By 2015, states increased oversight over provider networks to include more transparency of such networks.[29] Through network adequacy regulations, states and providers wield significant power over the reach of a carrier's network coverage.

40. Some states have additional requirements for health insurers to offer coverage in special parts of the states, such as in rural areas. For example, as a result of its majority rural population, New Hampshire has a desk-drawer rule that requires insurers to offer coverage to the entire state of New Hampshire as a prerequisite for licensure in New Hampshire. This is a prime example of a state adopting regulations deemed necessary to address local market conditions within its borders.

41. Insurance regulation is not limited to the regulations discussed above. State insurance regulatory oversight is more far-reaching and includes disclosure of material acquisitions and dispositions of assets laws, insurance holding company system laws, change in control laws, intercompany dividends rules, and broker, agent, or producer licensing laws.

I declare under the penalty of perjury that the foregoing is true and correct. Executed on 10/6/16, 2016 in OMAHA, NEBRASKA.

Senator Benjamin Nelson

[27] 45 C.F.R. § 156.230 (2016) (setting forth the requirements for qualified health plans to maintain a network "sufficient in number and types of providers...").

[28] Justin Giovannelli, et al., *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks*, The Commonwealth Fund, May 2015, at 2-3, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

[29] *Id.*

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, et al., *Plaintiffs*, v. ANTHEM, INC. and CIGNA CORP., *Defendants*.	Case No. 1:16-cv-01493 (ABJ)

[PROPOSED] ORDER

Having considered Plaintiffs' Motion *in Limine* to exclude from evidence opinion testimony in former U.S. Senator Benjamin Nelson's declaration and the expert testimony of Dr. Mark Israel and Dr. Robert Willig that relies on that declaration, the Court hereby grants the Motion for the reasons set forth by Plaintiffs.

SO ORDERED.

DATE: November _____, 2016

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AMY BERMAN JACKSON
United States District Judge