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 **REDACTED, PUBLIC VERSION; REFLECTS ERRATA (ECF NO. 430)**

ANTHEM'S POST-TRIAL PROPOSED FINDINGS OF FACT
PHASE II: THE ALLEGED LARGE GROUP AND MONOPSONY LOCAL MARKETS

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I. EXECUTIVE SUMMARY

1. Under *Baker Hughes*, Anthem may successfully defeat Plaintiffs' challenge to the merger either by discrediting the data in the government's prima facie case or by affirmatively showing why the merger is not likely to substantially lessen competition. 908 F.2d at 991. In Phase II of the trial, as in Phase I, Anthem has successfully defended the merger on *both* bases. As to discrediting the government's prima facie case, Anthem has established that Plaintiffs' market definitions are flawed in both their product and geographic dimensions, and that Plaintiffs' market-concentration calculations overstate Anthem's share (by combining Anthem with other Blues) and understate the shares of competitors (by using unreliable, outdated and incomplete data). As to affirmatively showing why the merger is not likely to substantially lessen competition, Anthem has established how various factors — including low "critical loss," confidential RFPs, numerous competitive alternatives, entry, efficiencies, and price-sensitive, sophisticated corporate customers (and consultants) — will ensure vibrant competition in a post-merger world. Indeed, the evidence established that the proposed merger will be decidedly *pro*-competitive because it will generate substantial medical-cost savings for employers (and their employees) and will also create a nationwide competitor that will offer better products at better prices than either Anthem or Cigna does today.

A. Plaintiffs' Effort To Establish Their Prima Facie Case Was Undermined By A Lack Of Rigorous Empirical Or Quantitative Analysis

2. Despite defining markets based on price discrimination, Plaintiffs' product market includes the sale of commercial health insurance to all "large group" employers, whether full insurance or ASO, regardless of whether the employer has 100 employees at a single site or 200,000+ employees at hundreds of sites (e.g., Wal-Mart). This indiscriminate grouping even

includes "national accounts" that Plaintiffs alleged to be "distinct" in Phase I. Here in Phase II, Prof. Dranove simply asserted that his product market includes "all current and future sellers" of insurance to large groups (Dranove Tr. 2337:3-5), but he did not do any testing to determine whether such a broad grouping was sound or whether a narrower grouping was more appropriate. Nor did Prof. Dranove explain why he took diametrically opposite approaches in Phase I and Phase II, with a narrow product market in the former and a broad market in the latter, neither of which was supported by any meaningful "critical loss" analysis or other empirical testing.

3. Plaintiffs' assertion of the thirty-five CBSAs as geographic markets was also devoid of proper analysis. Prof. Dranove defended the determination as "common sense" (Dranove Tr. 3700:7-3701:2), but this perfunctory assumption is anything but "common sense." In fact, the thirty-five CBSAs in question vary substantially in size, with some (such as New York-Newark-Jersey City) encompassing major, multi-state, metropolitan areas, others (such as Richmond, VA) encompassing mid-sized, single-state, metropolitan areas, and others (such as Laconia, NH) encompassing only one small, rural county. DDX0589, DDX0477. Plaintiffs offered no sound justification for the blind adoption of such diverse CBSAs as geographic antitrust markets, and Prof. Dranove neglected to consider travel patterns or to consider the significant implications of his 6% "critical loss" percentage.

4. Plaintiffs' market-concentration calculations were likewise deeply flawed. Plaintiffs relied upon market shares that combined Anthem's shares with those of unaffiliated Blues, an unprecedented step that materially inflated the combined shares of the merging firms and treated this merger essentially as one between the Blues and Cigna. Furthermore, although Prof. Dranove testified that his market included "all current and future sellers" of commercial insurance to large group customers (Dranove Tr. 2337:3-5), when calculating market size for

purposes of determining market shares he failed to include numerous current competitors (including TPAs representing as much as 20% of the market (DX0228)), neglecting to obtain data from many of them, and used stale data (from 2014 and earlier) from a patchwork of incomplete, unreliable sources. Dranove Tr. 2337:6-20 ("we did not get data on every current and future seller of health insurance, which would have been the goal.").

5. While Prof. Dranove asserted that he was comfortable that the data he failed to gather would not change his opinion (*id.*), evidence at trial showed that material changes have in fact occurred in the competitive environment since the period covered by Plaintiffs' data. *Compare* PX0751 (reporting [redacted] for Harvard Pilgrim in CT in 2015) *with* Roberts (Harvard Pilgrim) Dep. 23:12-14 ([redacted]); DX0428 at HPHC-ANTHEMDOJ-000212 ([redacted]); *see also* Dranove Tr. 3923:11-3925:11 (Kaiser committed to enter Santa Cruz in January 2017); *id.* at 3975:10-19 ([redacted]). Dr. Dranove missed the committed entry and expansion even of Plaintiffs' own trial witnesses, capturing no data at all in his market shares for them. *See* [redacted] in Virginia in 2016); Berfiend (IU Health) Tr. 2860:3-11 (IU Health grew to 200,000 members); Guertin (Anthem) Tr. 3519:15-3520:10, 3554:8-3555:7 (Tufts bid on 70 accounts). The losses to these entrants are material; indeed, Tufts has taken Catholic Medical Center from Anthem (Guertin (Anthem) Tr. 3518:13-3519:4), and Tufts has taken [redacted], from Cigna. [redacted]. Plaintiffs' failure to acquire reasonably complete or current data means the Court cannot know the full scope of the deficiencies in Plaintiffs' market-share calculations.

B. Under Plaintiffs' Concession Of Narrow Unilateral Effects, The Merger Will Not Substantially Lessen Competition

6. On competitive effects, Plaintiffs were forced to substantially narrow their price-effect allegations after Prof. Dranove conceded that even a modest 6% loss of business — be it to any combination of United, Aetna, regional carriers, PSPs, slicing, direct contracting, new entrants, etc., regardless of individual size or significance — would defeat a market-wide post-merger 5% price increase by the merged entity. Dranove Tr. 3695:24-3697:4; 3823:25-3825:6. This concession was tantamount to acknowledging that an attempt by the merged entity to impose any market-wide price increase would be folly and fruitless; Plaintiffs promptly and expressly abandoned any contention of any such price increase. Tr. 2709: 9-15. Prof. Dranove also admitted that other industry features, namely the RFP process, make an across-the-board price increase impossible. Dranove Tr. 4008:25-4009:2 ("Q. And given the RFP process in this industry, does it make any sense to ask the question: What if the merged firm raised all of its prices by 5 percent? A. No, it can't actually do that.").

7. Plaintiffs and Prof. Dranove not only disclaimed any allegation of a future market-wide price increase, but repeatedly disclaimed the existence of any coordinated effects. Instead, Plaintiffs and Prof. Dranove were forced to acknowledge that they were relying exclusively upon a "unilateral effects" theory under which the price of ASO fees (5-10% of the total spend for ASO clients), and the equivalent portion of full-insurance premiums, would increase for specific RFPs where Anthem and Cigna are closest competitors. Dranove Tr. 3864:2-7 ("The merger will have an effect on those customers for whom Anthem and Cigna are ranked first and second, or second and first."), 3856:3-10 ("what's critical to understanding the effect of the merger on pricing is the frequency with which Anthem and Cigna are 1 and 2 and 2

and 1, which is why I focus on these particular data"), 943:5-25 ("what I'm really going to be focusing on is how often Anthem and Cigna are 1 and 2 or 2 and 1"), 2283:5-16 ("It's the competition between one and two that ultimately determines that auction"), 3727:18-24 ("I think you have to always focus on when they are one and two. I don't know how you could draw meaningful conclusions otherwise, and that's what limits the sample size."). Horizontal Merger Guidelines § 6.1 ("Substantial unilateral price elevation post-merger for a product formerly sold by one of the merging firms normally requires that a *significant fraction* of the customers purchasing that product view products formerly sold by the other merging firm as their *next-best choice.*") (emphasis added).

8. Numerous customers in fact testified that they did not view Anthem and Cigna as close competitors. *See*, *e.g.*, Monti (Kroger) Dep. 18:5-21 ("I believe that in the way that Kroger purchases healthcare, that [Anthem and Cigna] are not close competitors, yes."); Record (Steel Dynamics) Dep. 35:18-36:11 (describing how Cigna is not competitive in terms of network discounts and thus is not a substitute to Anthem). The supposedly anticompetitive circumstances — with Anthem and Cigna as the two finalists — were so seldom that Prof. Dranove had difficulty identifying enough of them to conduct a switching analysis, and instead he was forced to include not just Anthem but other Blues, and had to go back six years for his data. *See*, *e.g.*, PX0753 at G-11.

9. Even though Plaintiffs' narrowed "specific RFP" theory did not identify particular customers nor identify a class of customers that could constitute a market, a battery of unilateral-effects analyses performed by Dr. Israel and Prof. Willig established that Anthem and Cigna are not close competitors, they do not lose a disproportionate share of business to one another, they do not have a statistically significant effect upon one another's pricing, and thus the loss of

Cigna as a competitor is not likely to substantially lessen competition. Unlike Prof. Dranove, Anthem's experts properly matched the data and looked at all diversions, not just the unusual situation where an incumbent is ousted. Moreover, Prof. Dranove also ran merger simulations, but, in addition to other errors, improperly combined Anthem shares with other Blues as an input.

10. Overwhelming evidence established that United is Anthem's closest competitor, and the merger will allow Anthem to extend this rivalry nationwide. Even Plaintiffs' own witness, Bo Hawthorne, testified that Anthem needs a nationwide network of its own to compete effectively for some of his clients. Hawthorne (Scott) Tr. 3006:1-3, 15-21.

11. Finally, it is undisputed that numerous firms have entered the market recently, proving that barriers to entry are low. Moreover, even "the *threat* of entry can stimulate competition in a concentrated market, regardless of whether entry ever occurs." *Baker Hughes,* 908 F.2d at 988 (emphasis in original). Here, if the merged entity were to try to raise prices post-merger, it would quickly realize "we're going to lose so much business to [a] dynamic mass of previous fringe players, we'd be foolish to try to get away with a price increase." Willig Tr. 4687:20-22.

C. Medical-Cost Savings Efficiencies Are Merger-Specific And Will Benefit Consumers And Providers

12. Even if this Court were to credit (or was able to quantify) Plaintiffs' theory of anticompetitive harm to specific RFPs where Anthem and Cigna are "1 and 2 or 2 and 1," Anthem established that any possible upward pricing pressure from the merger would be easily offset by the efficiencies gained. From the start of this action, and consistently throughout Phase I and Phase II of the trial, Plaintiffs have acknowledged that "the merger will lead to lower

provider rates." Dranove Tr. 2465:4-2467:6; Compl. ¶¶ 64, 71, 75, 85(d). Prof. Dranove conceded that such savings are "something to factor" as the Court determines whether the merger is procompetitive or anticompetitive. *Id*. Nonetheless, Prof. Dranove declined to incorporate any amount of these admitted savings into his models. Dranove Tr. 3862:11-12 (on medical cost savings: "I never compute a final number, and I certainly never plug one into my merger sim."). Only Anthem's economist Dr. Israel factored these merger-specific efficiencies into his model and, even with exceedingly conservative assumptions, found that the efficiencies comfortably swamp any upward pricing pressure from the loss of Cigna as an independent competitor.

13. Plaintiffs admit that insurers, as part of their RFP response, include projected medical-claims cost in their product offering. Tr. 4789:9-4790:17, 4927:22-24. Such costs are included in the total "price" of that product, as insurers are the ones who initially pay for those claims and then invoice the customer. Dranove Report ¶168; Kendrick (Anthem) Tr. 1179:7-17; *see also* Record (Steel Dynamics) Dep. 31:8-19, 31:21-32:8 (defining "prices" to include medical claims costs).

14. As the cost of medical claims decrease, the bottom-line price to the employer and employee also decreases. Abbott (WTW) Tr. 172:3-175:1 (describing how health plans cover the cost of healthcare and how if the costs of care are reduced, the employer and the employee benefit); Bisping (Caterpillar) Dep. 75:6-10, 12-20. Post-merger, Anthem would be able to pay less for the medical services of Cigna customers by getting Anthem's discount provider rates for Cigna customers. Israel Tr. 1845:7-1846:19, 4427:24-4430:1. But Anthem would continue to sell Cigna's health-plan products, including Cigna's distinctive customer-facing programs (such as wellness and specialty products) demanded by a segment of customers. Thus, Anthem would be selling Cigna's product at Anthem's cheaper price. The direct pass-through of cost savings

and the unique combination of the two companies' best assets creates the inherent efficiencies that will be realized post-merger. Prof. Dranove agreed that these efficiencies cannot be realized without the merger. Dranove Tr. 4791:19-22 ("Q. Well, if we kept the Cigna product, and we priced it less, that would be a new product that would be merger-specific, correct? A. Yes. That I agree with."); *see also* Dranove Tr. 4784:17-24 (conceding that today "Anthem cannot offer a Cigna product" and vice versa); Israel Tr. 4373:4-4374:11, 4376:9-23.

15. These efficiencies include benefits to the providers as well because, among other things, reduced reimbursement rates fuel the industry transition to value-based collaborations and create more efficient providers. [redacted]); Israel Tr. 1975:17-1976:12 ("[T]ighter reimbursements actually . . . reduce waste and lead to more efficient provider practices.").

D. Plaintiffs' Monopsony Claim Also Fails

16. Plaintiffs failed to prove that the "purchase of healthcare services by commercial health insurers" in the thirty-five CBSAs (Compl. ¶¶65-68) is a relevant product market in a properly defined geographic market. Plaintiffs never presented any economic evidence that such markets should be limited only to commercial insurers, or should be limited by CBSA. Plaintiffs' market-share calculations are flawed in their failure to include other payers and their failure to account for sprawling provider systems who frequently contract once for services rendered in various provider locations across a state.

17. Even if Plaintiffs had met their prima facie burden on their monopsony claim, there is no evidence of anticompetitive effects in the purchase of healthcare services. Plaintiffs did not conduct any empirical testing to evaluate whether the merger would reduce prices below

the competitive level or whether the merger would cause any reduction in output or quality. Dr. Israel did conduct such analyses and found no risk of monopsonistic harm because the merger will not move prices below the competitive level, output and quality will not suffer, and the vast majority of savings will be passed through. Israel Tr. 1969:21-1975:16. Plaintiffs ask this Court to find monopsony harm simply on the basis of increased bargaining leverage causing lower input prices. This is not the legal or economic test for monopsony and, if applied, would render virtually all horizontal mergers unlawful.

II. PLAINTIFFS' ALLEGED "LARGE GROUP" PRODUCT MARKET IS NOT PROPERLY DEFINED

A. Plaintiffs' Alleged Market For The Sale Of Commercial Health Insurance To Large Group Accounts Fails

18. Plaintiffs allege that the "sale of commercial health insurance to large groups" is a relevant product market and that "[l]arge group employers are distinct customers." Compl. ¶ 39. Plaintiffs fail to account for, or even test for, differentiation among larger employers and smaller employers within this alleged market, which even includes "national accounts" that Plaintiffs argued was a *distinct* product market in Phase I. This failure to address significant differences among "large group" customers renders meaningless Plaintiffs' market definition.

19. Prof. Dranove explained that "a critical loss analysis and a critical elasticity analysis [(i.e., SSNIP test)] essentially use the same inputs and generate the same conclusions." Dranove Tr. 3695:24-3697:15. But then to avoid the implications of his critical loss findings, he stated that critical loss is an inappropriate tool to use in auction markets like this one. *Id.* at 4008:13-24. Prof. Dranove cannot have it both ways — either his critical loss number applies, or his SSNIP test is inapplicable and his product market definition, *in both phases*, must fail.

1. Grouping "National Accounts" With The "Large Group" Market Confirms That "National Accounts" Are Not A Separate Market

20. In Phase I, Plaintiffs alleged that "the sale of commercial health insurance to national accounts" was a separate relevant product market because they have "unique needs and characteristics that set them apart." Pls.' Phase I Findings ¶¶ 52, 54. Yet Plaintiffs include "national accounts" in their "large group" market. Dranove Tr. 3689:6-21 (claiming large groups and "national accounts" "have similar needs"); *but see* Compl. ¶ 21 ("National accounts are distinct customers with *unique characteristics*."). These conflicting positions are irreconcilable and confirm that neither proposed market survives scrutiny. Fowdur Tr. 4210:1-12 (Prof. Dranove's differing opinions are "totally incongruent"); *see* Pls.' Phase I Findings ¶ 54.

21. In Phase II, Prof. Dranove testified that "national accounts" are not a separate product market (Dranove Tr. 3689:6-8), contradicting his Phase I testimony that "national accounts" are unique. *See* Pls.' Phase I Findings ¶ 54; Dranove Tr. 859:24-860:19 (sophistication of smaller employers "starts to differ from all the firms . . . that I'm including in my national accounts definition."). He also argued that "large groups go roughly through the same process [as "national accounts"], it's an RFP process," (Dranove Tr. 3724:2-14), again contradicting his prior testimony, (Dranove Tr. 855:23-857:15, 859:24-860:19), *and the Complaint*. *See* Compl. ¶¶ 20-21 ("National accounts are distinct customers with unique characteristics. They . . . undergo a lengthier, more resource-intensive purchasing process involving requests for proposals[and] are more likely to hire a large consulting firm to aid them . . . ."); *see also* Pls.' Phase I Findings ¶¶ 76, 81). All large groups almost uniformly rely on consultants to handle their health care needs (DeLacey (WBS) Dep. 34:2-8), which Plaintiffs asserted was unique to "national accounts." Pls. Phase I Findings § II.C.i.

22. As Anthem explained in Phase I, the "ASO healthcare solutions that industry participants provide to 'national accounts' are no different" than those provided to "smaller or less geographically dispersed" customers. *See* Phase I Findings § IV.F. Prof. Dranove now apparently agrees. Dranove Tr. 3691:11-13 ("there is a continuum"). Plaintiffs cannot have it both ways. Their proposed "national account" and "large group" markets both fail since Plaintiffs have not shown that either grouping is a distinct, well-defined antitrust product market.

2. Prof. Dranove Improperly Aggregates Large Group Accounts Of All Sizes, And His Testimony About Hypothetical SSNIP Tests Fails To Support Such Inappropriate Aggregation

23. To identify his proposed "large group" product market, Prof. Dranove asked the following question: "Would a hypothetical monopolist that controls all present and future sales of the candidate products profitably impose a SSNIP?" Fowdur Tr. 4204:8-10; Dranove Tr. 3685:24-3686:7 (referencing PDX033, at 3). However, as discussed below, Prof. Dranove never conducted hypothetical monopolist tests for any candidate products. Fowdur Tr. 4204:1-4206:1.

24. The Merger Guidelines state that "when the Agencies rely on market shares and concentration, they usually do so in the smallest relevant market satisfying the hypothetical monopolist test." Merger Guidelines § 4.1.1. Where prices are negotiated individually, "the hypothetical monopolist test may suggest relevant markets that are as narrow as individual customers." *Id*. at § 4.1.4; Dranove Tr. 3686:15-3687:5. But aggregating customers to define markets is appropriate if Plaintiffs can "define markets for groups of targeted customers, i.e., by type of customer." Merger Guidelines § 4.1.4; Dranove Tr. 3686:15-3687:5. Thus, Plaintiffs' proposed market must focus on customers that have similar needs. Fowdur Tr. 4204:1-4206:1.

25. Prof. Dranove's alleged market, however, includes customers with dissimilar needs. Fowdur Tr. 4204:1-4206:1. For example, it includes *any* employer with more than fifty

(or in four states, more than 100) employees. Compl. ¶ 39. But Prof. Dranove conducted no quantifiable analyses to test substitution into and out of any "candidate product markets" within his broad definition. Dranove Tr. 3689:22-3690:5; Fowdur Tr. 4204:1-4206:1 ("Dr. Dranove does not tell us which sets of attributes each of these types of customers have in common that would allow him to aggregate market shares across these dissimilar types of customers[.]"). Thus, Plaintiffs' failed to meet their burden to prove a "large group" product market.

26. The factual record shows that there are significant differences among customers, and sometimes "down-market" large groups are more similar to small group customers than to other large groups. *See e.g.*, Guertin (Anthem) Tr. 3559:17-3561:21; Rothermel (Anthem) Tr. 4075:10-4076:17. Prof. Dranove agrees that there are "some differences" and not all large groups are "going to be identical in terms of their needs." Dranove Tr. 3688:5-3689:5. For example, Prof. Dranove concedes that larger employers are more likely to self-insure and have employees in multiple locations, while smaller employers are relatively less likely to self-insure and more "focused geographically." *Id*. at 3688:5-3689:5. He further admits that "[a]lternative [funding arrangements] are not as attractive in the [alleged] national accounts market," but are attractive to smaller, large group employers. *Id.* at 3687:14-25. Dranove Tr. 3687:14-25; Willig Tr. 4545:24-4548:7 ("It's about what are the sources of competition available to the employer, even when it's talking to a national carrier who's offering a complete geographic solution to all of the *needs of the employer*.") (emphasis added).

27. The term "middle market" is "used in a number of contexts" in this industry to refer to employers in the middle size range of large groups. Dranove Tr. 3866:13-15; Fowdur Tr. 4210:13-19 ("Everything was simply lumped in together as if everybody had the exact same needs."). But Prof. Dranove never tested this candidate market empirically. Fowdur Tr. 4206:2-

4207:19, 4208:22-4209:22. Prof. Dranove also failed to account for differences in product needs between, for example, groups with fifty to 250 employees and groups with thousands of them. Fowdur Tr. 4204:1-4206:1; 4210:13-19; *see also* Guertin (Anthem) Tr. 3559:17-3560:6 ("[I]f a small group is 47 employees and technically a group of 61 is called large group, they're probably very similar in the benefits that they have, . . . compared to a large group of 5,000.").

28. Aetna recognizes a middle market for large groups, which it defines as employers with 101 to 3,000 employees, and further segments these groups into select accounts (101-300 employees) and key accounts (301-3,000 employees). Hayes (Aetna) Dep. 186:4-187:10. Cigna also has "middle market" or "regional client" groups of 250 to 4,999 employees, single-site employers with more than 5,000 employees, Taft-Hartley plans, and other groups as "regional client[s]." Guilmette (Cigna) Dep. 71:2-8; Engels (Cigna) Dep. 48:20-50:20. Such groups represent 53% of Cigna's medical customers. PX0284 at 8. Moreover, Cigna is less likely to even bid on groups of less than 300 employees. Mifsud (Melita) Tr. 3253:20-22 (Cigna is an infrequent player in the "smaller end" of large group), 3236:11-22.

29. Other industry participants, including carriers and brokers, also recognize "middle market" groups. *See e.g.*, [redacted]; Hillman (Anthem) Dep. 109:1-16 (Anthem in Indiana divides large groups into four categories, including groups of 51 to 250 employees, 250 to 1,000 employees, and 1,000 or more).

30. Prof. Dranove's aggregation of large groups — and failure to test customer types in the alleged market — indicates that he did not account for admitted differences among such customers that go directly to the standards for grouping customers for purposes of price

discrimination markets, product interchangeability, and other critical aspects of defining a product market. For example, a multistate employer needs access to local provider networks across many locations. Fowdur Tr. 4202:17-4206:1. A smaller, local "large group" account operating out of only one site, however, does not need access to networks across a large range of locations. Fowdur Tr. 4204:1-4206:1. Therefore, the competitive options attractive to two types of customers likely will vary, as will a hypothetical monopolist's ability to impose a SSNIP. Whether and to what extent such variation requires an alternative market definition is unknown, as Prof. Dranove never asked those questions. Fowdur Tr. 4208:22-4209:22.

31. Nevertheless, Prof. Dranove admits that different sizes of customers choose different insurance: some choose fully-insured plans while others self-insure via ASO plans. In fact, only 14% of employers with fewer than 100 employees and 30.1% of employers with 100 to 499 employees opted for self-insurance. Dranove Tr. 3865:18-3866:6 (referencing DDX0067). For groups with 500 employees or more, however, the number grew substantially to 80.4%. Dranove Tr. 3866:7-12; *see also* Guilmette (Cigna) Dep. 45:16-25 (estimating 80%-90% of "national accounts" are self-insured). This suggests that larger employers and smaller employers have dissimilar needs for insurance coverage. Dranove Tr. 3687:14-25 (noting the component of risk coverage is not as attractive to larger employers). Prof. Dranove, however, did not conduct a SSNIP test for ASO-only or fully-insured customers (Dranove Tr. 3905:7-9), and his unsupported ASO-only shares fail for the same reasons as his other calculations (*see infra* § IV).

3. Suppliers Of Healthcare Solutions To Large Group Customers Are Reasonably Interchangeable With One Another

32. By defining the product market as "commercial health insurance" sold to large groups, Plaintiffs' loose, proposed market must consider all suppliers of healthcare coverage

options. Any attempt by Plaintiffs to distinguish by suppliers — e.g., because they provide an HMO product (*compare* Dranove Tr. 3693:12-25; 3715:7-18 (dismissing Kaiser as a competitor), *with* Dranove Tr. 3690:1-8 (acknowledging that Kaiser is in the alleged product market) — ignores that such suppliers are reasonably interchangeable.

33. Large groups can choose from the same multitude of reasonably interchangeable options described in Phase I: a traditional carrier (Phase I Findings § III.C.), a TPA with a rental network or its own proprietary network (*Id.* at §§ III.D, III.F.), PSPs (*Id.* at § III.E.), multiple sliced carriers, including through a private exchange (*Id.* at §§ III.B, III.C.), or additional options available through direct contracting. *Id.* at § III.G. Alternatively, many entities offer services that are part of healthcare solutions that compete with Anthem and Cigna offerings. *See* Guilmette (Cigna) Dep. 105:24-107:5; Rothermel (Anthem) Tr. 4067:12-4068:9, 4076:2-17; *see also* Phase I Findings § III.H. Because these are all reasonably interchangeable solutions, they all must be included in the product market. Merger Guidelines § 4.1.1.

34. Employers can also choose from at least three plan types: PPOs, HMOs, and POSs. *See e.g.*, [redacted]; Wise (ConnectiCare) Dep. 42:6-25; Roberts (Harvard Pilgrim) Dep. 16:12-16; Phase I Findings at ¶¶ 90, 92, 96, 129. Carriers recognize that these plans can be interchangeable. For example, [redacted]. DX0362 at KP001625; *see supra* § V.E.1.a.i.

4. The Significant Differences Between ASO Services And Fully-Insured Products Call Plaintiffs' Product Market Into Further Question

35. There are significant differences between ASO and fully-insured products, and between the types of employers for which fully-insured or ASO products are an appropriate healthcare solution for their health insurance needs. Prof. Dranove's failure to perform any

empirical analysis to determine whether to include all products and types of employers in the same market shows that Prof. Dranove's market definition is unreliable. Some geographies are known as HMO states (e.g., New Hampshire and California) where all products are priced off of an HMO benchmark, but other states are not, such as where Kaiser is not present. Prof. Dranove never conducted any sensitivity analysis to consider such state-by-state differences, instead choosing to generalize across all thirty-five CBSAs at issue. DX0442 at 158 (New Hampshire); Rothermel (Anthem) Tr. 4077:13-4079:2 (California). This does not satisfy Plaintiffs' burden.

36. The products large groups seek and purchase for their healthcare needs are a combination of three basic components: insurance risk coverage, a healthcare provider network at certain discounted rates, and claims processing and other administrative services. Roberts (Harvard Pilgrim) Dep. 16:17-22, 17:1-15; Abbott (WTW) Tr. 69:5-23; PX0125 at 5; Kidd (Sodexo) Dep. 17:22-18:5; Dranove Tr. 3687:14-25. Each component can be acquired in different ways, and there may be variations based on local conditions. For example, some employers buy fully-insured products where the carrier bears financial risk for all claims (Abbott (WTW) Tr. 69:5-23; PX0125 at 5), while others choose to self-insurer and utilize a third party to administer claims and deliver a provider network at discounted rates. Abbott (WTW) Tr. 69:5-23, 166:5-14; PX0284 at 4; *see also* Rothermel (Anthem) Tr. 4077:13-4078:8, 4098:7-14 (some can also buy fully-insured HMOs, mixed fully-insured/ASO plans, or traditional ASO plans).

37. While it is true fully-insured products can constrain the pricing of ASO products, the two solutions have important distinctions. First, "the characteristics of the bidding process are different." Israel Tr. 4444:16-22. Second, ASO customers tend to have different sizes and characteristics than those that utilize fully-insured products. Hawthorne (Scott Insurance) Tr. 2986:5-2987:25; Hillman (Anthem) Dep. 115:24-116:19.

III. PLAINTIFFS HAVE NOT SHOWN THAT THE ALLEGED LOCAL MARKETS BASED ON CBSAS ARE VALID ANTITRUST GEOGRAPHIC MARKETS

A. Prof. Dranove Does Not Conduct A SSNIP Test For The Thirty-Five CBSAs To Show That All Or Any Of Them Are Relevant Geographic Markets For The Sale Of Commercial Health Insurance To "Large Groups"

38. The Merger Guidelines call for Plaintiffs to assess whether a SSNIP would be "defeated by substitution away from the relevant product or by arbitrage, e.g., customers in the region travelling outside it to purchase the relevant product." Merger Guidelines § 4.2.2. Prof. Dranove did not conduct any empirical analysis to support his proposed geographic markets for any of the thirty-five CBSAs. Fowdur Tr. 4211:12-4212:6. While he characterized his work as "a SSNIP analysis," his "analysis" considered of using "economic reasoning to conclude that [a SSNIP] could not be sustained" in a CBSA. Dranove Tr. 3707:11-3708:5, 3834:1-5.

39. After conceding that he did not "compute the actual geographic response to a five percent SSNIP," Prof. Dranove argued that because "there's been no relevant academic research" on geographic response, no CBSA-specific test is necessary. *Id.* at 3707:11-3708:5, 3834:6-15. Instead, he relies on Plaintiffs' assertion that employers need provider access where employees live and work, and "without any analysis" assumes that "a CBSA provides a reasonably clear boundary." Fowdur Tr. 4211:12-4212:6. This, however, is not an appropriate way to test for geographic markets. *Id.* at 4211:12-4212:6; Merger Guidelines § 4.2.2.

40. Prof. Dranove asserts that it is not necessary to test CBSAs as markets empirically because it is "obvious that the employers are going to want to buy from the . . . insurers that are selling locally." Dranove Tr. 3708:6-11. But the Merger Guidelines call for a "solid empirical analysis that will allow us to test whether a region forms a relevant geographic market if the price increase by the hypothetical monopolist would not be defeated by substitution, for

example, by customers in the region traveling outside of that region to purchase the relevant product." Fowdur Tr. 4211:12-4212:6; *see* Merger Guidelines § 4.1.3 ("When the necessary data are available, the Agencies also may consider a "critical loss analysis" to assess the extent to which it corroborates inferences drawn from the evidence noted above. Critical loss analysis asks whether imposing at least a SSNIP on one or more products in a candidate market would raise or lower the hypothetical monopolist's profits.").

41. There are many potential geographic markets that Prof. Dranove did not consider, including ZIP codes and regions such as "Combined Statistical Areas," which combine multiple CBSAs based on commuting and employment interchange. Dranove Tr. 3870:2-4, 3870:21-25, 3871:6-13, 3872:7-21, 3873:21-3874:14 (discussing DX0820). Prof. Dranove has previously acknowledged that market definition is "fact intensive" and there is no "obvious ad hoc approach" to define a healthcare market. *Id.* at 4762:18-4763:8 (discussing DDX0588).

42. Dr. Fowdur conducted empirical analyses based on the CBSA boundaries Plaintiffs allege. Fowdur Tr. 212:7-4213:4. Consistent with the Merger Guidelines, she accounted for Plaintiffs' assertions that "alternative insurers without networks of providers in a CBSA will not be reasonable substitutes for those with such networks," and that the network in a CBSA likely is a determinant of the significance of insurers in that CBSA. *Id.* 4212:7-4213:4 (discussing DDX0493 at slide 10). Thus, she defined the hypothetical monopolist as the only seller of insurance that provides access to networks within a given CBSA. *Id.* Although Prof. Dranove stated that insurers with networks outside of a CBSA are part of his hypothetical monopolist, a CBSA's boundary would be meaningless if such insurers were relevant. Dranove Tr. 4007:20-4008:5; Fowdur Tr. 4213:6-13 ("But that, to me, sounds nonsensical almost because the issue here is we're testing a boundary and networks within that boundary.").

43. Prof. Dranove incorrectly asks whether employers would forego buying insurance or move their employees outside of a CBSA in response to a SSNIP. Dranove Tr. 3700:7-3701:2, 3834:16-3835:1, 4693:9-24 ("[t]hey either stop providing insurance all together . . . or they move their employees"). But the relevant question is "how many people would purchase a network which is outside of the CBSA if faced with a price increase by the hypothetical monopolist," thus making the price increase unprofitable? Fowdur Tr. 4223:3-17.

44. To answer this question, Dr. Fowdur calculated the critical loss — the level of loss at which a SSNIP would be unprofitable. Fowdur Tr. 4211:12-4212:6. She noted that critical loss "is the Achilles' heel of Dr. Dranove's analysis." *Id.* at 4219:22-4221:1. Dr. Fowdur determined that a critical loss of 9.2% would defeat an attempted SSNIP, and Prof. Dranove's margin calculations imply an even lower critical loss of 6%. *Id*. at 4212:7-4213:4; Dranove Tr. 3823:25-3824:15. Therefore, if 6% of large group enrollees were willing to use another carrier (or other option) with networks outside of a proposed CBSA in response to a SSNIP, then the CBSA is not a proper geographic market. Fowdur Tr. 4223:3-4224:2.

45. Dr. Fowdur conducted an empirical analysis to determine how many large group enrollees living in a CBSA already use providers outside the CBSA, even before a SSNIP. *Id.* at 4215:7-4216:16 (discussing DDX0493 at 12). Dr. Fowdur presented three examples — Laconia, Keene, and Norwich-New London — that illustrate the high incidence of routine travel across CBSA lines. *Id.* The data revealed that on the inpatient side, almost 90% of large group enrollees in the Laconia CBSA already travel to providers outside of Laconia; on the outpatient side, over 40% travel to providers outside the CBSA; and for physician visits, about 50% leave the CBSA. *Id.* For all three CBSAs, Dr. Fowdur found that 40% to 90% of the residents in each

traveled outside the CBSA for inpatient care, 20% to 45% did so for outpatient care, and 30% to 50% did so for physician care. *Id*. at 4215:7-1216:16 (discussing DDX0493 at 12).

46. Dr. Fowdur's analysis indicates "that the networks that these employees consider to be relevant to them are local, but they span more than just the CBSA." *Id*. at 4215:7-4216:16, 4228:11-21 (referencing DDX0493 at 12). Dr. Fowdur determined, for example, that many Laconia residents receive healthcare in Concord and Manchester even though the same services are offered in Laconia. Fowdur Tr. 4218:10-4219:3; *see also* Lipman (LRG) Tr. 3293:15-3295:10. This was further supported by evidence that 20% of Anthem's covered New Hampshire residents are altogether outside the state. Guertin (Anthem) Tr. 3565:25-3566:10. Prof. Dranove should have done this analysis for all thirty-five CBSAs because Plaintiffs bear the burden to show that each CBSA is a properly defined market. Fowdur Tr. 4219:4-21.

47. In each of the three CBSAs, Dr. Fowdur found that the percentage of large group enrollees who could switch plans but keep their providers is well above the 9.2% threshold (or Prof. Dranove's 6% threshold) that would make an attempted price increase by the hypothetical monopolist unprofitable. *Id*. at 4224:23-4225:4 (referencing DDX0493). These enrollees already are traveling outside of their CBSAs to get healthcare even without a SSNIP, and no change in their travel patterns or providers is necessary for them to change health insurers. *Id.* at 4224:5-4225:6, 4225:13-4226:6 (referencing DDX0493 at 12). Employers can leverage the known preferences of their employees to travel outside of the CBSA for medical services to defeat a SSNIP. *Id.* at 4224:13-4226:5 (referencing DDX0493 at 13). Moreover, Dr. Fowdur pointed out that given the low critical loss figure, it would only take a relatively small number of residents on the borders leaving the CBSA for health care to defeat an SSNIP. *Id.* at 4218:1-4219:3 (discussing DDX0493 at 12). Alternatively, an employer can slice employees who

already receive care outside of the CBSA away from the hypothetical monopolist, thus confirming that the proposed markets are not properly defined. *Id.* at 4214:6-16, 4224:23-4225:6.

B. The Proposed CBSA Markets Are Too Narrow And Miss A Significant Proportion Of Employees Who Work For Employers Located In The CBSA But Live Outside The CBSA

48. CBSAs are made up of small geographic regions: seventeen of the CBSAs at issue each span a single county. Dranove Tr. 3876:10-3877:4 (discussing DDX0477). Most large groups located in the CBSAs at issue have a substantial number of enrollees who reside outside of the CBSA where the employer is based. Fowdur Tr. 4231:16-4232:15 (referencing DDX0493 at 14). Thus, most employers need to purchase health insurance across multiple CBSAs, and not just within the CBSA where they are based. *Id.* at 4232:16-4233:4. If an employer has employees living outside the employer's CBSA, "then saying that that employer is going to be affected if the hypothetical monopolist in one of those CBSAs acquires market power doesn't really make sense." *Id.* at 4229:9-21. "[A]ny individual CBSA does not capture enough of these employers' lives to be competitively significant." *Id.* at 4232:16-4233:4.

49. Dr. Fowdur conducted an additional test on geographic dispersion in order to determine the extent to which Cigna's large groups have most of their employees living within the CBSAs at issue. *Id.* at 4232:16-4233:4 (referencing DDX0493 at 15). This analysis revealed that in ten of the CBSAs at issue, Cigna had *no* local large groups with more than 75% of enrollees residing in the CBSA. *Id.* at 4233:5-12 (referencing DDX0493 at 15). In [redacted] CBSAs, Cigna had [redacted] large groups with more than 75% of employees living in the CBSA. Fowdur Tr. 4233:5-12 (referencing DDX0493 at 15). This geographic dispersion further reveals that CBSAs are inadequate markets and that, because so few accounts have most of their

lives within the same CBSA, these types of accounts differ from one another. *Id.* at 4233:23-4234:11; *see also* Willig Tr. 4537:21-4538:17 (geographic dispersion contributes to differentiation). The competitive significance of the various alternatives available will be different for each type of account. Fowdur Tr. 4233:23-4234:11.

50. This dispersion has significant implications for Anthem's ability to compete with other carriers for certain accounts. As Mr. Hawthorne testified, Anthem is not as competitive for accounts headquartered in local areas, such as Richmond, that have dispersed lives:

> The problem becomes, for Anthem in that situation, that it ends up becoming more expensive for them because they, ultimately, then have to pay network access fees to other Blue Cross states, which then enables them, in certain situations, not to be as competitive with a Cigna, an Aetna, United, because they have a true national network.

Hawthorne (Scott Insurance) Tr. 3005:10-3006:21.

C. Market Participants Do Not Consider CBSAs To Be Geographic Markets

51. Market participants do not utilize CBSAs to assess competition because CBSAs fail to account for the commercial realities of the marketplace. Fowdur Tr. 4234:12-24 (explaining that the Merger Guidelines and case law require consideration of commercial realities, so that a lack of industry recognition of CBSAs as markets is relevant). In fact, many participants have never even heard of the term CBSA. *E.g.*, Mahoney (SML) Tr. 3666:9-25; Guertin (Anthem) Tr. 3537:7-9; Rowe (Granite) Tr. 2831:18-25; Martenet (Anthem) Dep. 113:11-17; Wilhelmsen (Southern New Hampshire) Dep. 79:20-24, 80:1-5, 80:7; Hatch & Aubrey (AmeriBen) Dep. 23:24-24:9; [redacted]; Espinoza (CNIC Health) Dep. 24:21-25:9; Aumock (DaVita) Dep. 145:11-19; [redacted]

[redacted]. Instead they use varied geographic definitions in the ordinary course of business, including state-wide and regional definitions. *See e.g.*, Schmidt (Aetna/Prodigy Health) Dep. 116:13-117:2 (organizing members and plan sponsors by state); [redacted]; Rothermel (Anthem) Tr. 4079:7-21; Martenet (Anthem) Dep. 112:18-113:1.

52. Insurers are not regulated at the CBSA level. *See e.g.*, King (Anthem) Tr. 3087:8-18 (Virginia state regulation); Guertin (Anthem) Tr. 3564:13-16 (New Hampshire licensing is statewide); Spinazzola (E&S) Dep. 65:12-22 (New Hampshire regulations require approval of rate increases for all carriers in the state); Spooner (Tufts) Dep. 50:19-51:4 (Tufts' health insurance license grants "the ability to sell health insurance anywhere in [the state]"); Gray (Key Benefit Administrators) Dep. 43:20-44:22 (TPAs only require a state license to administer fully-insured plans in all states except North Carolina).

53. "[E]mployers don't purchase health insurance in discrete CBSA-by-CBSA units, and neither do health insurance plans sell their networks in discrete CBSA-by-CBSA level basis." Fowdur Tr. 4234:12-24, 4214:23-4215:6 ("[W]hen employers purchase health insurance, they don't purchase health insurance in discrete CBSA nuggets."). For example, given the small area comprising New Hampshire and neighboring states, market participants may treat New Hampshire and nearby states or counties as one market, particularly because a client-employer may have employees that commute across state lines. *See* DX0042 at SEDX280, SEDX287, SEDX300 ([redacted]); *see also* DX0425 at HPHC-ANTHEMDOJ-002508; DX0609 at HPHC-ANTHEMDOJ-008331; *see also supra* §

III.B. In New Hampshire, a state of about 1.2 million, an estimated 200,000, or one sixth of the population, obtain insurance through an out-of-state employer. Guertin (Anthem) Tr. 3527:9-19. Even for the largest state, California, Plaintiffs' CBSA approach bears no resemblance to customer purchasing patterns or pricing differences. Rothermel (Anthem) Tr. 4079:7-4080:3.

IV. PROF. DRANOVE'S MARKET SHARES ARE NEITHER ACCURATE NOR AN APPROPRIATE BASIS TO ASSESS POTENTIAL COMPETITIVE EFFECTS FROM THE MERGER

A. Prof. Dranove's Share Calculations Are Based On Stale, Incomplete Data And Unreliable Methodologies

1. Prof. Dranove's Data Used To Calculate Shares Are Largely From January 1, 2015 And Thus, Even If Shares Were Informative, The Shares Ignore How The Industry Has Evolved In The Past Two Years

54. The competitive landscape in the healthcare industry is dynamic and changes frequently over time. Williams (Cigna) Dep. 170:24-171:10; Wilhelmsen (Southern New Hampshire) Dep. 27:24-29:16 (trends in healthcare are "changing all the time"). Despite such dynamism, Prof. Dranove uses data from January 1, 2015, and in some cases from earlier. To calculate shares, Prof. Dranove relies in part on CID data from September 30, 2015, that reflects no competition in 2016. Dranove Tr. 3839:5-20. For competitors for which he lacks CID data, he relies on January 1, 2015 HLI data that reflects competition from 2014. Dranove Tr. 3838:5-7, 3838:20-24, 3839:21-24. Even Prof. Dranove concedes that HLI data has "problems" and is "not ideal." Dranove Tr. 2288:1-12. Nevertheless, Prof. Dranove takes the HLI data and parses it using Mark Farrah data for the first quarter of 2015, in an attempt to estimate the enrollees that may be in large groups. Dranove Tr. 3907:8-3908:1. Plaintiffs have not shown that these stale shares and concentrations are similar to the shares and concentrations that exist today.

55. In addition, such static shares are deficient because they do not account for rapid entry or expansion, which should be accounted for using a separate analysis that Prof. Dranove

did not perform. Fowdur Tr. 4241:3-4242:6. For example, static shares cannot account for the expansion of well-known market participants such as Aetna, United, Harvard Pilgrim, Kaiser, and Optima. Fowdur Tr. 4241:3-4242:6; Willig Tr. 4554:13-4555:18. They also fail to account for rapid entrants, including existing firms, like Harvard Pilgrim, that have expanded into new geographic locations such as Connecticut. Fowdur Tr. 4241:3-4242:6. Moreover, static shares do not account for dynamism resulting from other forms of competition such as from TPAs, private exchanges, direct contracting, and professional employer organizations. Fowdur Tr. 4242:17-4244:11 (referencing DDX0493, at 23-28); Willig Tr. 4568:8-4572:3.

56. "Firms not currently earning revenues in the relevant market, but that have committed to entering the market in the near future, are also considered market participants." Merger Guidelines § 5.1; Dranove Tr. 3924:20-3925:4 (discussing DDX0443); Willig Tr. 4551:20-4552:8. Nevertheless, Prof. Dranove's market shares do not account for the future significance of market participants, even for participants like Kaiser, who has committed to open facilities in Santa Cruz, CA in January 2017. Dranove Tr. 3923:11-3925:11, 3928:24-3929:2 (discussing DDX0282) (he did not have data for Kaiser's projected sales). Similarly, Prof. Dranove failed to obtain projections for Harvard Pilgrim's growth or expansion in 2016 and 2017. Dranove Tr. 3930:19-3931:1. Prof. Dranove's data also do not reflect an increase of 3,201% in IU Health's share from January 2015 to January 2016. Dranove Tr. 3931:14-3932:15.

57. Moreover, static shares cannot account for the fact that a small number of large account losses can cause wide fluctuation in CBSA-level shares. Fowdur Tr. 4244:12-4245:23 (referencing DDX0493, slides 28 & 29) (finding "a lot of variation in enrollment [at the CBSA level] that occurs from year to year"). Shares can swing "tremendously" over a two-year period when a large account is lost. Guertin (Anthem) Tr. 3528:12-3529:6. To take one example, in the

Santa Cruz-Watsonville, CA CBSA, Anthem's enrollment increased by 7% in 2013 relative to 2012, but then fell by over 20% in 2014, and then fell again in 2015 by about 20%. Fowdur Tr. 4246:6-4247:12 (referencing DDX0493 at slide 29). Because the "loss of one or more" large accounts "can cause big swings in the shares . . . reliance on those shares at a static point in time becomes problematic." *Id.* at 4236:10-4237:9.

58. Similarly, in many of the CBSAs there are only a few accounts where the majority of members are within the CBSA. Fowdur Tr. 4247:14-4249:2 (referencing DDX0493, slide 31). For instance, in each of the Lafayette-West Lafayette, IN and [redacted] CBSAs, a single account generates more than 90% of Cigna's share. Fowdur Tr. 4247:14-4249:2 (referencing DDX0493, slide 31). The loss of a very small number of accounts "would literally cause Cigna's share in those two CBSAs to vanish." Fowdur Tr. 4249:12-18. There are yet other CBSAs with just a handful of large groups. Guertin (Anthem) Tr. 3562:21-3563:20, 3564:7-12 (noting that New Hampshire is very rural, and Anthem has just eight accounts in a CBSA like Berlin, and will drop to seven accounts in 2017).

2. Prof. Dranove Vastly Overstates Shares Because He Elected Not To Obtain Data From Many Industry Participants, Including TPAs, And Therefore His Shares Do Not Match His Alleged Markets

59. Prof. Dranove purports to define his market as "all current and future sellers" of health insurance, and yet excludes all future sellers of health insurance, and numerous current sellers, including most TPAs and over 100 insurance companies. Dranove Tr. 2243:3-10, 4693:9-24; *see also* Phase I Findings ¶ 225. Remarkably, not one future seller appears in Prof. Dranove's denominator. *Supra* § IV.A.1. Prof. Dranove also failed to request data from over 100 insurance plans and *all* standalone TPAs. *See* Phase I Findings ¶ 225. Instead, in Phase II, he used data through CIDs from just seventeen insurers, and then used January 1, 2015 HLI data

to estimate enrollment for forty-five insurers. Dranove Tr. 4761:13-4762:2; DX0831; *see also* Phase I Findings ¶ 225.

60. In Phase II, as in Phase I, Prof. Dranove used two methods to calculate his denominator for estimating shares. *See* Phase I Findings ¶ 240; Dranove Tr. 3713:23-3715:6. In the "build-up" approach, for each CBSA he summed the numerators of the carriers that he calculated using CID and HLI data. *Id*. In the "census" approach, he used public census survey data. *Id.* Prof. Dranove claimed the census approach was a "robustness check" that should account for all market participants, including those whose data was not in the build-up approach. Dranove Tr. 3714:1-3715:6. As in Phase I, Prof. Dranove used whichever approach generated the larger denominator, which resulted in his using the census approach for twenty-four out of the thirty-five CBSAs. Dranove Tr. 3842:11-17 (discussing PDX033 at slide 24).

61. Prof. Dranove collected CID data from only twenty-six firms beyond the merging parties, and used CID data from only seventeen firms to calculate market shares for local large groups in each of the thirty-five CBSAs. Dranove Tr. 1052:8-22, 3835:24-3836:14. For the remaining forty-five competitors that Prof. Dranove included in his build-up approach, he used January 1, 2015 HLI data. *Id.* at 3837:2-4, 3837:16-24; *see also* DX0831.

62. Prof. Dranove's use of the "census approach" is not a "robustness check" because the build-up approach exceeds the census approach nearly one-third of the time, and sometimes by significant amounts. Dranove Tr. 3842:11-17, 3714:1-3716:6 ("There are four markets where the build-up approach is more than 10 percent bigger than the census approach."). Even more concerning, "there's significant evidence here that Dr. Dranove's census approach is understating the total universe of employees." Fowdur Tr. 4256:5-4257:11. That is because there is a "statistically larger difference between the census and the build-up" for CBSAs in the

Anthem states that are not the CBSAs at issue here, "indicating that the methodology is biased to somehow understate within the 35 [CBSAs] what the total denominator ought to be." Fowdur Tr. 4256:5-4257:11; *see also* Willig Tr. 4558:15-4559:15. Thus, the census approach overstates shares by understating the denominators in the twenty-four CBSAs where it was used.

63. Leaving aside the fact that Prof. Dranove ignored enrollment for many insurers and used stale data for the rest, Prof. Dranove's shares do not account for many health coverage solutions he vigorously asserts are in his alleged markets, such as independent TPAs. *Compare* Dranove Tr. 3689:22-3690:5 (stating that "HMOs, TPAs; all of these are included in my product market" definition), *with* Dranove Tr. 3715:24-3716:2 ("I'm not certain if there's any TPAs in HLI beyond those three"), *and* Willig Tr. 4522:17-4523:4 (HLI data excludes TPAs and direct contracting, which magnifies concentration levels), *and* Fowdur Tr. 4295:21-4296:16 (TPAs do not report membership to HLI so data would need to be sought directly from them).

64. The omission of these admitted market participants is striking given the substantial portion of health coverage solutions industry that they represent. For example, it is estimated that there may be hundreds of TPAs that account for at least [redacted] of the self-insured market, about [redacted] *See* DX0228 at CI-LIT-00053081 (20% of the commercial health insurance market uses an independent TPA); [redacted]; Benedict (Cigna) Dep. 176:5-6, [redacted] (there are 350 to 400 TPAs); Willig Tr. 2220:2-14 ("we know that the TPAs are left out"); Dranove Tr. 3688:1-4 (including TPAs in list of "sellers [that] are available for large group customers").

65. Most troublesome, Prof. Dranove never presented the number of enrollees in his denominator used to calculate market shares for the thirty-five CBSAs, effectively insulating his market share calculations from scrutiny. Dranove Tr. 3967:9-15, 4756:21-4757:18.

3. There Is No Basis To Attribute Other Blues' Shares To Anthem

66. Prof. Dranove presents no evidence of collusion, bid rigging, or price fixing in any of the alleged local markets. Dranove Tr. 3957:23-3958:2. However, as in Phase I, Prof. Dranove combines Anthem with other Blues when calculating shares. Dranove Tr. 3830:13-21. Therefore, if a company headquartered outside of an Anthem state has employees who live in New Hampshire, those lives would be included in Prof. Dranove's combined Anthem/Blues shares, even though Anthem did not take part in the bidding competition, and that competition occurred in a different state. Dranove Tr. 3830:22-3831:12. Prof. Dranove similarly uses combined Anthem/Blues shares in his UPP analysis and merger simulation. Dranove Tr. 3863:7-18. As in Phase I, Prof. Dranove's share calculations here are therefore the same as they would be if Anthem merged with all of the other Blues. Dranove Tr. 3908:2-12.

67. Anthem should be treated as distinct from other Blues because it is inappropriate to combine the shares of companies "as if they are part of a cartel or that they have already merged together into one distinct entity." Fowdur Tr. 4258:18-25. As with the "national account" shares, attributing members of other Blues to Anthem overstates Anthem's competitive significance in the Plaintiffs' alleged local markets. *See* Phase I Findings § VI(B)(2).

68. Prof. Dranove testified that calculating shares with the Blues separate "obviously, . . . leads to lower estimated market shares," but he disagrees that "we're supposed to not count those Blue lives." Dranove Tr. 3710:25-3712:1. Of course, other Blue lives should be counted, but only for the Blue entity that provides the health insurance. Fowdur Tr. 4259:1-4260:4.

69. Prof. Dranove also presents shares for the alleged local markets with Anthem separate from other Blues. Dranove Tr. 3909:12-3910:14; PX0751. When Anthem is treated as an individual competitor, the post-merger HHI in sixteen CBSAs falls under the 2500 HHI

presumption in the Merger Guidelines. Dranove Tr. 3912:7-3913:9 (discussing PDX033 at slide 32); PX0751. All of the CBSAs in Colorado, Georgia, Missouri, and New York fall below the 2500 presumption. Dranove Tr. 3913:19-3916:9 (discussing PDX033 at slide 32 & DDX0124).

4. Prof. Dranove's State-Only Market Shares Fail

70. In rebuttal, Prof. Dranove presented market shares for states as a whole. Dranove Tr. 4700:5-11; PX0751. These shares include the data problems discussed above, such as Prof. Dranove's use of stale HLI data and the omission of relevant competitors from his denominator. Dranove Tr. 4767:18-4768:12. *See supra* § IV.A.1 & 2. Furthermore, Prof. Dranove could have used revenue to calculate ASO-only shares, but did not. Dranove Tr. 3905:15-18.

71. In addition, Prof. Dranove's state-only, Blues separate shares show that [redacted]. PX0751. And [redacted]. *Id*. Finally, Prof. Dranove conceded that at least forty firms compete in these states by including in his shares data from seventeen CID recipients and forty-five HLI firms. Dranove Tr. 4761:13-25.

B. Market Shares Are Inappropriate For Assessing Potential Competitive Effects Because Health Insurance Solutions Are Differentiated Products

72. In differentiated product markets, bright line market boundaries — and consequently market share concentrations — are not appropriate to measure the industry. Willig Tr. 4530:24-4531:13; *see also* Phase I Findings ¶ 218 (citing Willig Tr. 2165:18-2166:12; Fowdur Tr. 1307:24-1308:19). For that reason, the DOJ and FTC recommend using diversion ratios rather than shares and concentration when assessing unilateral price effects in such markets. Phase I Findings ¶ 218 (citing Merger Guidelines § 6.1).

73. The products included in Prof. Dranove's market are differentiated by characteristics and geography, as are the products offered by Anthem and Cigna. *See* Phase I Findings ¶¶ 219-220; Dranove Tr. 3687:14-25 (ASO, full-insurance, and alternative funding are options); Willig Tr. 4547:9-4548:20. This differentiation is especially true for the varied groups in Plaintiffs' "large group" market, which include groups of fifty employees to customers as large as 10,000 employees or more, which would be considered "national account" customers according to Prof. Dranove. Dranove Tr. 3689:6-21, 3690:9-17. Such varied groups may require different healthcare solutions, some of which may be "more attractive" for local large groups than purported "national accounts." Dranove Tr. 3687:14-25.

74. Shares based on an amalgamation of differently-sized groups with different needs do not reflect competitive conditions in a market. *See* Fowdur Tr. 4210:1-19; Willig Tr. 4540:2-4543:17 (expressing no surprise that market shares are uncorrelated with pricing due to the inapplicability of HHI to capture competitive effects). By presenting shares without testing to determine if his market is too broad, Prof. Dranove runs into a problem he warned against: "What the merger guidelines do say you should be concerned about if you decide to go broader, as I have done here . . . is that you might be combining two markets in which the sellers in those markets really don't substitute for each other very well[.]" Dranove Tr. 3691:20-3693:11.

75. The only commonality that Prof. Dranove identifies among these groups is the "need to provide coverage for their employees who are working in the area in which the company is located." Dranove Tr. 3694:17-3695:6. He admits that "many, many things can vary across geography," including demand, but nevertheless thought it "pointless" to identify factors that affect local demand for insurance. Dranove Tr. 4778:3-8, 4778:19-4779:16.

76. Prof. Dranove also does not match his purported geographic markets to the shares he calculates for them. The markets he alleges are based on the CBSA in which an employer is located. Dranove Tr. 3829:13-3830:1; *see also* Phase I Findings ¶ 221. However, he measures market shares only according to where *employees* live, and ignores employer location altogether despite the fact that the location of the employer is included in his market definition. Dranove Tr. 3829:13-3830:1 ("To define market shares, I'm defining it around the people who live in the area . . . ."). Thus, the shares do not reflect the concentration markets he has defined.

77. The inherent difficulties with defining market boundaries in a differentiated product market shows why shares alone are an unreliable way to test for the likely competitive effects of this merger. Willig Tr. 4562:17-4563:2; 4685:13-4688:1. Due to such difficulties, the Merger Guidelines recommend tools to measure the value of diverted sales in these markets that do not suffer from these problems, including econometrics, diversion ratios, UPP analyses and merger simulations. *See* Willig Tr. 4529:17-23; *see also* Phase I Findings ¶ 222; Merger Guidelines § 6.1. Prof. Dranove, however, elected not to perform a traditional UPP analysis, instead using a "truncated merger simulation exercise . . . that UPP actually deliberately avoids." *See* Willig Tr. 4600:8-4601:7. The findings of these tools are discussed in more detail below.

V. THE MERGER WILL NOT ADVERSELY AFFECT COMPETITION IN THE SALE OF HEALTH INSURANCE TO LARGE GROUPS

78. Plaintiffs failed to establish that there likely will be a substantial lessening of competition in the sale of health insurance to large groups post-merger. Plaintiffs have not offered proof that the merger will increase coordinated interaction among insurers, TPAs, or the many other entities that provide access to healthcare coverage. Nor have they proven that efforts

to raise prices by the merged firm would be successful despite the low critical loss and the price constraints imposed by the many other competitors and potential entrants in the alleged markets.

A. Plaintiffs' Alleged Harm Would Affect An Extremely Small Number Of Large Group Customers — Only Six To Seven RFPs Per Year Per CBSA

79. Given that Plaintiffs allege harm only to those customers when Anthem and Cigna were the finalists (*see e.g.*, Dranove Tr. 3724:2-3725:1; Tr. 2709:9-18 (statement of Peter Schwingler)), Prof. Dranove's unreliable switching study (*infra* § V.C.6) shows that only between *six and seven* large groups in each CBSA per year will, on average, suffer Plaintiffs' alleged anticompetitive effects, *even if these effects come to fruition*, which they will not. This comes from the fact that Prof. Dranove identified a total of [redacted] (PX0753 at G-10 & G-11) and [redacted] large group RFPs across the three or four years (depending on the database) of Anthem data (*id.* at G-12, G-13, G-14 & G-16). *See* Phase I Findings ¶ 14 (demonstrating that Plaintiffs allege potential harm to only *nine* national accounts per year).

B. Plaintiffs Have Offered No Proof Of Potential Increased Coordinated Interaction Post-Merger

80. Plaintiffs have offered no evidence of possible competitive harm flowing from increased coordinated interaction post-merger. *See* Phase I Findings § VIII.A. Prof. Dranove reiterated his Phase I testimony that he has no evidence of collusion, price-fixing, or bid-rigging among competitors in the health insurance industry. Dranove Tr. 3957:20-3958:2, 1018:24-1021:8. In addition, Prof. Dranove presented no analysis to support a finding of likely competitive harm due to increased coordinated interaction. Dranove Tr. 3960:4-11; Israel Tr. 1985:23-1986:22 ("this industry is about as far from coordination as you can get" and Plaintiffs offer no analysis suggesting that the merged firm would "work more closely" with competitors).

C. Plaintiffs Have Not Shown That The Merged Firm Could Impose A SSNIP, Either Across-The-Board Or In Specific RFP Situations

81. Because Prof. Dranove has calculated that the critical loss for a hypothetical monopolist attempting to impose a SSNIP is just 6% based on Anthem's and Cigna's profit margins, if the hypothetical monopolist lost 6% of these price sensitive customers (or 6% of their covered lives collectively) in a given geographic market, then that "would be sufficient to defeat" the attempted price increase. Dranove Tr. 3823:25-3824:18, 3825:3-6.

1. Prof. Dranove's Merger Simulation And "UPP" Analyses Fail Because They Rely Upon His Decision To Merge Nearly All Blues

82. Plaintiffs cannot prove any unilateral effects due to the flaws in Prof. Dranove's analyses that underlie his merger simulation and "UPP" analyses. First, there is even less basis to aggregate the Blues in the local markets than the "national accounts" market, as Plaintiffs acknowledged (Trial Tr. 4856:9-20 (Plaintiffs)), and it is not appropriate to do so. *See* § IV.A.3; *see also* Phase I Findings § VI.B.2. Therefore, all of Prof. Dranove's merger simulations must be disregarded because they rely upon his market share calculations that aggregated the Blues together. Dranove Tr. 3862:21-3863:18; Israel Tr. 4404:6-4406:2 (discussing DDX0498 at 7). Further, all of his "UPP" analyses must be dismissed because they either rely upon these same market share calculations or they rely upon Prof. Dranove's switching analyses, which also merged all of the Blues when Prof. Dranove assessed the Cigna data. Dranove Tr. 3862:21-3863:2 (discussing PDX033, slide 45); *id.* at 3965:8-11; *see also* PX0753 (G-11 at n.2).

83. Separately, but importantly, his competitive effects analyses fail because he combines "national accounts" with local large groups (i.e., large group employers that are not "national accounts") (*supra* § II.A.1-2); and he inappropriately combines ASO products with fully-insured products (*supra* § II.A.4), and these are two critical inputs to his merger simulation

and "UPP" analysis. Israel Tr. 4404:6-4406:2 (discussing DDX0498 at 7). Further, his shares were compiled using January 1, 2015 HLI data and exclude significant market competitors, and these problems are additional reasons why his unilateral effects analyses fail. *Supra* § IV.A.

2. Prof. Willig's Regression Analyses Show That There Is No Relationship Between Insurer Concentration Or Market Share And ASO Fees Or Fully-Insured Premiums

84. Prof. Willig tested Plaintiffs' contention that higher insurer concentration will lead to higher prices, and demonstrated through scatterplots and regression analysis that there is no relationship between insurer concentration or market share and ASO fees or fully-insured premiums. *See e.g.*, Willig Tr. 4521:6-21, 4524:12-4525:16, 4533:4-4534:6, 4536:6-20. Although Prof. Dranove criticized Prof. Willig as using an outdated regression model (OLS) (Dranove Tr. 4716:8-4718:19), Prof. Dranove himself endorsed OLS when criticizing Dr. Israel's regressions. *Id.* at 4796:6-4797:2. Additionally, Prof. Willig controlled for Prof. Dranove's only other criticism, as well as for a variety of other potentially causal variables, and he ran sensitivity analyses to show his regressions are reliable. Willig Tr. 4536:21-4539:23.

3. Potential Rapid Entry And Expansion In The Alleged Markets Constrains The Ability Of The Merged Firm To Impose A SSNIP

85. In all of the alleged markets, and as described below (*see, infra,* §§ V.E, V.F), the evidence shows that many companies offer healthcare coverage solutions. In fact,

[redacted]

[redacted]. *See* PX0751 at 2; *see also* Willig Tr. 4558:7-4560:6.

[redacted] Willig Tr. 4554:4-4556:15 (reviewing PX0751). By Plaintiffs' own calculation, this merger is not the 4-to-3 merger that Plaintiffs' depict it to be.

86. The presence of numerous competitors in the thirty-five CBSAs and in each state means that a critical loss of business likely would occur were the combined firm to attempt a SSNIP, whether through expansion by existing competitors or entry by new competitors or the threat posed by it. Willig Tr. 4551:20-4552:8. As Prof. Willig explained:

> Now, all of a sudden, ***there's a firm that thinks it might have market power***, or we in the courtroom or the government thinks there may be a firm which has new market power as a result of a merger, and that firm would have to undertake a SSNIP. Now, ***in that picture of the market, the entrants have a way to do much better than they were doing before without the market power being attempted to be exercised because now there's a firm raising price, and that gives them new profit opportunities to enter and to expand***. Those who have been only 1 percent all of a sudden can go after the business of the firm that's trying to raise price, and they go from 1 percent to 3 percent. ***And if two of them do that, that overcomes the critical loss threshold.*** And the big firm who was thinking "Oh, boy, we're going to make some money here by exercising market power" realizes, ***"No, we're going to lose so much business to that dynamic mass of previously fringe players, we'd be foolish to try to get away with a price increase."*** And that's very important in terms of the economics form of competition, which ***in the guidelines and in economics generally means that's not a marketplace where we have to be concerned about a merger***.

Willig Tr. 4687:2-4688:1.

87. To determine the effect of entry and expansion on the likelihood of post-merger price increases, the merged firm's share is multiplied by the critical loss to see how much entry

or expansion is needed to make a SSNIP unprofitable. Willig Tr. 4548:24-4560:10. For example, if the combined firm had 40% share in a market, competitors entering and expanding need only take 2.4% of the merged firm's business (either in clients or pieces of clients' business) (6% critical loss multiplied by the 40% share) to make an SSNIP unprofitable. *Id*. at 4550:11-4552:8 (*discussing* Dranove Tr. 3823:25-3824:15, 3825:3-6). This is a *small* critical loss compared to other industries, such as those requiring industrial capacity that must be invested in or expanded, which means that "it's pretty easy to imagine" entry and expansion occurring in response to a SSNIP by the combined company. Willig Tr. 4556:4-4557:6.

88. As Prof. Willig explained, entrants in the last one or two years account for 1-2%, or more, of a given market *in the absence of a SSNIP*, and the presence of large competitors like Aetna and United, regional competitors, and small players, all of whom can expand, means a SSNIP would not be profitable in an alleged market. *See e.g.*, Willig Tr. 4554:13-4555:8 (discussing PX0751 at 2), 4558:8-4560:10 ([redacted] on PX0751 at 2).

89. Furthermore, barriers to enter the alleged markets are low. TPAs administering self-insured plans generally do not need to obtain a license from state insurance departments. Gray (Key Benefit) Dep. 43:20-44:22. Entities offering fully-insured or ASO products in any part of a state are generally free to offer those products in all parts of the state, including a new CBSA, because state insurance licensing is statewide. *See e.g.*, Spooner (Tufts) Dep. 50:19-51:4. This means that any competitor present in a state should be considered for purposes of market share calculations because they can readily acquire provider networks in a new part of a state and otherwise face no barriers to expansion into a new area of a state. Willig Tr. 4564:12-4566:24 (citing Matheis Tr. 1488:13-1489:4 and Drozdowski Tr. 1661:16-1662:5).

90. Prof. Willig identified a number of recent entrants, including four not found in Prof. Dranove's HLI data and examples that had recently achieved "meaningful" entry (i.e., greater than 1% market share in that state) that show that entry, as well as expansion, would also inhibit a SSNIP. Willig Tr. 4563:3-4564:3, 4567:23-4569:25, 4570:15-4572:9. The fact that many entrants have only small shares demonstrates that the minimum viable scale to operate is small, because the entrants are able to persist in an area despite these small shares. *Id.* at 4567:23-4569:18. That some entrants have also exited within a few years means that exit is possible, which encourages the taking of risk and entry. *Id.* at 4570:2-14, 4685:13-4686:4. Moreover, that small firms are exiting suggests competition from incumbent firms. Willig Tr. 4570:2-14, 4685:13-4686:4 ("There's an old maxim in economics that exit barriers are entry barriers. If potential entrants know they can't get out, then that makes them more reluctant to come in in the first place."). The dynamic nature of the alleged markets taken together with the presence of competitors ready to expand means that the combined firm would be unlikely to impose a SSNIP. *See e.g.*, *id.* at 4686:5-4688:1. Yet Prof. Dranove's shares do not account for this dynamism and the possibility for entry and expansion. Fowdur Tr. 4241:3-4244:11.

4. Prof. Willig's UPP Analysis Demonstrated That There Is Net *Downward* Pricing Pressure On Products Sold To ASO Customers

91. Prof. Willig conducted a UPP analysis, a tool endorsed by the Merger Guidelines to assess unilateral effects in differentiated product markets. Willig Tr. 4574:3-4575:24; Merger Guidelines §6.1. For any two merging companies whose products have any degree of substitution, the UPP will result in a positive number due to the positive diversion between the two companies' product, but that does not mean that a price increase will necessarily occur. Willig Tr. 4576:23-4578:3. The agencies and antitrust economists recognize that a UPP around

5% is not concerning and around 10% is not very large either — even without accounting for efficiencies (the equivalent to Prof. Willig's GUPPIs) — although the agencies do not use the term "safe harbor." *Id.* at 4586:11-23; *see also* Remarks of Carl Shapiro, Deputy Ass't. Attorney Gen. for Econ., Antitrust Division, U.S. Dep't. of Justice to Am. Bar Ass'n Section of Antitrust Law Fall Forum, Nov. 18, 2010 at 24; Joseph Farrell and Carl Shapiro, *Antitrust Evaluation of Horizontal Mergers: An Economic Alternative to Market Definition*, 10 B.E. J. of Theoretical Econ 1, 9-10, 12 (2010) (describing a "standard deduction" of efficiencies for merging parties and using 10% as the example such "efficiency credit").

92. When using the diversion ratios he calculated, Prof. Willig found GUPPIs of [redacted] which are "pretty modest" and below or near thresholds that do not present a concern, even before any cost savings are considered. Willig Tr. 4587:5-19 (discussing DDX0497 at 16).

93. One strength of UPP is that it allows the direct integration of aspects of the relevant markets that may create downward pricing pressure, such as quantifiable improvements in product quality, and medical cost savings that will result from the merger. Willig Tr. 4575:25-4576:22, 4592:1-23, 4604:11-4605:14; Carl Shapiro, *The 2010 Horiz. Merger Guidelines: From Hedgehog to Fox in Forty Years*, 77 Antitrust L.J. 701, 727-729 (2010). This allows the UPP to assess the net directional pressure and force on price — here, the total price from the perspective of the employer including ASO fees and medical claims costs. Willig Tr. at 4578:4-4580:11. Because Dr. Israel calculated the medical cost savings of the merger, Prof. Willig was able to directly factor these savings into his results. *Id.* at 4587:20-4588:3. When such savings — but not variable cost savings — are included, the result is net *downward* pricing pressure, meaning that the merged company will be incentivized to offer a lower-priced product to customers. *Id.* at 4588:4-21, 4589:20-24. Note that because the UPP focuses on the direction of a merger's price

effects, not the magnitude of the effects, the amount of pass-through need not be considered. Willig Tr. 4590:19-4593:2; Joseph Farrell and Carl Shapiro, *Antitrust Eval. of Horiz. Mergers: An Econ. Alternative to Market Definition*, 10 B.E. J. of Theo. Econ. 1, 19 (2010).

94. By using Dr. Israel's calculated medical cost savings, Prof. Willig was able to directly factor in the downward pricing pressure these variable cost savings offer to the merging parties and their customers — the employers. Willig Tr. at 4587:20-4588:3. When such savings are included, in the UPP calculation, the result is net *downward* pricing pressure, meaning that the merged company will have a net incentive to offer a lower-priced product to customers — thus, suggesting no anticompetitive concern. *Id.* at 4588:4-21, 4589:20-24.

95. Prof. Willig conducted his UPP analysis twice — once using his diversion ratios and once using the ratios Prof. Dranove applied in his own analyses. *Id*. at. 4597:10-4598:1. To further minimize dispute, Prof. Willig used the profit margin that Prof. Dranove calculated. *Id.* at 4585:12-23. The result, *even using Prof. Dranove's diversion ratios*, including the Anthem Large Group snapshot that Plaintiffs questioned Prof. Willig about on cross-examination, is *net downward pricing pressure*. *Id.* at 4660:16-4667:7, 4677:4-19.

96. Prof. Willig's UPP analysis was conservative because it does not consider numerous factors prevalent in this industry, including entry by new firms and repositioning by existing firms. Willig Tr. 4593:4-4596:11 (discussing DDX0497 at 18). It also does not account for variable administrative cost savings and Cigna's customer-facing product features that will be incorporated into the merged company's new products. *Id.* These factors point to more downward pricing pressure than calculated by Prof. Willig. *Id.* at 4594:16-20.

97. While Prof. Dranove labels one of his analyses "UPP," he acknowledged that it is not the type of UPP analysis endorsed by the Merger Guidelines. Dranove Tr. 3862:3-3863:18;

Willig Tr. 4600:8-4601:7. Instead, he ran a simplified merger simulation that relied on untenable assumptions, such as imposing an incumbency requirement and minimizing pass-through, whereas the real UPP requires no assumptions and simply puts all downward pricing pressures "on the same level playing field as the upward pricing pressure." *Id.* at 4600:8-4602:15. Prof. Dranove criticized the UPP as inappropriate for auction markets like this one (Dranove Tr. 4739:21-4740:3), but this is inconsistent with the economics literature. *See* Serge Moresi, *The Use of Upward Price Pressure Indices in Merger Analysis*, Antitrust Source, at 4-5 (Feb. 2010).

5. Anthem And Cigna Are Not Close Competitors In The Local Markets

98. The evidence shows that Anthem and Cigna are not each other's closest competitor. "The extent of direct competition between the products sold by the merging parties is central to the evaluation of unilateral price effects." Merger Guidelines § 6.1. Thus, "substantial unilateral price elevation post-merger . . . normally requires that a significant fraction of the customers . . . view products formerly sold by the other merging firm as their ***next-best choice***." Merger Guidelines § 6.1 (emphasis added). Prof. Dranove agrees "that what's critical to understanding the effect of the merger on pricing is the frequency with which Anthem and Cigna are 1 and 2 and 2 and 1." Dranove Tr. 3856:3-10. Since Anthem and Cigna are not the next best options for customers, the merger will not have anticompetitive effects.

99. Anthem and Cigna are not close competitors in any alleged local market (*See, infra*, §[V.D.]) or for "national accounts" (Phase I Findings, §VIII.C.1.A). Prof. Willig considered Anthem's analysis of discount rates in RFPs by Anthem, Cigna, United, and Aetna, and found that of the 701 bids when Anthem had the lowest discount rates, United was tied or second [redacted] of the time, compared to [redacted] for Aetna and [redacted] for Cigna. Willig Tr.

4580:12-4582:9 (citing DDX0497 at 15). This shows that, for the most important price-driving factor, United is a far closer competitor to Anthem than Cigna is. *Id.* at 4582:19-4583:12.

100. While Prof. Dranove conducted a switching study of large groups based on Anthem and Cigna win/loss data, the results of this switching study are unreliable (*infra* § V.C.6) and do not outweigh the overwhelming evidence that Anthem and Cigna are not closest competitors or next best substitutes. *See also* Phase I Findings, §VIII.B.1.a.

6. Prof. Dranove's Diversion Ratios Are Flawed, But Nevertheless Show That Anthem And Cigna Are Not Next Best Substitutes

a. Prof. Dranove's Switching Analyses Incorrectly Combine All Of The Blues As If They Merged

101. Prof. Dranove's switching analyses based on Win-Loss data for the local markets suffer from the same flaws as Prof. Dranove's Win-Loss data for national accounts. Phase I Findings at ¶¶ 359-61. First, Prof. Dranove testified that his large group switching analyses in PX0753 are based upon wins and losses of Anthem combined with the Blues, as if they merged. Dranove Tr. 3965:8-11; *see also e.g.*, PX0753 (G-11 at n.2). Thus, not only are these diversion ratios unreliable, but they are biased to find a higher degree of diversion by overstating the number of wins or losses attributable to Anthem. *See* Israel Tr. 4404:6-4405:2; *supra* § IV.A.3 (explaining further Prof. Dranove's lack of basis to attribute other Blues' shares to Anthem).

102. Moreover, Prof. Dranove cannot reliably draw any conclusions from his comparison of diverted shares to the implied diversion ratio based on market shares because the percentage implied by market shares is based in turn upon Prof. Dranove's flawed share calculations. *See e.g.*, PX0753 at G-15, G-17; *see also* Dranove Tr. 3863:7-12; *supra* § IV.

b. Prof. Dranove's Switching Analyses Improperly Condition On Incumbency, Fail to Match, And Aggregate Data

103. Prof. Dranove "use[d] the same approach as in . . . the national accounts analysis, where [he] conditioned on incumbency using the same data." Dranove Tr. 3725:15-23, 3855:23-3856:2. His switching analysis is improper because it unjustifiably assumes that a losing incumbent is the second best bidder. Willig Tr. 4594:21-4596:11; Phase I Findings at § VIII.C.1.a. It also improperly relies on the losing bidder's perceptions of the winner, without confirming the actual winner through available data. Phase I Findings at ¶¶ 359-61.

104. Prof. Dranove's restriction on incumbency caused him to omit so many competitive situations that he had to aggregate data across all thirty-five CBSAs, as there were too few observations in any individual alleged market from which he could draw conclusions about diversions. Dranove Tr. at 4713:25-4714:14; Fowdur Tr. 4250:16-4251:20.

105. Dr. Fowdur disaggregated Prof. Dranove's Cigna data that spanned seven years and found his aggregated diversion ratios misleading because "there's a significant variation across time in terms of the proportions of these Cigna accounts that are being lost to each of these competitors." Fowdur Tr. 4250:16-4251:20 (discussing DDX0493 at slide 35). Furthermore, to be consistent with Prof. Dranove's purported markets, Dr. Fowdur looked at his diversion data on a CBSA-by-CBSA level and found that "diversions from Cigna to Anthem are, in fact, lower in most cases relative to what the share-based diversions indicate," implying that "the closeness of competition between Anthem and Cigna is actually lower than what shares would predict." Dranove Tr. 4252:13-4253:8 (discussing DDX0493 at Slide 36).

c. Prof. Dranove's Switching Data Show That Anthem Is A Closer Competitor To United And Others Than Cigna

106. To the extent Prof. Dranove's switching analyses say anything about the closeness of competition, they indicate that Anthem and Cigna are not each other's next best substitutes.

107. For example, Prof. Dranove's G-15 purports to report Anthem's Large Group Account Losses from 2013-2016. PX0753 at G-15. The "Total" column indicates that the most Anthem losses are to "Other," which have 36% of the share. *Id*. As established repeatedly during trial, "Other" in Prof. Dranove's data can contain significant competitors. *See e.g.*, Dranove Tr. 3948:19-3950:10. After "Other," G-15 shows that United is Anthem's number one competitor, with 22% of wins from Anthem. PX0753 at G-15. Aetna is Anthem's next closest competitor with 20%. *Id.* Cigna appears fourth, with only 17% of losses to Anthem. *Id.*

108. In New Hampshire and Maine, Prof. Dranove's G-15 shows that Anthem's closest competitor is Harvard Pilgrim, which has 64% and 52% of the switching from Anthem, respectively. *Id.* [redacted] *Id.* [redacted] . *Id.* [redacted] . *Id.* [redacted] . *Id.*

109. Even for individual states in which Prof. Dranove's diversions show that Anthem lost most to Cigna, there are many competitive options. As Prof. Dranove conceded, "Harvard Pilgrim is a strong option for employers in Maine and New Hampshire." Dranove Tr. 3917:6-9. While Dr. Dranove's diversion shows Harvard Pilgrim with only [redacted] in Connecticut, [redacted] (Roberts (Harvard Pilgrim) Dep. 23:12-14) and has projected nearly [redacted]. DX0428 at HPHC-ANTHEMDOJ-000212. [redacted]

[redacted]

[redacted]. PX0751 at 6.

7. Customers Are Price Sensitive And Willingly Switch Carriers Due To Small Price Changes

110. Employers work hard to control healthcare costs, which are substantial and continue to rise. Harlin (Wells Fargo) Tr. 3384:18-20; *see also* Phase I Findings ¶ 319. Large groups of all sizes use brokers and consultants to help them control costs (Dranove Tr. 3724:2-14), and this enables them to push for lower prices. Willig Tr. 4539:24-4541:4; *see also* Hawthorne (Scott Insurance) Tr. 3001:4-13. When large groups choose a health insurance product, price is the "number one" consideration. Hillman (Anthem) Dep. 184:4-18; *see also* King (Anthem) Tr. 3069:21-24; Mifsud (Melita) Tr. 3225:7-14; Martenet (Anthem) Dep. 140:19-141:8; Hummel (Anthem) Dep. 91:6-23; [redacted].

111. Employers will switch carriers for savings of just 2-3%. Hawthorne (Scott Insurance) Tr. 3016:20-3017:13 (saving $300,000-$400,000 per year on $16 million in medical spend justified administrative cost of switching); Monti (Kroger) Dep. 37:22-38:13, 39:2-39:4; Fowdur Tr. 1363:19-1364:3 (customers can switch, or threaten to switch, to many competitive options in order to find lower prices). Mr. Hawthorne noted that clients ask "to go to market in order to make sure that we not only have the best program but the best cost." Hawthorne (Scott Insurance) Tr. 2991:7-2992:13. Ms. Guertin said that New Hampshire customers are "extraordinarily price sensitive." Guertin (Anthem) Tr. 3553:23-3554:1. Witnesses from Virginia, Maine and California describe similar price sensitivity. *See e.g.*, Kidd (Sodexo) Dep. 51:9-11, 51:14-22; Burke (MEA Trust) Tr. 4027:10-12; Rothermel (Anthem) Tr. 4097:7-16.

D. Regulation And Industry Practice Would Prevent A Monopolistic Price Increase

112. Plaintiffs have included fully-insured plans in their alleged product market. Dranove Tr. 3691:4-19. But suppliers of fully-insured plans are limited by state and federal regulation from imposing price increases. Willig Tr. 4542:24-4543:17. Each state has adopted accreditation standards to ensure "high quality financial solvency and market conduct oversight" across state lines. DX0434 at ¶ 13. Thus, each state has a regulatory process in place that protects consumers from the imposition of an anticompetitive price increase. *See* DX0434 at ¶ 15. In fact, in nine out of the ten states at issue, prior approval or review by the state insurance department is required for large group fully-insured rates. DX0434 at ¶ 26.

113. In addition, the ACA standardized medical loss ratios ("MLRs") requiring carriers to pay at least 85% of premiums earned from fully-insured large groups in the form of medical claims. Pls.' Stip, Civil Action No. 16-1493 (ABJ), October 20, 2016 at ¶ 15. If a carrier does not, then it is "required to pay rebates to enrollees." *Id*. at ¶ 15. MLRs act as a price constraint prohibiting the hypothetical monopolist from imposing a SSNIP. HHS's analyses have consistently shown that MLRs have significantly constrained any rise in premiums. DX0292 at 2 ("[T]he over $1.1 billion in rebates provided through [MLRs] show that insurance companies can no longer pass excessive administrative costs and profits on to consumers."); DX0293 at 1.

E. The Evidence Shows That The Merged Company Cannot Profitably Raise Prices (Unilateral Effects) And That Barriers To Entry Are Low In Plaintiffs' "Feature Markets"

114. Plaintiffs have not established that the merged firm can profitably raise prices in the purported "feature markets." In each of these areas, many competitors are able to constrain any attempted price increase. Moreover, Anthem and Cigna are not the closest competitors to

each other in these alleged markets and, even if they were, barriers to entry are low, making it easy for new entrants to respond to any effort to raise prices. Given these facts, Plaintiffs have not established that anticompetitive effects are likely to occur in the alleged "feature markets."

1. California

115. Anthem's competitors recognize that California is "[redacted]." *See* Hilty (Blue Shield) Dep. 140:2-4, 140:6-9; *see also* DX0362 at KP001625, KP001672. Every year Anthem competes for 10,000 new accounts and most of its 3,600 existing accounts with traditional carriers, PSPs, TPAs and trusts. Rothermel (Anthem) Tr. 4067:5-4068:17, 4069:7-21, 4070:22-4073:3, 4080:4-19, 4095:3-4097:21. Anthem often does not know who the next competitor will be, or even what type of competitor Anthem will face. *Id.* at 4080:4-19. Even setting aside the TPAs and trusts, employers have numerous carrier options. [redacted].

116. Competition in California has increased with the successful, recent competitive entry by PSPs. Rothermel (Anthem) Tr. 4080:4-19; *see also* [redacted]. These PSPs do not depend on their own employees for entry or growth, as evidenced by [redacted], [redacted], and by Sharp, which is growing by selling directly to employers through CalPERS. [redacted]; Rothermel (Anthem) Tr. 4084:11-23, 4085:6-25. PSPs are taking advantage of the trend among employers to switch to high-deductible plans with narrow networks, instead of paying premium increases. DX0633 at ANTM-DDC-002891708. As a result, PSPs are expanding and winning new member. DX0633 at ANTM-DDC-002891708; *see also* [redacted]; DX0633 at ANTM-DDC-002891648, Mahoney (SML) Tr. 3663:3-14; [redacted].

117. Anthem sells over 1,200 "standard" products and "tens of thousands" of customizable options in California. Rothermel (Anthem) Tr. 4077:20-23. The typical California customer purchases a fully-insured HMO or a fully-insured/ASO combination, which is why Kaiser is dominant and California is known as an HMO state. *Id*. at 4077:13-4079:2. By contrast, about one in ten customers purchase an ASO-only product. *Id.* at 4098:7-14.

118. Anthem also rents its network to trusts and TPAs in California, which compete against Anthem for large groups. Rothermel (Anthem) Tr. 4069:11-13, 4070:15-24, 4067:2-4. Prof. Dranove defines the product market as the market "for the sale of insurance, not the sale of local provider networks," but his shares did not exclude the membership attributed to the rental of Anthem's network. *See* Dranove Tr. 4691:3-13 (PDX0044 at 2). This rental business is larger than Anthem's direct ASO business. Rothermel (Anthem) Tr. 4067:5-7, 4069:7-10, 4114:14-21 (almost one million lives are covered by TPAs renting the network and another 700,000 lives are covered by trusts, compared with just over 600,000 lives that Anthem covers itself with an ASO product). Thus, Prof. Dranove's market share analysis is misleading.

a. Numerous Health Insurance Competitors And A Variety Of Company Types Serve California

119. CalPERS, a trust with 1.5 million members statewide, provides a telling example of the intensity of California competition, the use of slicing to drive competition, and the absence of Cigna as a close competitor to Anthem. Eight carriers bid for CalPERS' business, and CalPERS sliced its business among six: Anthem, Kaiser, Blue Shield, Sharp, HealthNet, and United. Rothermel (Anthem) Tr. 4080:20-4081:24. CalPERS has since announced that, beginning January 2018, it will add WHA. *Id*. at 4080:20-4081:19. Aetna and GEMCare also bid, but were not selected. *Id*. at 4081:8-12. Cigna did not bid. *Id*. at 4081:13-14. The entire

state of California will remain competitive post-merger and a plethora of competitors are available to provide competitive constraints on the merged firm. Fowdur Tr. 4260:5-23 (DDX0493 at 41); *see also* [redacted].

120. Anthem describes competition for large group in 2016 as [redacted] and [redacted] DX0816 at ANTM-DDC-002603330. United and Blue Shield appear as Anthem's [redacted] competitors in sales summary reports. DX0816 at ANTM-DDC-002603330 (United "has emerged as the most aggressive competitor across the state"); Rothermel (Anthem) Tr. 4103:13-4104:3, 4105:17-4106:2, 4107:1-17. Other frequently mentioned competitors include Aetna, Kaiser, [redacted]. DX0814; DX0815. But Anthem's 2015 and 2016 reports seldom mention Cigna. Rothermel (Anthem) Tr. 4107:1-17.

121. In the Los Angeles-Long Beach-Anaheim, Oxnard-Thousand Oaks-Ventura, San Francisco-Oakland-Hayward, and San Jose-Sunnyvale-Santa Clara CBSAs, even Prof. Dranove's flawed calculations show that the merger may be presumptively unlawful only if Anthem is aggregated with other Blue licensees, even though Prof. Dranove concedes Blue Shield competes in California and its shares should not be aggregated with Anthem. Dranove Tr. 3716:3-3719:8, 3929:16-21 (discussing PX0751 at 2); *see also* Rothermel (Anthem) Tr. 4082:11-4083:8; Schlegel (Anthem) Tr. 1403:14-1404:1; [redacted].

122. In the Santa Cruz-Watsonville CBSA where Cigna is the [redacted] share, and the Santa Maria-Santa Barbara CBSA where Cigna is tied with [redacted] share, Prof. Dranove opines that the acquisition should be presumptively unlawful. PX0751 at 2. However, Prof. Dranove fails to consider the significant competition from TPAs. PX0751 at 2; Fowdur Tr. 4260:5-23 (DDX0493 at 41). Even if Prof.

Dranove's [redacted] share calculations for Cigna were accurate, they would vastly overstate Cigna's competitive significance and the likely effect of the acquisition.

i. Employers May Obtain Healthcare Coverage Through Single Carrier And Slice Arrangements

123. **Kaiser**. Kaiser's penetration and popularity makes it the "market leader." DX0633 at ANTM-DDC-002891647, 648, 651; [redacted]; Mascolo (Wells Fargo) Dep. 162:9-12, 162:14-163:7; Rothermel (Anthem) Tr. 4111:3-4112:13 (Kaiser has about 47% share of fully-insured California members, compared to about 20% for Anthem). [redacted]. Hilty (Blue Shield) Dep. 129:3-130:1; DX0569 at 8.

124. Kaiser competes throughout California, serving large clients such as [redacted]. Guptill (Kaiser) Dep. 55:8-21, 145:20-146:16; Rothermel (Anthem) Tr. 4080:20-4081:4. Kaiser's pricing has become the benchmark for Anthem's products. *Id*. at 4078:9-4079:2, 4093:9-4094:20. Customers looking at an ASO option will convert the total ASO cost of care to a "premium equivalent" to measure the ASO against Kaiser's HMO pricing. *Id*. at 4078:9-4079:2, 4092:24-4094:20. Therefore, Anthem and other competitors' ASO pricing is driven by, and responds to, Kaiser's HMO pricing. Rothermel (Anthem) Tr. 4078:9-4079:2, 4092:24-4094:20; Mascolo (Wells Fargo) Dep. 149:12-151:9; Burnell (Buck) Dep. 90:2-4, 90:8, 90:10-16. [redacted]. DX0362 at KP001625 ([redacted]).

125. Prof. Dranove admits he has not estimated demand or price sensitivity on the basis of Kaiser's presence or absence from California. Dranove Tr. 3844:11-3845:11. Yet he declares that "Kaiser competes, but it's not really the same product as Anthem and Cigna are

relative to each other" and "Kaiser's competitive impact is not quite as large as Cigna." Dranove Tr.3693:22-25, 3694:8-15. Prof. Dranove's conclusions are clearly contradicted by the record.

126. Even in slice situations, there is a very real risk that Kaiser will eventually win the entire contract on a full replacement basis. Rothermel (Anthem) Tr. 4092:24-4093:8; DX0815; [redacted]; Mascolo (Wells Fargo) Dep. 149:12-151:9; *see also* Donneson (CalPERS) Dep. 79:16-21 (Kaiser plans compete with Anthem plans). Anthem has lost many accounts to Kaiser after slicing resulted in Kaiser winning significant portions of the accounts' membership. DX0632 at ANTM-DDC-000299941; DX0666 at ANTM008690622; DX0635; Rothermel (Anthem) Tr. 4092:9-23. Kaiser is increasingly winning clients outright, including almost twenty clients in 2016 from Anthem. Rothermel (Anthem) Tr. 4092:9-19; *see also* Kehaly (Anthem) Dep. 31:4-15; [redacted]; Mahoney (SML) Tr. 3663:16-20; Mifsud (Melita) Tr. 3260:19-3261:18; DX0815; [redacted]; Mascolo (Wells Fargo) Dep. 149:12-151:9.

127. **United**. United has been Anthem's primary competitor in California throughout 2016 for all product types. Rothermel (Anthem) Tr. 4102:13-23, 4083:24-4084:10, 4084:9-10, 4092:5-8; DX0816 at ANTM-DDC-002603330 (United has "emerged as the most aggressive competitor [to Anthem] across [California]"); *see also* PX0737 at ANTM-DDC-001065822 ([redacted]). Anthem is "three times more likely . . . to lose to United than to Cigna." Rothermel (Anthem) Tr. 4102:25-4103:5. [redacted]. DX0569 at 8.

128. In 2015 and 2016, United has systematically and successfully targeted Anthem. Rothermel (Anthem) Tr. 4106:14-4109:19; DX0629 at ANTM008777307 ("[redacted]."); DX0630; DX0632 at ANTM-DDC-000299941 ("[redacted]

[redacted].”); DX0814. United’s strategy included bonus payments for brokers moving clients to United. DX0630 ([redacted]); Eddy (Tolman & Wiker) Dep. 120:21-22, 120:24-121:7; Rothermel (Anthem) Tr. 4107:19-4109:19; Mifsud (Melita) Tr. 3254:1-16;. As noted in a 2016 MOR, [redacted] Aetna & United are highlighted for this month.” DX0814.

129. **Blue Shield**. Blue Shield competes vigorously against Anthem. [redacted]; [redacted]; Tallman (HealthNet) Dep. 62:21-25; Mifsud (Melita) Tr. 3252:3-15; Rothermel (Anthem) Tr. 4082:14-4083:8. It targets Anthem’s large group clients with a pledge to return any profit over 2% to its customers, ensuring Anthem must substantiate its pricing, products, and services. DX0570 at 7; [redacted]; Rothermel (Anthem) Tr. 4082:14-4083:8. Anthem consistently ranks Blue Shield as its first or second most effective competitor in California. Rothermel (Anthem) Tr. 4102:15-23, 4107:1-17, 4083:17-4084:4. [redacted]. Hilty (Blue Shield) Dep. 61:7-11, 61:22-25, 87:24-88:5, 162:1-13. Anthem has also struggled to win against Blue Shield’s “zero percent” renewal and its rate cap strategies. DX0814; Rothermel (Anthem) Tr. 4105:7-14; DX0816 at ANTM-DDC-002603330.

130. **Aetna**. [redacted]. DX0569 at 8. Aetna has been pricing aggressively in 2015 and 2016 and, like United, is paying out significant broker commissions to grow faster. [redacted]; DX0630; Rothermel

(Anthem) Tr. 4107:19-4108:7. Anthem considers Aetna to be "fast-approaching third" to Blue Shield and United. Rothermel (Anthem) Tr. 4107:1-4108:7, 4125:10-22; DX0814. Anthem lost more existing business to Aetna than to Cigna. Rothermel (Anthem) Tr. 4092:5-8.

131. **HealthNet**. HealthNet, recently acquired by Centene, has 30 years of brand recognition and a full range of products offered in California and the Western U.STallman (HealthNet) Dep. 27:2-12, 42:18-21, 58:5-13, 97:12-25, 128:17-129:13. HealthNet is a leading rival of Anthem's and — [redacted]. Rothermel (Anthem) Tr. 4098:18-23; DX0816 at ANTM-DDC-002603330; DX0569 at 8; [redacted]; [redacted]; DX0522 at UHC0012399; DeRosa (Cigna) Dep. 123:20-124:11, 161:3-5, 161:8-22. HealthNet, Kaiser and Blue Shield typically offer the lowest prices for California large groups. Mahoney (SML) Tr. 3663:16-20.

132. **Sutter**. Sutter is a not-for-profit HMO plan sponsored by a dominant hospital system in the greater Sacramento-San Francisco region. [redacted], DX0567 at 42-3; DX0633 at ANTM-DDC-002891664; DX0517. Sutter has had [redacted] growth during its three years in operation: [redacted] to date who are not from employers affiliated with Sutter. Schirmer (Sutter) Dep. 23:23-24:8, 34:6-11, 44:9-24, 50:3-15, 56:20-57:5, 57:7, 80:9-25; DX0567 at 4; *see also* Mifsud (Melita) Tr. 3259:4-6.

133. As Plaintiffs concede, Sutter entered in Northern California and quickly gained 130 large groups. Trial Tr. 4852:9-4853:15. Sutter's customer base is already equal to over 10% of Anthem's 1,200 large groups in Northern California. *See* Rothermel (Anthem) Tr. 4077:8-12. [redacted]. Schirmer (Sutter) Dep. 23:3-18.

134. **WHA**. WHA is a provider-sponsored HMO operating in northern California. DX0633 at ANTM-DDC-002891676. It can potentially "price [Anthem] out" with its aggressive rates. Rothermel (Anthem) Tr. 4086:1-8; Brown (Gallagher) Dep. 49:11-50:1; *see* Dahms (Anthem) Dep. 214:5-7. WHA's pricing advantage creates a threat of disintermediation in San Francisco similar to what Sharp has done in San Diego. Rothermel (Anthem) Tr. 4086:1-8. Other health plans consider WHA a key competitor. [redacted]; [redacted]; Tallman (HealthNet) Dep. 63:6-11.

135. **"Triple Macho Combo"**. Internally, Anthem refers to fierce competition against the joint efforts of Kaiser, WHA, and Sutter as the Double or Triple Macho Combo. Rothermel (Anthem) Tr. 4086:12-4087:7, 4089:13-16; DX0668 ([redacted]"); *see also* Dahms (Anthem) Dep. 212:2-214:4 (discussing PX0369). By 2015, Anthem had lost enough large groups to these combos that it began trying to track these losses. DX0667; PX0749; *see* Rothermel (Anthem) Tr. 4167:22-4169:6, 4151:16-23, 4088:8-4090:14; DX0634. Arthur J. Gallagher has created an exchange to market these three plans together, over typical carriers. DX0517; Rothermel (Anthem) Tr. 4086:24-4088:3.

136. **Sharp**. Sharp is a significant competitor for large group business in southern Los Angeles and San Diego. *See* Tallman (HealthNet) Dep. 138:12-21; Rothermel (Anthem) Tr. 4080:4-19 (Sharp is winning large group business). Sharp has been pricing below Anthem and winning CalPERS business from Anthem in the San Diego area. Rothermel (Anthem) Tr. 4084:11-4085:25; *see also* [redacted]; Donneson (CalPERS) Dep. 79:16-21. Anthem "can no longer compete" with Sharp and has only 237 HMO members in CalPERS in San Diego; by contrast, Sharp has approximately 10,000 members, or 20% of CalPERS's total enrollment in the greater San Diego area. Rothermel (Anthem) Tr. 4084:11-4085:5.

137. **ACOs**. To compete with "market leader" Kaiser in San Francisco, other health systems are partnering with one another to launch ACOs, which are collaborations focused on improving health outcomes. DX0633 at ANTM-DDC-002891648 (ACO formation increasing as "first ACOs have proven to be successful at keeping premiums for employers from rising"); DX0633 at ANTM-DDC-002891650-51, 56; [redacted]; *see also* [redacted]; [redacted].

ii. Employers Can Also Obtain Coverage From Other Entities, Including TPAs And Trusts

138. **TPAs**. Prof. Dranove's statement that "TPAs have not made major inroads in the larger group market," is not credible, especially considering that TPAs are larger than Anthem for ASO customers in the state. *Compare* Dranove Tr. 4711:6-15 ("They're not an attractive option for many employers"); *with* Rothermel (Anthem) Tr. 4067:5-7, 4069:19-21 (Anthem's rental business to TPAs is nearly twice as large as Anthem's ASO business). Anthem competes directly with almost fifty TPAs headquartered in California, in addition to TPAs outside of California. Rothermel (Anthem) Tr. 4075:2-9, 4171:4-17. Many TPAs offer networks that compete against Anthem's network and TPAs that rent Anthem's network can also compete against Anthem. *Id.* at 4067:2-4, 4075:2-9, 4172:21-4173:14 (Anthem's TPA contracts are "all individually negotiated" and TPAs "can and do" compete with Anthem despite such contracts).

139. Anthem has no control over prices or products offered by TPAs using Anthem's network. *Id.* at 4067:2-4, 4075:2-9. TPAs can still use Anthem's network to compete for any of the 10,000 new client opportunities that Anthem competes for each year. *Id.* at 4095:3-11. This

is true even if a TPA that rents Anthem's network has negotiated a rental agreement that excludes the TPA from competing for Anthem's current clients. *Id.* at 4075:2-9, 4095:6-11.

140. Many TPAs compete directly with Anthem for large groups, including: HealthSmart, CoreSource, Collective Health, Health Now, Capital Administrators, HealthComp, Meritain, Pinnacle, EBA&M, BRMS, HealthSCOPE, and Delta Health Systems. Archer (HealthSmart) Dep. 29:6-30:14, 32:3-15, 119:8-24; [redacted]; Rothermel (Anthem) Tr. 4131:14-17, 4132:10-13; DX0569 at 8; Brown (Gallagher) Dep. 107:6-108:1, 108:12-15; Mahoney (SML) Tr. 3653:12-15; Edwards (HealthSCOPE) Dep. 16:25-17:1, 17:3-10, 59:6-7; DX0360; *see also* [redacted].

141. **Direct contracting.** In addition to forming PSPs that are sold to employers, providers contract directly with diverse employers. *See* [redacted]. A customer that contracts directly can readily use a TPA to administer claims. Rothermel (Anthem) Tr. 4081:20-4082:10. By "disrupting the traditional relationships between the major health plans and employers," direct contracting is another "competitive threat." Abbott (WTW) Tr. 209:7-17; Rothermel (Anthem) Tr. at 4081:20-4082:6; [redacted]; Rothermel (Anthem) Tr. 4081:20-4082:6.

b. Anthem And Cigna Are Not Close Competitors In California

142. Cigna is a distant competitor to Anthem in the six alleged California CBSAs and within the state as a whole. Kaiser, Blue Shield, United, Aetna, and HealthNet are Anthem's closest competitors, and the ones with which it competes most often. Rothermel (Anthem) Tr. 4092:5-19, 4098:18-23, 4102:15-4103:7, 4106:7-4107:18.

143. Cigna and Anthem do not often compete head-to-head — Anthem bids against Cigna once in every ten accounts. *Id.* at 4091:12-15. Anthem leads with its HMO product,

which is Anthem's top selling product in California. *Id.* at 4077:13-19. Anthem's accounts are mostly fully-insured, whereas Prof. Dranove states that Cigna primarily sells an ASO product. Dranove Tr. 3822:19-3823:2; *cf.* Rothermel (Anthem) Tr. 4098:11-14. Anthem is more likely to be competing for membership with Kaiser than any other carrier generally, and with United, Blue Shield, and Aetna as compared to Cigna on an account basis. *Id.* at 4102:25-4103:7; 4082:14-4083:8. Even for ASO accounts, where Cigna is most active, Anthem wins and loses more accounts to TPAs, collectively, than it does to Cigna. *Id.* at 4175:1-9.

144. [redacted] third parties testified that Cigna's presence is limited and that it is not as large or competitive relative to Anthem as compared to other carriers, such as United. [redacted]; Mifsud (Melita) Tr. 3236:11-3237:8, 3252:20-3253:22; [redacted]; Tallman (HealthNet) Dep. 62:21-63:5, 64:2-15, 139:10-23, 140:18-141:4; DX0507 at 16. Cigna also does not bid when it believes Kaiser would capture too great a slice of an account. DeRosa (Cigna) Dep. 180:21-182:3. That Cigna did not bid for CalPERS — and its 1.5 million lives — reflects Cigna's weak presence. Donneson (CalPERS) Dep. 24:7-16, 79:16-21; Rothermel (Anthem) Tr. 4081:8-14.

145. Cigna is not competitive in the lower end of the alleged large group market. [redacted]; Mifsud (Melita) Tr. 3236:11-3237:8, 3252:20-3253:22. Despite offering a "level funded" product that Cigna acquired from Great West, this product still only serves a very niche group of smaller employers with unique claims histories. Mahoney (SML) Tr. 3677:5-22; Mifsud (Melita) Tr. 3237:9-22, 3262:14-3263:5; *cf.* Rothermel (Anthem) Dep. 258:20-259:14 (Anthem also sells very few balance funded product accounts). Cigna does not bid on accounts with under fifty employees even though small group employers purchase large

group products. Bailey (Cigna) Dep. 13:17-21, 60:7-15; Welch (Cigna) Dep. 19:7-22; Rothermel (Anthem) Tr. 4075:10-4076:1.

146. Cigna and Anthem are also not close competitors on the basis of shares. *See* Rapisardi (Cigna) Tr. 3611:20-22; [redacted]; DX0569 at 8; [redacted]; Schumacher (United) Dep. 71:9-11, 73:22-74:3, 74:25-75:9 ([redacted]).

147. Anthem and Cigna are not close competitors for provider collaborations. Rothermel (Anthem) Tr. 4115:13-4116:16 (explaining that the goal of Vivity was to draw business from Kaiser and stating witness was unaware of Cigna provider collaborations); *see also* [redacted]; Rapisardi (Cigna) Tr. 3607:25-3608:4; Rapisardi (Cigna) Dep. 120:19-121:4. Cigna's provider collaboration goal was also to compete with Kaiser, not Anthem. Rapisardi (Cigna) Dep. 192:21-194:14. Even with collaborations as a goal, Cigna admits it is difficult to partner with providers in California[redacted]; Rapisardi (Cigna) Tr. 3611:4-16, 3611:20-22.

c. There Are Low Barriers To Entry And Numerous Companies Are Capable Of Expansion And Rapid Entry Into The Sale Of Health Insurance In California

148. The successful expansion by current competitors demonstrates how ease of entry makes California "fiercely competitive" for health insurers. Rothermel (Anthem) Tr. 4080:4-19. Existing firms can readily expand in terms of their product range and their geographic scope, including TPAs, which "hav[e] the ability to shift [business at] any time." *Id.* at 4080:4-19.

149. [redacted]. DX0362 at 6. It is [redacted], and continues to deepen its presence in Los Angeles. Guptill

(Kaiser) Dep. 219:22-220:2; Rothermel (Anthem) Tr. 4093:4-8, 4116:7-16 (Kaiser's Los Angeles expansion motivated Anthem to launch Vivity).

150. United's rapid rise illustrates the ease in entering California and having a significant impact on competition. Eddy (Tolman & Wiker) Dep. 120:21-22, 120:24-121:7; Donneson (CalPERS) Dep. 26:3-27:2; [redacted]. United's potential limitless expansion is a critical competitive constraint post-merger. Fowdur Tr. 4260:5-23. Today, United accounts for more Anthem wins and losses statewide than any other competitor.

151. Similarly, Sutter's expansion across northern California that even for a *de novo* entrant, obtaining an insurance license to expand is easy. Sutter began in January 2014 in the Sacramento, Sierra, and Central Valley service areas, and expanded into counties in the San Francisco Bay area and parts of Sonoma in 2015. Schirmer (Sutter) Dep. 15:13-16:5, 82:1-83:1; DX0567 at 4-5; Mahoney (SML) Tr. 3662:16-22; Mifsud (Melita) Tr. 3259:4-6; Rothermel (Anthem) Tr. 4090:15-4091:2, (DDX0399), 4150:5-4151:3 . [redacted]. Schirmer (Sutter) Dep. 82:1-22.

152. WHA is another example of successful expansion and ability to expand further. It has been expanding from Sacramento into the San Francisco area. DX0633 at ANTM-DDC-002891676; [redacted]; Rothermel (Anthem) Tr. 4086:1-9; *see also* Schirmer (Sutter) Dep. 24:20-25:10, 25:17-26:4 ([redacted]").

153. Additionally, HealthNet has expanded from southern California into northern California. Donneson (CalPERS) Dep. 26:3-27:2.

154. **Providers Have A Compelling Incentive To Enter And A Price Advantage Over Existing Carriers**. PSPs face low entry barriers because they have integrated, proprietary networks and can price below existing carriers and TPAs. [redacted]; Rothermel (Anthem) Tr. 4084:11-4085:23, 4086:1-8. [redacted]. [redacted]; [redacted]; DX0633 at ANTM-DDC-002891693-699 (Sutter's physicians and facilities are typically excluded from narrow network plans).

155. [redacted]. For example, even where Sutter does not have facilities, Sutter contracts with unaffiliated hospitals and physicians. *Id.* at 82:23-83:11; DX0633 at ANTM-DDC-002891664 (Sutter contracting with Brown & Toland Physicians in the greater San Francisco Bay Area). [redacted]. [redacted].

156. **Brokers And Private Exchanges Facilitate Entry**. Brokers are gatekeepers for substantially all large group business. Rothermel (Anthem) Tr. 4087:8-23 (Anthem sells 99% of its services through brokers). Entrants can leverage brokers to take business from incumbents, which they are effectively doing in California. *See supra*, § V.E.1.a.i (discussing United's broker bonus program). Brokers are marketing Sutter and WHA as competitive alternatives to Anthem. DX0634 ([redacted]); *see also supra*, § V.E.1.a.i.

157. Private exchanges, such as CalChoice and the NorCal Gallagher Exchange, also facilitate entry. DX0633 at ANTM-DDC-002891664 (Sutter is a "popular choice for employers

in the Bay Area through CalChoice"); Schirmer (Sutter) Dep. 58:7-59:11 ([redacted]).

158. **Regional Carriers Can Enter Into California**. Insurers from outside California can and have entered California. Oscar Health Plan, a New York carrier, entered the Los Angeles area and has plans to enter Northern California. Guptill (Kaiser) Dep. 20:24-21:18, 22:1-5; DX0633 at ANTM-DDC-002891695; Hilty (Blue Shield) Dep. 149:4-10. [redacted]; Rapisardi (Cigna) Dep. 144:21-145:13; [redacted].

2. **New Hampshire**

159. New Hampshire has a population of about 1.2 million and a total commercial large group enrollment of about 500,000 lives. Guertin (Anthem) Tr. 3528:12-3529:6. Outside of southern New Hampshire, "there are not a lot of customers," and "those that are tend to be small business." Guertin (Anthem) Tr. 3565:4-18; Rowe (Granite) Tr. 2833:11-21 (about three-fourths of the state's population resides in the southeastern portion of the state). The areas north of Concord, NH are rural and sparsely populated. *See* Guertin (Anthem) Tr. 3562:16-3563:20; Lipman (LRG) Tr. 3269:18-22 (Laconia population is only 16,000). Most large customers in the state are municipalities and hospitals; there are only eighteen accounts with over 1,000 members. *See* Guertin (Anthem) Tr. 3518:20-3519:4, 3539:22-3540:13.

160. New Hampshire residents regularly travel between CBSAs for medical care. Plaintiffs allege that the Anthem-Cigna merger would harm large groups in six New Hampshire CBSAs: Berlin, Laconia, Claremont-Lebanon, Concord, Keene, and Manchester-Nashua. Compl. ¶ 41. Yet Plaintiffs' selection of six CBSAs in New Hampshire excludes two counties

adjacent to the Manchester-Nashua CBSA: Rockingham and Strafford. *See* DX0502; Guertin (Anthem) Tr. 3562:13-3563:20 (discussing DDX0373). These two counties are highly populated and account for nearly one-third of the large groups in New Hampshire, including groups that Plaintiffs focused on extensively during their examination of Ms. Guertin. Guertin (Anthem) Tr. 3562:13-3563:20 (ninety of Anthem's 300 large groups are located in the Boston CBSA), 3502:8-3512:6 (Sig Sauer and Town of Salem identified by Plaintiffs during Ms. Guertin's examination are not in CBSAs at issue). Furthermore, in some CBSAs, there are just a handful of large groups and the switching of one or more of these accounts could dramatically change shares in the CBSA. *See* Guertin (Anthem) Tr. 3528:12-3529:5, 3562:13-3563:20, 3565:4-18.

161. The concept of the CBSA is not a tool used or recognized by industry participants in New Hampshire. *See e.g.*, Guertin (Anthem) Tr. 3537:7-9; Rowe (Granite) Tr. 2831:18-25; Lipman (LRG) Tr. 3291:14-25; McKean (Town of Salem) Dep. 54:6-11; Roberts (Harvard Pilgrim) Dep. 21:9-13; Wilhelmsen (Southern New Hampshire) Dep. 79:8-24, 80:1-5, 80:7.

162. The definition of small and large groups in New Hampshire is set by regulation. Guertin (Anthem) Tr. 3559:17-3560:6. Because these regulations use counting rules based on full-time equivalents, they do not impose any practical minimum number. *See* Guertin (Anthem) Tr. 3559:17-3560:6, 3561:5-21. An Anthem account with only eleven members can be a "large group" under these regulations. Guertin (Anthem) Tr. 3561:5-21. The product offerings are also not "completely distinct" between small and large groups. Guertin (Anthem) Tr. 3559:17-3560:6 ("Any large group can buy a standard product that's just like our small group portfolio."). Smaller large group accounts are "probably very similar [to small groups] in the benefits that they have." *See* Guertin (Anthem) Tr. 3559:17-3560:6. The "average large group size" . . . "behav[es] a lot like the larger end of small group." Guertin (Anthem) Tr. 3560:10-17.

a. Beyond The Merging Companies, Numerous Health Insurance Competitors And A Variety Of Company Types Serve New Hampshire

163. Significant competition for the sale of health insurance in New Hampshire exists today and will continue to exist after the transaction closes, demonstrating that the merger is not likely to substantially lessen competition. *See* Guertin (Anthem) Tr. 3530:8-23. Examples of these competitive options are: Harvard Pilgrim; PSP offerings from Granite Health Network (Tufts Health Freedom Plan) and Dartmouth-Hitchcock and Elliot Health System (ElevateHealth); Minuteman Health; United; Aetna; TPAs like EBPA, [redacted], UltraBenefits, and HPI; PEO arrangements like TriNet; and direct contracting. Guertin (Anthem) Tr. 3540:20-3541:13; [redacted]; DX0469.

164. **Harvard Pilgrim.** Harvard Pilgrim is a very strong competitor for large groups in New Hampshire and is Anthem's closest competitor for these customers. *See* Phase I Findings ¶¶ 92-93; Roberts (Harvard Pilgrim) Dep. 176:16-17; Spinazzola (E&S Insurance Services) Dep. 68:11-21; Guertin (Anthem) Tr. 3516:24-3517:1 (Harvard Pilgrim competes "very vigorously"), 3536:10-16 (Harvard Pilgrim is the "constant" that Anthem sees "on a regular basis"), 3536:19-3537:1, 3535:16-3536:2 (discussing DDX0386). [redacted]. *See* Roberts (Harvard Pilgrim) Dep. 24:15-25:2, 106:20-107:2. Additionally, as a non-profit, it has tremendous pricing advantages. *See* Guertin (Anthem) Tr. 3530:24-3531:18.

165. **Tufts Health Freedom Plan.** Tufts was the first insurance company in the United States formed as a joint venture between hospital systems — Granite — and an insurance company. Guertin (Anthem) Tr. 3518:13-19; Rowe (Granite) Tr. 2805:2-20. The hospital systems that make up Granite — Catholic Medical Center, Concord Hospital, Exeter Health

Resources, LRG, Southern New Hampshire Health System, and Wentworth-Douglass Hospital — are some of the most powerful providers in New Hampshire, accounting for 60% of all hospital beds in the state. *See* DX0600 at 1; Guertin (Anthem) Tr. 3547:2-11; DX0558 at 1, 2 (stating that Granite employs close to 900 providers, has operating revenue of over $1.5 billion, and "[t]ouches close to 500,000 New Hampshire residents in their primary service area").

166. The Tufts-Granite combination is a vigorous competitor for large groups. It began actively marketing its large group plans in January 2016 and now has about 18,000 members. Rowe (Granite) Tr. 2852:4-8; Guertin (Anthem) Tr. 3542:17-3543:23 (discussing DDX0372); 3545:2-6. Ms. Guertin views the entry of powerful PSPs like Granite as a significant competitive threat because they financially benefit directly from selling insurance and can offer their own customers a significant price advantage at the hospitals they operate. *See* Guertin (Anthem) Tr. 3547:12-3548:6; *see also* Lipman (LRG) Tr. 3300:22-3301:1 (stating that LRG has a profit incentive to see Tufts succeed and that is "one aspect that [LRG is] trying to achieve"). For example, the members of the State of New Hampshire account, which make up nearly one quarter of Anthem's large group members in New Hampshire, utilize Concord Hospital — one of the largest Granite members — more than any other hospital in the state. *See* Guertin (Anthem) Tr. 3541:14-23, 3542:17-3543:13 (discussing DDX0372), 3592:9-24.

167. Tufts is an aggressive and active competitor that Anthem frequently encounters in head-to-head competition for large groups and has rapidly expanded its position in the state since entering in early 2016. *See* Guertin (Anthem) Tr. 3519:15-3520:10 ("They took ten large groups from us in December alone. They've been in the market for less than a year at this point, and I am very worried. . . . They're quoting on everything. We are seeing them in the last quarter of this year. They quote on every account that Harvard quotes on.").

168. Tufts has bid on and won a variety of accounts, including its member hospitals, which are some of the largest accounts in the state. *See* Guertin (Anthem) Tr. 3518:20-3519:4, 3520:11-3521:4 ("And I would just encourage you not to dismiss the importance of the membership in those hospitals because there aren't that many big games in town."). [redacted]. *See* Spooner (Tufts) Dep. 243:3-244:11, 244:17-18, 244:20-245:5. Similar to Harvard Pilgrim, Tufts uses its non-profit tax advantages to offer prices to customers that are typically lower than what Anthem can offer. *See* Guertin (Anthem) Tr. 3530:24-3531:18.

169. Moreover, Tufts's rapid growth and expansion is underscored when viewed against the total number of members that Anthem competes for in the open market in New Hampshire. Specifically, if Anthem's two government accounts — HealthTrust and the State of New Hampshire — are excluded, Tufts's growth in less than one year equals approximately one-quarter of the remaining large group members that Anthem serves. *See* Guertin (Anthem) Tr. 3542:4-3544:6 (discussing DDX0372), 3542:15-3543:13. [redacted]. Spooner (Tufts) Dep. 244:1-11, 244:17-18, 244:20-245:5.

170. **ElevateHealth.** In late 2013, Dartmouth-Hitchcock, Elliot Health System and Harvard Pilgrim, launched ElevateHealth, a joint venture that facilitated the entry of two of the largest provider systems in New Hampshire into the insurance business. *See* Guertin (Anthem) Tr. 3546:15-3547:1, 3547:2-11. Dartmouth-Hitchcock has been referred to as the [redacted]. *See* DX0811 at 1; Guertin (Anthem) Tr. 3545:20-3546:14 (discussing DDX0376 at 1). As such, Anthem has recognized the potential implications of Dartmouth-Hitchcock's entry as a PSP due to its size, reach, and ability to provide preferential pricing. *See* Guertin (Anthem) Tr. 3547:12-3548:6;

[redacted] This pricing advantage allows ElevateHealth to effectively target large group business, including some of the most significant large groups. [redacted] *See* [redacted].

171. In 2016, the ElevateHealth partners expanded their provider relationships to include Frisbie Memorial and St. Joseph Hospital in a new population health venture: Benevera Health. *See* DX0655 at 1; Roberts (Harvard Pilgrim) Dep. 25:12-17, 26:5-10, 26:11-19. By expanding such relationships, Dartmouth-Hitchcock and its equity provider partners have an even greater incentive to promote their own plan offerings to customers. *See* DX0808, at ANTM-DDC-001885470 (for example, the President and CEO of Frisbie Memorial promoted ElevateHealth directly to an existing Anthem customer in August 2015 by stating that it "could offer superior coverage and also save [the customer] some significant dollars…").

172. **Minuteman.** [redacted]. Boudreau (Minuteman) Dep. 12:17-19, 112:7-8. [redacted]. Boudreau (Minuteman) Dep. 13:11-14-22, 14:14-20, 21:5-10. [redacted]. *See* Boudreau (Minuteman) Dep. 21:11-14, 63:16-20, 64:16-65:7; DX0494 at Minuteman00014.070 ([redacted]); Guertin (Anthem) Tr. 3554:8-12, 3555:2-11.

173. **United.** United opportunistically competes for large groups in New Hampshire. *See* Guertin (Anthem) Tr. 3539:1-14, 3512:7-14. United took large groups from Anthem in 2016 and continues to compete for them. *See* Guertin (Anthem) Tr. 3539:1-14, 3558:20-3559:4. Some reports indicate that United's presence in New Hampshire is equal to or even greater than that of Cigna. Guertin (Anthem) Tr. 3532:25-3533:19. Other reports also indicate that United has "one of the strongest discounts in the state." *See* Guertin (Anthem) Tr. 3592:9-24.

174. **Aetna.** Aetna is also an opportunistic competitor for large groups in New Hampshire. *See* Guertin (Anthem) Tr. 3512:7-14, 3539:1-14. Aetna services some of the largest accounts in the state. *See* Guertin (Anthem) Tr. 3539:1-10. Aetna has taken large group business from Anthem in 2016. *See* Guertin (Anthem) Tr. 3538:20-25 (testifying that Aetna took a 350-member account from Anthem in 2016), 3539:1-14.

175. **TPAs.** TPAs are a competitive force for large groups as well, including HPI, EBPA, UltraBenefits, and [redacted] among others. *See* Guertin (Anthem) Tr. 3540:20-25, 3541:2-13; [redacted]; DX0469; DeLacey (WBS) Dep. 58:15-17. TPAs offer flexibility that allows for customizable products as well as more tailored and sometimes more cost-effective administrative fees. DeLacey (WBS) Dep. 58:18-59:25, 60:3-24 (because carriers tend to charge higher ASO fees than TPAs, a TPA "is a good alternative"). HPI, a "separate but wholly-owned entity" of Harvard Pilgrim, vigorously competes for self-insured accounts in New Hampshire. *See* Guertin (Anthem) Tr. 3491:8-18; [redacted]

176. **PEOs.** New Hampshire employers can organize into or join professional employer organizations ("PEOs") that allow them to leverage their combined purchasing power

for health insurance. *See* Fowdur Tr. 4242:17-4244:11. In the past year, Anthem lost at least two large groups when these accounts joined PEOs. *See* Guertin (Anthem) Tr. 3541:2-13.

177. **Direct Contracting.** Customers in New Hampshire can and do obtain healthcare services directly from providers. For example, the City of Manchester directly contracts with Elliot Health System and Catholic Medical Center for additional provider discounts. *See* DX0422 at 2, 4 (contract terms include additional provider discounts of 3%); *see also* DX0808 at ANTM-DDC-001885470 (Frisbie Memorial Hospital engaged in direct discussions with the City of Rochester regarding potential creative solutions between the hospital and customer).

b. Anthem And Cigna Are Not Close Competitors In New Hampshire

178. Cigna is not a particularly close competitor to Anthem in New Hampshire because they largely sell different products and rarely compete for the same accounts. As mentioned above, Cigna is an opportunistic competitor and does not compete "day-to-day" in the state. *See* Guertin (Anthem) Tr. 3512:7-14, 3539:1-14. New Hampshire is a managed care environment where over [redacted] of customers purchase HMO/POS plans. *See* DX0442 at 158; Guertin (Anthem) Tr. 3561:22-3562:1. While Anthem's business in New Hampshire is approximately 75% HMO, Cigna "almost exclusively" sells PPO products. *See* Guertin (Anthem) Tr. 3488:11-17, 3496:2-6, 3561:22-3562:1, 3562:7-12. In addition, Cigna does not compete regularly for New Hampshire fully-insured business, and instead, tends to focus on ASO accounts. *See* DeLacey (WBS) Dep. 94:7-24; Guertin (Anthem) Tr. 3555:16-25.

179. Harvard Pilgrim is Anthem's closest competitor in New Hampshire. Guertin (Anthem) Tr. 3503:13-3504:6, 3530:24-3531:18, 3536:14-16; Spinazzola (E&S Insurance Services) Dep. 68:11-21. Similar to Anthem, Harvard Pilgrim offers HMO products in the state.

See Guertin (Anthem) Tr. 3562:7-10 (Harvard Pilgrim is a close competitor and Anthem most commonly competes for HMO business against Harvard Pilgrim, Tufts, and Minuteman).

180. Conversely, Cigna does not frequently bid on New Hampshire accounts. Boudreau (Minuteman) Dep. 36:16-21. Anthem encounters Harvard Pilgrim and Tufts far more often than Cigna. Guertin (Anthem) Tr. 3495:22-3496:1. Of the 133 Anthem large groups that went to bid from February 2016 through January 2017, Cigna only bid on eight accounts — the same number as Minuteman. Guertin (Anthem) Tr. 3500:23-3501:2, 3503:13-3504:6 (Cigna "sat out on about 90 percent of the bids for our business"), 3554:8-12, 3555:2-14. In contrast, Harvard Pilgrim bid on 103 and Tufts bid on seventy accounts. Guertin (Anthem) Tr. 3555:2-14.

181. Prof. Dranove's diversion calculations demonstrate the lack of head-to-head competition between Anthem and Cigna. *See* Dranove Tr. 3858:1-9 (discussing PDX033 at slide 40 and PX0753, Exhibit G-17). From his market share calculations, Prof. Dranove expected that [redacted] of Anthem's wins should have been from Cigna. *Id.* In reality, the win-loss data indicated that the diversion from Cigna to Anthem was only [redacted], suggesting that Prof. Dranove's calculated shares are not indicative of competitive realities. *Id.*

182. [redacted]. Of the forty-three New Hampshire large groups that Anthem lost from February 2016 through January 2017, Cigna won only four. Guertin (Anthem) Tr. 3558:20-3559:2. Harvard Pilgrim won nineteen of these large groups from Anthem, while Tufts won fifteen. Guertin (Anthem) Tr. 3558:20-25.

c. There Are Low Barriers To Entry To Serve New Hampshire And Numerous Companies Are Capable Of Rapid Entry

183. Recent entrants have dramatically changed the competitive landscape in New Hampshire since January 2015, showing that entry can quickly impact competition in the state. *See* Guertin (Anthem) Tr. 3492:16-3493:1; Butler (Cigna) Dep. 195:18-196:7; Guertin (Anthem) Tr. 3530:8-23, 3536:4-3537:1 (testifying that there is a "changing [competitive] climate" in New Hampshire and "new entrants, as well as the provider's entry into the insurance base").

184. [redacted]. *See* DX0494 at Minuteman00014.006. [redacted]. Spooner (Tufts) Dep. 36:2-12, 79:7-15, 79:23-80:13, 81:6-10, 96:23-97:16.

185. It is possible to establish a provider network quickly, particularly given the small size of the state and the fact that [redacted]. *See* DX0547 at ANTM013143718; Guertin (Anthem) Tr. 3582:18-20. [redacted] Boudreau (Minuteman) Dep. 84:7-12, 87:14-17. [redacted]. Boudreau (Minuteman) Dep. 14:14-16, 121:9-16, 122:5-6.

186. [redacted] Boudreau (Minuteman) Dep. 64:3-65:7. [redacted]. Boudreau (Minuteman) Dep. 64:3-65:7, 120:22-121:8.

187. Tufts took a different approach. As a *de novo* PSP, it had a built-in advantage by leveraging Granite's member hospitals in combination with the rest of its strong statewide network. *See* DX0603 at 1; Spooner (Tufts) Dep. 85:7-9. The hospitals joined with Tufts Health Plan, a well-regarded Massachusetts-based insurance carrier. *See* Rowe (Granite) Tr. 2805:2-2806:9; Spooner (Tufts) Dep. 30:23-31:16, 31:18-24. [redacted] Spooner (Tufts) Dep. 57:16-19, 57:21-58:1, 58:3-11. Tufts has taken large groups from several competitors, including both Anthem [redacted] *See* DX0560; Guertin (Anthem) Tr. 3518:20-3519:4, 3519:15-3520:10, 3539:15-21; [redacted]; DX0561.

188. In just nine months since entry, Tufts' bid activity exceeds all but that of Harvard Pilgrim. "They're quoting on everything." Guertin (Anthem) Tr. 3519:15-3520:10, 3554:8-3555:9 (Tufts bid against Anthem on sixty-two more accounts than Cigna).

189. Additional entrants are on the horizon. The former CEO of Southern New Hampshire Health System testified that other hospitals may not be far behind in pursuing collaborations similar to Tufts and ElevateHealth. *See* Wilhelmsen (Southern New Hampshire) Dep. 120:12-14, 120:16-17. Similarly, Community Health Options is a potential entrant. [redacted] Roberts (Harvard Pilgrim) Dep. 56:17-57:6. It has since left the state, but its impact was effective in a short time: within a single year, it took 7% of Anthem's small group business in New Hampshire. *See* Boudreau (Minuteman) Dep. 102:11-15; Guertin (Anthem) Tr. 3523:15-3524:11.

d. Providers In New Hampshire Are Powerful And Rapidly Entering The Health Insurance Business

190. There are only twenty-six hospitals in the state, many of which are geographically isolated from competing providers and thus operate as geo-monopolies. *See* Guertin (Anthem) Tr. 3582:18-20, 3550:1-23 ("I've always felt that the hospitals in New Hampshire are very powerful because of our geography . . . .").

191. Due to the geographic isolation of many hospitals, they have strong bargaining leverage since Anthem believes that it needs most, if not all, of them in its network. Guertin (Anthem) Tr. 3550:1-23, 3568:5-22. The hospitals' bargaining leverage has led to near discount parity among payers. *See* Guertin (Anthem) Tr. 3488:1-10, 3569:11-25.

192. [redacted] DX0547 at ANTM013143718. Two of the largest hospital systems, Dartmouth-Hitchcock and Granite, account for 85% of total healthcare delivery in the state. *See* Guertin (Anthem) Tr. 3530:24-3531:18, 3545:23-3546:14 (discussing DDX0376).

3. Virginia

193. Plaintiffs have alleged that the proposed merger would harm large group employers in the Richmond, Lynchburg, and Virginia Beach CBSAs in Virginia. Compl. ¶ 41. As with the other CBSAs, Plaintiffs have not offered sufficient evidence to establish that these CBSAs are valid geographic markets. *See, supra* § III. In the Richmond CBSA, Prof. Dranove estimates that [redacted] have approximately the same share. PX0751 at 2. In the Virginia Beach-Norfolk-Newport News CBSA, Prof. Dranove finds that Cigna is [redacted] In the Lynchburg CBSA, Prof. Dranove finds that Cigna is [redacted]

194. But market share is difficult to track accurately in Virginia for a number of reasons. *See* King (Anthem) Tr. 3041:14-20. Anthem's enrollment in Virginia is also exaggerated and does "[redacted] because [redacted]. PX0419 at DOJ-EMAIL-00072416; *see* Dranove Tr. 3840:5-12. Accordingly, Anthem's share of enrollees resulting from local large group commercial competition in Virginia is smaller than the shares calculated by Prof. Dranove suggest. Dranove Tr. 3790:8-14; s*ee* Fowdur Tr. 4256:5-4257:11.

a. Competition In Richmond Will Not Be Adversely Affected By The Merger

i. Many Companies Serve Richmond

195. The landscape of large group commercial insurance in Virginia today is "[h]ighly competitive." King (Anthem) Tr. 3107:22-24. There are many competitors that will remain post-merger in Richmond, Lynchburg, Virginia Beach, and the rest of Virginia, including: carriers such as Aetna, CareFirst, Cigna, Kaiser, and United; PSPs such as Optima (Sentara), Piedmont (Centra), Innovation Health (Inova), and Bon Secours; and numerous TPAs. Khatib (EBCA) Dep. 60:22-61:2, 61:5-62:2, [redacted], [redacted]; DX0436 at ANTM-DDC-002871644; King (Anthem) Tr. 3083:3-9. Aside from Anthem and Cigna, at least three other insurers — Optima, Aetna, and United — have "large and comparable" networks in Richmond, and PSPs are very successful there. Harlin (Wells Fargo) Tr. 3371:16-25; *see* King (Anthem) Tr. 3093:21-3094:16; DX0442 at 270 ([redacted]).

196. There are no regions of Virginia where the only competitive options for large groups are Anthem and Cigna. King (Anthem) Tr. 3107:18-21.

197. **Aetna.** [redacted]. PX0419 at DOJ-EMAIL-00072417. Recently, Anthem lost part of its largest Virginia account, Commonwealth of Virginia, to Aetna. *Id.*; King (Anthem) Tr. 3078:7-9.

198. **Kaiser.** Kaiser recently expanded its service area to include Hanover and Caroline counties, both within the Richmond CBSA. *See id.* at 3055:15-3056:4.

199. **Optima.** Optima is one of Anthem's strongest competitors in Richmond in the sale of health insurance and, and with numerous accounts over 1,000 lives, Optima derives strength from its "competitive[ness] on price, on service, [and] on [its] provider network." King (Anthem) Tr. 3077:8-23. Notably, through a relationship with Bon Secours, which operates four hospitals in Richmond, Optima receives the same provider rates as Anthem in Richmond. *See id.* at 3060:13-15; Wheeler (Bon Secours) Tr. 3390:24-3391:3, 3398:22-3399:6, 3399:12-20. In some areas of Virginia, Optima's share is almost [redacted]. [redacted].

200. Optima sees Richmond as a good "growth opportunity." *Id.* at 58:1-59:2; DX0645 at SEN-ANTH-051017. In fact, it recently launched a new product in Richmond directed towards large groups, which allows a [redacted]; Fowdur Tr. 4286:2-20. Employers find Optima to be an attractive alternative to Anthem due to its [redacted]; DX0436 at ANTM-DDC-002871644.

201. Optima has won large groups from Anthem in Richmond. [redacted]; *see e.g.*, PX0419 at DOJ-EMAIL-00072417 (Optima won over Anthem for

Commonwealth Assisted Living). Optima and Anthem were also the finalist bidders on the large Richmond account, Henrico County. King (Anthem) Tr. 3079:2-7.

202. **United.** United is also an aggressive competitor in Richmond. *Id.* at 3043:16-22, 3084:4-8. [redacted]. PX0419 at DOJ-EMAIL-00072417; PX0570 at ANTM-DDC-000003490.

203. **TPAs.** In addition to traditional insurance carriers, TPAs continue to be a viable competitive threat in Richmond. *See* King (Anthem) Tr. 3083:3-9. These include Allied, Benefit Plan Administrators, CoreSource, HealthSmart, [redacted], Gateway, MedCost, Kleis, UMR, and WellNet. *Id.* at 3082:1-8, 3085:22-3086:6; Horvath (CoreSource) Dep. 43:25-44:5, 45:5-6; Archer (HealthSmart) Dep. 30:12-14; [redacted].

204. TPAs are able to win business in Virginia from traditional health insurance companies due to their flexibility and "lean cost structure," which allows them to keep administrative fees low. King (Anthem) Tr. 3085:10-17. Anthem lost twenty-five large groups in Virginia to TPAs over the last year, roughly 15% of all of Anthem's losses. *See id.* at 3083:10-25. For example, Anthem recently lost two large group employers located in Richmond to MedCost. *Id.* at 3083:3-9; DX0420 at 1.

205. [redacted]. *See e.g.*, DX0457 at 3; DX0461 at 1. [redacted] DX0457 at 1; DX0460 at 1. [redacted]. *See e.g.*, DX0420 ([redacted]); DX0421 at 3 ([redacted]); DX0462 at 2 ([redacted]

[redacted]); DX0459 at 1 [redacted]). [redacted] DX0457 at 3; DX0460 at 4; DX0462 at 2. [redacted]. DX0459 at 1. "[redacted]. DX0457 at 1; DX0461 at 1. [redacted] DX0460 at 1.

206. **Slicing.** Many employers in Richmond slice their health insurance among multiple carriers, allowing employees a broader selection of insurance products to choose from. *See* King (Anthem) Tr. 3077:24-3078:18, 3086:7-12. For example, the Commonwealth of Virginia has its highest concentration of employees — approximately 30,000 — in Richmond, and slices among Anthem, Aetna, and Kaiser; this resulted after a competitive bidding process where United, Optima, and Piedmont Community Health Plan submitted quotes. *See id.* at 3055:8-10, 3077:24-3078:18. Cigna did not attempt to bid on that account. *Id.* at 3078:7-18.

207. **Broker Sponsored Captives.** In Richmond, brokers also offer captive insurance company solutions, which are financial risk-sharing mechanisms where employers partner together to achieve economies of scale in their healthcare offerings. Hawthorne (Scott Insurance) Tr. 3009:5-3010:21. This ultimately enables employers to buy less insurance, as the risk is spread across a greater number of lives and helps lower administrative costs for smaller self-funded employers. *Id.* at 3009:5-3010:21, 3012:19-22. These captive solutions create a

"more competitive environment," by allowing smaller companies to aggregate purchasing and expand the range of offerings available to them. *Id.* at 3011:15-3012:17.

208. **PSPs.** Employers in Richmond are also able to obtain healthcare services directly from healthcare providers such as Bon Secours. *See* King (Anthem) Tr. 3094:4-16; Harlin (Wells Fargo) Tr. 3373:22-25. In mid-2016, after partnering with a TPA, Bon Secours launched its own PSP, the Value Health Network, offering self-funded products to large group employers in Richmond. King (Anthem) Tr. 3093:21-3094:16, 3111:11-18. As of October 2016, the Bon Secours Value Network had over [redacted] DX0618 at 2-3. Although Bon Secours only introduced the Value Health Network in the last few months, it already has clients including Veritas Schools located in Richmond. DX0449 at 2. The plan is currently only available to employers in Central Virginia, but Bon Secours intends to offer it in Hampton Roads by the end of 2016. *Id.* at 2. Bon Secours has also been approached by [redacted] as a potential partner to expand [redacted] into the Richmond [redacted] areas. Wheeler (Bon Secours) Tr. 3443:23-3444:21; [redacted].

ii. Anthem And Cigna Are Not Close Competitors In Richmond

209. Win/loss history shows that Anthem and Cigna are not each other's closest competitor in Richmond. *See* [redacted]; King (Anthem) Tr. 3051:9-18, 3076:25-3077:7. Anthem often is a finalist alongside United. *See e.g.*, Parker (PrimeLine) Dep. 86:5-87:2, 87:7-13, 87:15-24 (stating that Anthem and United were finalists for PrimeLine in 2008 but United won due to its "cost competitiveness"). In 2016, Anthem lost more large

groups to United than to Cigna in Richmond. King (Anthem) Tr. 3051:9-18 (also noting that Anthem lost more large groups to Aetna than to Cigna in Richmond in 2015). This is consistent with Anthem's losses to Cigna statewide: in the last year, Anthem lost less than twenty-five accounts to Cigna. *Id.* at 3076:25-3077:3. In contrast, Anthem lost fifty Virginia large groups to Optima. *Id.* at 3077:5-7; *see also* [redacted].

210. [redacted].

211. Anthem and Cigna also have different networks which limits Anthem's ability to be as price-competitive for certain customers. *See* Hawthorne (Scott Insurance) Tr. 3005:10-3006:21. Unlike Cigna, Anthem does not have a "true national network" and, as a result, the network access fees it must pay to other Blues can render Anthem "not to be as competitive" for employer accounts based in Virginia but with employees outside the state. *Id.*

212. Any back-and-forth competition between Anthem and Cigna is the type of churning that occurs between Anthem and every other major competitor in the Richmond area. King (Anthem) Tr. 3078:19-3079:1. Each bidding cycle is a mix and match of carriers (and potentially other options, such as TPAs), such that there are accounts for which Anthem does not bid, and there are accounts for which Cigna does not bid. *See* Hawthorne (Scott Insurance) Tr. 3004:20-3005:3; *see* King (Anthem) Tr. 3078:7-18 (testifying that Cigna did not bid on the Commonwealth of Virginia account).

iii. There Are Low Barriers To Entry To Serve Richmond

213. Because insurer licensing in Virginia is on a statewide basis, once a company is licensed it can do business anywhere in the state. DX0434 at 3-4. This means that companies active in certain parts of Virginia can readily expand to other areas, including Richmond. *See e.g.*, King (Anthem) Tr. 3082:18-22. [redacted]. In addition, Bon Secours began offering a new ASO product in Richmond in 2016. King (Anthem) Tr. 3082:18-3083:2; Fowdur Tr. 4262:14-4263:4 (citing Bon Secours as an example of "[o]ther provider-sponsored plans" that "are in [an] excellent position to be able to expand."). Bon Secours also sponsors rapid entry and expansion in Richmond, as it allows carriers, in certain instances, to match the lowest reimbursement rate in the area. Wheeler (Bon Secours) Tr. 3438:6-3439:7.

214. **Innovation Health.** Innovation Health competes against Anthem and other carriers in the entire northern Virginia area and has explicit plans to enter Richmond. King (Anthem) Tr. 3082:9-3083:2; DX0599 at AET-P006-0007594445 (stating that the "likelihood to renew is higher for Innovation Health than both Aetna and other ACOs"); [redacted]; [redacted]. It also has the ability to enter Richmond rapidly because it has access to Aetna's networks, [redacted]; [redacted].

215. Innovation Health has already grown quickly in Virginia, [redacted]. [redacted]; [redacted]; *see* Fowdur Tr. 4264:3-20 (Innovation Health's membership is primarily comprised of many large groups "with account sizes of 3,000 or more" rather than of Inova Hospital employees). It has also grown geographically, from offering products in three counties to seven. [redacted]. [redacted] *See* PX0570 at ANTM-DDC-000003488. [redacted]; DX0038 at AET-P005-007290926; *see also* DX0599 at AET-P006-0007594445 ([redacted]").

216. **Piedmont.** Piedmont, a PSP owned by Centra (one of the most dominant hospital systems in Virginia), competes against Anthem in multiple areas in Virginia. King (Anthem) Tr. 3094:4-16, 3107:15-17; [redacted]. Piedmont describes itself as "one of the fastest growing health care plans in the region" featuring a provider network with "more than 98 percent of the area's physicians, other health care professionals, and the full resources of the Centra Health system." Adams (Centra) Dep. 40:7-41:7. Piedmont is able to rapidly enter the Richmond area because it currently supplements its network with the Multiplan network, which "offers access in all states to over 4,500 hospitals, 70,000 ancillary care facilities, and 700,000 health care professionals." *Id.* at 54:13-55:4 (quoting DX0372). [redacted]. *See id.* at 29:9-29:12.

217. **VCU Health.** VCU, a major hospital system in Richmond, already offers Medicaid and Medicare coverage in Richmond and "can leverage those competenc[ies] to enter the commercial health insurance space as well." Fowdur Tr. 4262:14-4263:4.

b. Competition Will Not Be Adversely Affected By The Merger In The Rest Of Virginia

218. Across Virginia, Anthem competes for large group health insurance customers against Aetna, Cigna, Optima, United, and TPAs such as Gateway, MedCost, and Benefit Plan Administrators; in certain parts of Virginia including Virginia Beach (Tidewater) and Lynchburg, Anthem also competes against Kaiser, Piedmont, and Innovation Health. King (Anthem) Tr. 3042:8-15, 3082:1-8, 3085:22-3086:6, 3107:9-14; [redacted]; *see also* Harlin (Wells Fargo) Tr. 3380:4-20, 3382:11-3382:16. Piedmont, in particular, has a very strong presence in Lynchburg and currently insures over fifty large groups in this area, including the City of Lynchburg. Adams (Centra) Dep. 52:4-52:14; King (Anthem) Tr. 3107:9-27; DX0574.

219. In Virginia, Anthem averages about 140 lost accounts each year (10% of its 1,400 total accounts), so it needs to pick up 140 new accounts to maintain its membership. King (Anthem) Tr. 3075:24-3076:5. However, Anthem will have lost a higher number of accounts in the past year — closer to 170 or 180 — because of "competitive pressures from Optima and United." *Id.* at 3076:10-14. Only twenty to twenty-five of these were losses to Cigna. *See id.* at 3076:25-3077:3. By comparison, Anthem lost fifty large groups to Optima in 2016, twenty-five to thirty to United, and about twenty-five to independent TPAs. *Id.* at 3083:10-16, 3084:9-19.

220. Anthem has seen "a number of competitors expand their geographic footprint throughout the state." *Id.* at 3082:18-3083:2. For example, Optima recently has exhibited both

"aggression and expansion." *Id.* at 3077:8-23; PX0570 at ANTM-DDC-000003490 ([redacted]). [redacted]. DX0442 at 270. It is now a state-wide competitor, selling insurance everywhere except select areas adjacent to Washington, D.C. [redacted] Employers find Optima to be an attractive alternative to Anthem [redacted]; DX0436 at ANTM-DDC-002871644. For example, Optima has comparable provider discounts with Anthem in the Tidewater area and while Cigna maybe "in the picture" for clients located in this area, "they are a very distant third." Hawthorne (Scott Insurance) Tr. 3015:6-23 (a recent re-pricing analysis showed Anthem and Optima as the top two).

221. [redacted]. PX0519 at ANTM003921221. [redacted] *Id.*; DX0512 ([redacted]); *see* Fowdur Tr. 4286:2-20.

222. Piedmont is another robust competitor that competes against Anthem in the state. King (Anthem) Tr. 3107:15-17; [redacted]. Additionally, Piedmont has previously insured groups [redacted]. Anthem recently lost the bid for Printing Progress to Piedmont. *Id.* at (Centra) Dep. 50:10-50:16.

223. "Innovation Health has shown success in Northern VA with [redacted] market share." [redacted]. Innovation Health competes against Anthem in Virginia and is able to [redacted]. *See* Henderson (Innovation Health) Dep. 122:25-123:7; King (Anthem) Tr. 3082:9-3083:2. [redacted] Henderson (Innovation Health) Dep. 113:25-114:12; 114:15-16; 144:12-144:16.

224. Every year in Virginia, Anthem loses on average 10% of its customers to competitors. King (Anthem) Tr. 3075:24-3076:5. If Anthem were to increase its rates above the prevailing market rate, Anthem would lose even more accounts, particularly given Virginia's extremely competitive environment. *Id.* at 3075:24-3076:14; *see* PX0519 at ANTM003921220 [redacted]); DX0436 at ANTM-DDC-002871643 ("[I]f after the merger Anthem/Cigna were not to offer EBCA and BDG highly competitive rates we could turn in a heartbeat to many other health insurance companies and TPAs as alternatives that offer competitive prices and services."); Fowdur Tr. 4249:23-4250:15 ("[A]s these accounts are churning, if you increase the prices on them, the likelihood that you will lose the account will also increase, i.e., you won't be able to replace them."). [redacted]. DX0537 at ANTM010303021.

225. TPAs are also a competitive force in Virginia, depending on the strength of their networks in a given area. Harlin (Wells Fargo) Tr. 3373:6-12; King (Anthem) Tr. 3110:24-3111:7; Hawthorne (Scott Insurance) Tr. 3016:16-19 (unaware of any restrictions on independent TPAs operating in Virginia). Anthem has lost the City of Danville and public schools to

Gateway, which are both very large accounts. King (Anthem) Tr. 3110:24-3111:7. In addition to independent TPAs MedCost and Benefits Plan Administrators, Anthem also competes with UMR, a TPA owned by United. *Id.* at 3085:22-3086:6.

226. **Slicing.** In addition to the Commonwealth, Riverside Health System, one of Anthem's largest accounts with 5,000 employees located around Newport News, Hampton, and Williamsburg, has chosen to slice between Anthem and Aetna. *Id.* at 3086:7-16.

i. Post-Merger, The Synergies From The Combined Anthem-Cigna Company Will Benefit Customers And Providers In Virginia

227. Virginia customers will benefit from the synergies of the combined entity. *See id.* at 3096:25-3098:12. Anthem currently has contracts with all 100 hospitals in Virginia and over 20,000 physicians. *Id.* at 3086:17-22. Therefore, post-merger, Cigna customers will not face changes in their provider networks but will instead be able to access those networks at lower cost. *Id.* at 3096:25-3098:12. At least one customer has already expressed its wish to have Anthem's strength in analytics and data and Cigna's wellness programs combined in one company. *See* Parker (PrimeLine) Dep. 97:20-98:8, 98:12.

228. Post-merger, the combined Anthem-Cigna company will allow Anthem to compete in northern Virginia where it does not compete currently (and where CareFirst is the Blue Cross Blue Shield licensee that occupies the territory). King (Anthem) Tr. 3096:25-3098:12. Also, Anthem will not take away any product features from Cigna post-merger; customers will now be able to access the best of both Anthem's and Cigna's product offerings. *Id.*; *see* Khatib (EBCA) Dep. 129:24-130:16 ("By combining Cigna's wellness programs with Anthem's competitive health insurance products, the merged firm will be able to offer more

competitive products to consumers, increasing the overall level of competition of health insurance."); DX0436 at ANTM-DDC-002871643-45.

229. Providers in Virginia will benefit from the merger, too, as the combined entity is able to grow and strengthen its value-based payment models which reward providers via a bonus when they hit certain quality and efficiency metrics. King (Anthem) Tr. 3069:9-20, 3071:8-19. Successful value-based payment models also benefit customers as they improve care and drive down costs — savings which are passed on to ASO customers. *Id.* at 3071:14-24.

230. Providers will not be significantly affected by the merger, as the efficiencies calculated will be "spread across all hospitals, all physicians; so it would not have a significant impact on any one provider in [Anthem's] network." *Id.* at 3101:11-15; [redacted] ([redacted]).

231. [redacted] *See* Torcom (Sentara) Dep. 74:10-75:12 ([redacted]).

ii. Provider Systems In Virginia Have Substantial Market Power And Would Prevent The Combined Entity From Unfairly Lowering Rates Post-Merger

232. Under the MCHIP regulations, Anthem is required to have primary care physicians located within thirty miles and a hospital located within sixty miles of its members. King (Anthem) Tr. 3087:23-3088:19. If Anthem fails to provide such network access to its members, the Commonwealth can prevent Anthem from offering products in those areas. *Id.* at 3088:9-19. Therefore, it is vital that Anthem keep most providers in its network if it wants to continue selling its products all across Virginia. *See id.* at 3087:23-3088:19.

233. Anthem considers [redacted] hospitals in Virginia, [redacted] to be "must-haves" in order to create a "viable network" for its customers. King (Anthem) Tr. 3087:1-7; DDX0211 at 2. This is in part why Anthem has never dropped a single hospital from its network due to rate negotiations. *See* King (Anthem) Tr. 3090:4-12.

234. Additionally, hospital systems in Virginia are extremely consolidated, giving them significant leverage in negotiations. *See id.* at 3087:1-7. For example, Centra has at or above 90% share for a variety of medical services and Sentara has roughly [redacted] in certain areas. Adams (Centra) Dep. 24:15-26:14; DX0571 (showing only Centra hospitals in Lynchburg); Torcom (Sentara) Dep. 24:15-18; DX0646 at SEN-ANTH-051046.

235. If the combined entity attempted to unfairly lower rates post-merger, providers would simply drop out of Anthem's network or threaten to terminate their contracts with Anthem as they have done in the past. King (Anthem) Tr. 3090:4-3091:11.

236. **Bon Secours.** During contract negotiations with Bon Secours in 2014, Anthem attempted to negotiate lower reimbursement rates, as Bon Secours was receiving "significantly higher rates" than other similarly situated hospitals. *Id.* at 3091:12-3092:6. Additionally, Bon Secours was engaging in "egregious billing practices" such as "billing for services at the highest cost location they could find within their system." *Id.* at 3091:12-3092:21. Such billing practices are important because they directly raise costs for members. *Id.* at 3092:7-21. After months of private negotiations, Bon Secours "went public with the dispute in early 2015 by issuing a media statement" and sending notices of termination to some of Anthem's customers, causing anxiety and uncertainty. *See id.* at 3091:12-3092:6. Despite these public notices, Anthem continued to negotiate with Bon Secours and was eventually able to come to an agreement by making certain concessions to Bon Secours, such as modifying the quality hospital

incentive program. King (Anthem) Tr. 3093:4-19; Wheeler (Bon Secours) Tr. 3408:8-3409:15, 3435:9-3436:9. With its new ASO product, Bon Secours' threat to drop out of Anthem's network and sell directly to employers is even more credible. King (Anthem) Tr. 3094:4-16. Moreover, Bon Secours has said that it would continue to "look for ways to negotiate" with the merged entity the same as it has with Anthem. Wheeler (Bon Secours) Tr. 3415:24-3416:2.

237. **Patient First.** Anthem faced a similar situation when Patient First threatened to drop out of Anthem's network when Anthem did not immediately agree to guaranteed fee increases that Patient First requested. King (Anthem) Tr. 3094:17-20. Patient First was already receiving fees which were 25-30% higher than its competitors. *Id.* at 3094:21-3096:8. Patient First eventually issued a public statement regarding the dispute, dropped out of Anthem's Medicaid network (endangering the most vulnerable population Anthem serves), and sent letters to customers stating Patient First would not be accepting any new Anthem patients. *Id.* at 3094:21-3096:8. Eventually Anthem was able to keep Patient First in its network by offering concessions of a new bonus program. *Id*.

238. **Sentara.** [redacted]. Torcom (Sentara) Dep. 80:25-81:18, 108:21-109:1. [redacted]

Id. at 80:25-81:18. [redacted]

Id. at 50:19-51:2, 80:25-81:18.

F. The Evidence Shows That The Merged Company Cannot Profitably Raise Prices (Unilateral Effects) And That Barriers To Entry Are Low In Plaintiffs' Other Alleged Markets

239. As with the purported "feature markets," Plaintiffs have not established likely anticompetitive effects will occur in the remaining alleged markets as a result of the merger. Even crediting Prof. Dranove's flawed market share calculations — and assuming Plaintiffs established valid product and geographic markets — the merger would not be presumptively unlawful in twelve of the remaining twenty CBSAs, including all of the CBSAs at issue in Colorado, Georgia, Missouri and New York. *See* PX0751 at 2 (Blues Separate table).

240. In addition, for all twenty remaining CBSAs and the states in which they are located, the record is replete with evidence that many competitors serve these areas or can easily do so. The record is similarly clear that the merging entities are not each other's closest competitors, particularly when Prof. Dranove's flawed market share calculations are replaced with better predictors of competitive effects, such as diversion ratios assessing the level of direct competition between Anthem and Cigna.

241. Given these facts, Plaintiffs have not established that there will likely be a substantial lessening of competition in the remaining alleged markets.

1. Colorado

Plaintiffs allege harm in four CBSAs in the state of Colorado's "Front Range" region — Fort Collins, Boulder, Denver-Aurora-Lakewood, and Colorado Springs. Compl. ¶¶ 41, 68. Prof. Dranove's own calculations show that the proposed merger is not presumptively unlawful for any of these CBSAs under the Merger Guidelines when Anthem is properly considered separately from other Blue licensees. Dranove Tr. 3912:10-23 (discussing PDX033, slide 32), 3913:19-25 (confirming that all of the Colorado CBSAs fall below the presumption line of

2500); PX0751 at 2. This is the case even though Prof. Dranove's market share calculations were completed without receiving CID data from several significant competitors, including Rocky Mountain, or data from TPAs, including UCHealth Plan and CNIC. DX0730; Dranove Tr. 1052:11-19. Indeed, Plaintiffs themselves argue that "the top five insurers in the Colorado markets have roughly similar shares." Pls' Phase I Opening Statement Tr. 2751:16-22.

a. Colorado Is A Competitive Market With Several Carrier Options And Low Barriers To Entry

242. Colorado has a robust and competitive large group insurance landscape that serves members that live in Colorado, as well as those who travel to the state for care. *See e.g.*, Marchesini (HCA) Dep. 16:20-25.

243. In each of the Plaintiffs' alleged CBSAs throughout the state, there is "a plethora" of significant health plans, TPAs, "exchange options," and hospitals that frequently compete for large group business, including United, Kaiser, Anthem, Rocky Mountain, Aetna, Humana, HealthSCOPE, Ameriben, CNIC, EBMS, and UMR. Bailey (Cigna) Dep. 90:13-91:13, 92:2-12, 184:21-186:5; Walker (Rocky Mountain) Dep. 25:11-14, 25:25-26:3, 26:8-10; 96:1-20, 97:11-16, 98:20-23, 99:14-24; [redacted]; Ramseier (Anthem) Dep. 54:24-55:15; [redacted]; McCreary (UCHealth) Dep. 20:12-22, 20:25-22:20; PX0401 at ANTM006141622-18. Colorado providers are engaged with multiple payers of varying sizes, including TPAs. *See* McCreary (UCHealth) Dep. 20:12-22 (testifying that there are "a lot of small insurers…there's just a ton of them. I can't name them all"), 25:5-7; Cavin (Denver Health) Dep. 10:7-25 ([redacted]), 14:11-22; Carley (Centura) Dep. 40:3-6 (explaining that Centura has contractual relationships with more than 100 payers), 45:24-46:5. Colorado

providers also compete for large group business by directly contracting with employers. *See* McCreary (UCHealth) 25:10-22 (UCHealth has directly contracted with employers, including the Colorado Rockies baseball team).

244. United has the largest market share in Colorado, and is recognized as being in the "top tier" of carriers in the state. Bailey (Cigna) Dep. 184:21-25; *see also* PX0401 at ANTM006141622-10 [redacted]; Major (UCHealth) Dep. 28:22-29:15 (identifying United as one of UCHealth's most "significant competitors"); Espinoza (CNIC) Dep. 36:24-37:3; Walker (Rocky Mountain) Dep. 96:1-20, 98:20-23, 99:14-24. Aetna has targeted Cigna's large groups in Colorado (Bailey (Cigna) Dep. 298:7-14), and Humana is known to be particularly aggressive with their premiums for large groups. Walker (Rocky Mountain) Dep. 20:3-9, 21:2-13. Rocky Mountain has won large group business from both Anthem and Kaiser on the Front Range (Walker (Rocky Mountain) Dep. 25:11-14, 26:8-10), and has a "stronghold" of large groups in the West Slope region. Walker (Rocky Mountain) Dep. 22:23-23:6; *see also* Pogar (Anthem) Dep. 152:14-25, 170:3-11 (identifying Rocky Mountain as a "big player" in the West Slope and Grand Junction areas as well as in some regions [redacted]).

245. CNIC, Rocky Mountain's Colorado-based TPA, competes against Anthem, Meritain, Kaiser, United, Cigna, and UMR, as well as regional TPAs EBMS, Tall Tree, and RCI, and has targeted as prospects Colorado-based customers with incumbent TPAs HealthSmart, Cypress, Starmark, and CoreSource. Espinoza (CNIC) 24:14-16, 36:24-37:3, 51:9-14, 53:9-54:6, 54:22-56:9; Walker (Rocky Mountain) Dep. 104:19-23; DX0580. UCHealth Plan, a TPA of major Colorado provider UCHealth, competes against a variety of payers including Anthem, United, Aetna and Cigna [redacted] and [redacted]

[redacted]. Major (UCHealth) Dep. 20:21-21:12, 28:22-29:14, 35:24-36:11, 38:7-24, 41:4-42:25; DX0043; DX0453; DX0454. Numerous out-of-state TPAs as well compete for and have customers in Colorado, including Key Benefit Administrators, [redacted], HealthSmart, and [redacted]. *See* Gray (Key Benefit Administrators) 48:24-49:4; [redacted]; Archer (HealthSmart) 29:23-25; [redacted].

246. Several powerful PSPs actively compete in Colorado, including Denver Health Medical Plan, a Denver Health entity, which provides commercial health insurance and [redacted]. Goss (Denver Health) Dep. 9:2-21, 24:7-25:13. Anthem anticipates even greater competition in the future from these integrated providers due to their interest in starting health plan partnerships and investing in TPAs. Ramseier (Anthem) Dep. 101:16-103:2 (providing the example of DaVita Healthcare buying several large integrated practices in Colorado, and Anthem's anticipation that they may become a health plan competitor in the future).

247. A small number of large hospitals and provider systems in Colorado, including UCHealth, Centura, and HCA have significant scale and are extremely powerful in the state. *See e.g.*, Pogar Dep. 103:21-104:15 ([redacted]), 296: 20-297:1 ("[Providers] are willing to walk away."), 389:19-391:18; *see also* McCreary (UCHealth) Dep. 32:16-33:5, 69:22-70:16. These large hospital systems and consolidated physicians are able to keep barriers to entry low for new health insurance options by promoting and, to some extent, dictating competition through [redacted] Pogar (Anthem) Dep. 168:20-169:14; *see also* Ramseier (Anthem) Dep. 67:10-68:2 (explaining that powerful providers are responsible for the discount positions of insurance carriers being "very similar"); McCreary (UCHealth) Dep. 32:16-

33:5, 69:22-70:16. [redacted]. *See* Pogar (Anthem) Dep. 168:20-169:14 ([redacted]). Moreover, providers in Colorado are averse to exclusive affiliations with one health plan, instead preferring to be part of several carrier networks. *See* Pogar (Anthem) Dep. 225:16-21; Carley (Centura) Dep 42:8-16 [redacted]).

248. In addition to the dominance of large hospitals and provider systems, health plans are [redacted] about paying attention to entry opportunities as [redacted] PX0401 at ANTM006141622-10; Ramseier (Anthem) 100:7-16 ("[T]here's always rumor of new entrants coming into the Colorado market."). Moreover, these providers have shown a strong interest in "starting health plan partnerships or investing in TPAs" which is expected to increase competition and fragmentation among health plans in the coming years. Ramseier (Anthem) Dep. 101:16-103:2; PX0401 at ANTM006141622-10, ANTM006141622-18.

249. Colorado's competitive environment has also encouraged companies like Kaiser to expand their footprints throughout the state. [redacted] Ramseier (Anthem) Dep. 108:1-15 (confirming that Kaiser has expanded to "southern Colorado, northern Colorado, and recently into the Summit County or Eagle County"); Pogar (Anthem) Dep. 184:16-185:7.

b. Anthem And Cigna Are Not Close Competitors In Colorado

250. Anthem and Cigna each compete along a separate "axis" by offering different value propositions to their respective customers. *See* DeRosa (Cigna) Dep. 198:22-199:13 (explaining that Anthem competes along a "price axis," offering a low cost product, while Cigna competes along a "service axis"). This is true for Colorado as Anthem competes most closely with United. *See* McCreary (UCHealth) Dep. 116:17-117:5 (stating that Anthem and United have a "basically equal [commercial] market share" in Colorado); *see also* DX0442 at 32. Among all of its competitors, Anthem identified [redacted] in Colorado with a [redacted] PX0401 at ANTM006141622-10. In competing to be the market leader in Colorado, [redacted] Pogar (Anthem) Dep. 166:8-15; *see also* [redacted] Cigna competes closely with Aetna in Colorado as "Aetna, in particular" has targeted Cigna's large group business. Bailey (Cigna) Dep. 298:7-14.

2. Connecticut

251. Plaintiffs allege anticompetitive harm in five CBSAs in Connecticut. Compl. ¶ 41. However, some industry participants consider the state of Connecticut its own geographic market, while others view it as part of the "New England" market. *See* Butler (Cigna) Dep. 26:22-27:6, 46:9-14; [redacted]; Wise (ConnectiCare) Dep. 27:18-23, 29:4-7. Expert testimony supports industry participants' broader view of geographic markets. Fowdur Tr. 4219:4-21; Israel Tr. 4357:15-4358:4 (a "CBSA is too small to be a meaningful unit of analysis"); Willig Tr. 4638:24-4639:17. In addition, the evidence shows that there is substantial competition for the sale of commercial health insurance in Connecticut and this competition will continue post-merger.

a. Connecticut Is A Competitive Market With Several Carrier Options And Low Barriers To Entry

252. The landscape of large group commercial insurance in Connecticut is "tightly competitive." [redacted]; DX0591 at HPHC-ANTHEMDOJ-008262-63 ([redacted]); Roberts (Harvard Pilgrim) Dep. 279:7-10 ([redacted]). In addition to Anthem and Cigna, [redacted]. Butler (Cigna) Dep. 125:13-21; [redacted]; Roberts (Harvard Pilgrim) Dep. 274:9-12. [redacted]. Roberts (Harvard Pilgrim) Dep. 23:12-17; *see also* Wise (ConnectiCare) Dep. 15:8-10.

253. ConnectiCare is a major competitor in Connecticut, covering approximately 305,000 members, earning an annual revenue of $1.9 billion, with a network of 20,000 providers throughout the state and [redacted]. Wise (ConnectiCare) Dep. 14:6-15:10, 45:15-17, 45:19-25, 46:2-5, 70:15-25, 71:2-11, 104:16-22, 104:24-25, 105:2, 132:25-133:8; DX0506 at CTCARE-0000160.

254. Within five months of submitting its rate filing to the state in 2014, Harvard Pilgrim began selling insurance products in Connecticut. It has already grown its network to more than [redacted] providers. [redacted]. Roberts (Harvard Pilgrim) Dep. 23:6-17, 75:9-11,

114:7-19, 142:6-15, 284:18-285:2; DX0428 at HPHC-ANTHEMDOJ-000212, 222 ([redacted]). Harvard Pilgrim has become a "very formidable competitor" to Anthem in less than two years. Hummel (Anthem) Dep. 116:1-2, 116:4-15; *see also* Roberts (Harvard Pilgrim) Dep. 218:6-22-219:2 ([redacted]).

255. Numerous TPAs such as [redacted], HealthSmart, and [redacted] are also available in Connecticut and provide employers with highly competitive large group ASO options. *See* Wise (ConnectiCare) Dep. 81:12-24; [redacted]; Archer (HealthSmart) Dep. 31:6-8; [redacted].

256. Additional new entrants are poised to rapidly enter the Connecticut market. *See* DX0559 ([redacted]). For example, Collective Health, [redacted] Batniji (Collective Health) Dep. 124:14-125:4. Value Care Alliance (a combination of smaller community hospitals and Hartford Healthcare) and Aetna are planning to enter Connecticut with a new hospital-based product (i.e. vertically integrated) rather than an Aetna product. Butler (Cigna) Dep. 147:8-148:13.

257. New entrants have provided effective competition to Anthem and have prevented Anthem from meeting its growth and retention targets in Connecticut. Augur (Anthem) Dep. 70:18-71:25 (noting that new entrants as well as United, ConnectiCare, Cigna, Aetna, and Harvard Pilgrim have contributed to Anthem missing its targets in Connecticut).

b. Anthem And Cigna Are Not Close Competitors In Connecticut

258. Aetna takes the highest number of existing accounts from Anthem. Hummel (Anthem) Dep. 168:16-169:5 (discussing DX0596 at ANTM-DDC-001749952, which indicates that Anthem lost five groups and [redacted] to Aetna in the first quarter of 2016). Anthem lost three existing commercial accounts each to United, ConnectiCare, and Cigna. Hummel (Anthem) Dep. 168:16-169:5 (discussing DX0596 at ANTM-DDC-001749952). United is a close competitor to Anthem in Connecticut, having [redacted] with [redacted]. [redacted]; *see also* Hummel (Anthem) Dep. 217:16-18, 217:20-218:14, 218:16-17, 218:19-219:1. And Harvard Pilgrim competes most aggressively against Anthem by price in the fully-insured commercial space. Hummel (Anthem) Dep. 168:16-169:13, 169:25-170:9, 172:6-173:5 (discussing DX0596 at ANTM-DDC-001749952-3).

3. Georgia

259. In both CBSAs in Georgia where Plaintiffs allege there will be anticompetitive harm to large group employers — Gainesville and Atlanta-Sandy Springs-Roswell — Prof. Dranove's own calculations show that the merger is not presumptively unlawful when Anthem is properly treated as a separate competitor and not aggregated with other Blue licensees. Dranove Tr. 3914:1-8 (discussing PX0751).

a. Georgia Is A Competitive Market With Several Carrier Options And Low Barriers To Entry

260. Georgia benefits from a "highly competitive" market "composed of a variety of competitors." Novack (Cigna) Dep. 43:21-44:9; Fetherston (Anthem) Dep. 93:5-14; Leopold (Anthem) Dep. 342:24-343:5. This includes "major industry competitors" like Aetna, Blue Cross and Blue Shield of Georgia, Centene, Humana, Kaiser, and United in addition to smaller

insurers such as Federated. Caldwell (Alliant) Dep. 35:23-36:10; Fetherston (Anthem) Dep. 93:5-14, 300:10-301:5; Leopold (Anthem) Dep. 342:12-343:5; Novack (Cigna) Dep. 72:17-77:7, 116:12-24, 155:15-22; [redacted]; [redacted].

261. TPAs, including CoreSource, Group Resources, BAS, Meritain, HealthSmart, Paragon, BRMS, and Ameriben offer wellness programs and pharmacy benefits that contribute to Georgia's competitive market. Novack (Cigna) Dep. 72:17-77:7; Fetherston (Anthem) Dep. 104:19-105:23, 109:22-110:1; *see also* Novack (Cigna) Dep. 77:8-79:7, 155:15-22. In Georgia, Anthem has also competed against Group Resources, SecureHealth, and a number of other TPAs. Fetherston (Anthem) Dep. 106:21-107:1. As a result, there are a number of customers in Georgia using TPAs for their insurance needs because "anything a carrier does, a TPA can do as well." Fetherston (Anthem) Dep. 104:19-105:9, 121:3-10.

262. Recent new TPA entrants, like [redacted] and [redacted], show that it is not difficult to enter and expand within Georgia. *See* [redacted]; [redacted]. TPAs face few regulatory barriers precluding entry, and many of them "may obtain a network either through a traditional carrier" or through "rental networks out there that are not traditional TPAs" like First Health. Fetherston (Anthem) Dep. 103:8-17; Novack (Cigna) Dep. 76:23-77:3. TPAs also now have greater access to client populations through brokers across the state. Caldwell (Alliant) Dep. 96:10-16, 98:22-98:23, 98:25-99:23; Fetherston (Anthem) Dep. 93:5-14.

263. Similarly for all product types, as ownership of hospitals across the state of Georgia has consolidated, Anthem and Cigna face new entrants (and the threat of further entry) from PSPs. [redacted]; PX0751 at 4 ([redacted]

[redacted]); [redacted]; Leopold (Anthem) Dep. 342:12-343:7, 343:12-14; [redacted]; Fetherston (Anthem) Dep. 241:14-242:1; *see also* DX0563 at PHC_AnthemProd001_0002546 (noting that "[t]he Atlanta [health system inpatient] market is rapidly consolidating" and discussing provider acquisitions).

264. In areas like Gainesville, providers like Alliant are [redacted] and emerging as competitors. For example, because Alliant has received its statewide insurance license, and can make margins on the procedures it performs for its covered lives, it can establish a favorable discount position from which it can expand its business within the northern portion of the state in a way that the major carriers cannot. Caldwell (Alliant) Dep. 27:6-28:5, 30:18-25, 49:3-49:11, 86:14-87:6, 87:8-88:13; Guptill (Kaiser) Dep. 104:24-112:8.

265. Insurers are also seeing key customers as competitors. For example, [redacted] Guptill (Kaiser) Dep. 111:19-112:8. These customers are [redacted] *Id*.

b. Anthem And Cigna Are Not Close Competitors In Georgia

266. Anthem and Cigna are not thought of as close substitutes in Georgia. [redacted]. Prof. Dranove's data confirms this perception.

267. When looking at diversion data in Georgia, "75 percent of Anthem's losses are to competitors other than Cigna." Dranove Tr. 3851:20-23; PX0753 at G-15. In terms of Anthem's large group account wins, Cigna's expected share-based diversion was greater than the actual diversion from Cigna to Anthem. Dranove Tr. 3856:23-3857:7. Prof. Dranove's own calculations indicate that, in Georgia, only [redacted] of Anthem's large group wins are from Cigna —

merely half of the predicted [redacted] share-based diversion. Dranove Tr. 3732:2-9 (discussing PDX033 at slide 40); 3856:23-3857:7; PX0753 at G-17. As Dr. Fowdur explained, when the actual diversion between Anthem and Cigna is smaller than the share-based diversion ratio, it suggests "that the closeness of competition between Anthem and Cigna is actually lower than what the shares would predict." Fowdur Tr. 4252:13-18.

268. Cigna acknowledges that "well-heeled, well-schooled, intelligent rivals" in Georgia foster intense competition — not just on price, but on product quality as well. Novack (Cigna) Dep. 43:21-44:9. Anthem agrees, noting that a "number of different carriers" apply pressure on market participants to retain quality of service while pursuing lower rates. Fetherston (Anthem) Dep. 91:23-92:11, 93:5-93:14.

269. In addition to Anthem and Cigna, a variety of payors, such as Aetna, Kaiser, United, Alliant, Humana, Cigna, and others also compete in Georgia for provider collaborations, including those focused on primary care physicians and patient-centered medical home models. Leopold (Anthem) Dep. 264:23-265:25.

4. Indiana

270. Plaintiffs allege competitive harm in three Indiana CBSAs: Indianapolis-Carmel-Anderson; Lafayette-West Lafayette (approximately sixty-five miles from Indianapolis); and Terre Haute (approximately seventy-eight miles from Indianapolis). Compl. ¶ 41. In Lafayette-West Lafayette and Terre Haute, as well as statewide, Prof. Dranove's own calculations show that the merger is not presumptively unlawful when Anthem is properly treated as a separate company. Dranove Tr. 3716:3-3719:8 (discussing PX0751 at 2); PX0751 at 6.

271. In Indianapolis-Carmel-Anderson, Prof. Dranove opines that the acquisition would be presumptively unlawful where Cigna has the [redacted].

Even if Prof. Dranove's [redacted] share calculation for Cigna were accurate, it vastly overstates Cigna's competitive significance in Indiana and the effect of the acquisition. Fowdur Tr. 4261:9-19 (explaining that Prof. Dranove ascribed a share "approximately four times the size of Cigna's" to a category called "[o]ther").

a. Indiana Is A Competitive Market With Several Carrier Options And Low Barriers To Entry

272. In addition to Cigna, Anthem competes against United, Aetna, Humana, and PSPs like IU Health, Southeastern Indiana Health Organization (SIHO), and Physicians Health Plan of Northern Indiana (PHP). Hillman (Anthem) Dep. 210:15-214:2; PX0516 at 3.

273. In recent years, TPAs have "become more aggressive and [have] captured more market share." Hillman (Anthem) Dep. 211:15-213:1. Large group employers in Indiana, such as Steel Dynamics, consider TPAs to be viable options. Record (Steel Dynamics) Dep. 13:12-14:12 (discussing Employee Plans TPA in Indiana). Indiana "is a state where a lot of third-party administrators exist." Phillips (Cigna) Dep. 94:1-6. At least four independent, national TPAs — Key Benefits Administrators, [redacted], HealthSmart, and [redacted] — have customers in Indiana. Gray (Key Benefits Administrators) Dep. 48:24-49:10; DX0309 (listing dozens of Indiana large groups for Key Benefits Administrators); [redacted]; Archer (HealthSmart) Dep. 31:12-22; [redacted]; DX0594 ([redacted] membership by state); Hillman (Anthem) Dep. 242:19-243:15; *see also* Phase I Findings ¶¶ 118, 395, 412. Additional TPAs competing in Indiana for large groups include Allied Benefits Services, Starmark, Core Benefits, and ProClaim. DX0475 ([redacted]); DX0474; Cahill (PHP) Dep. 141:2-15, 141:18-142:3, 158:17-25.

274. In the past two years, Anthem has lost large groups to a number of TPAs including CoreSource, Key Benefits Administrators, United Group Administrators, UMR, and Meritain. Hillman (Anthem) Dep. 242:19-243:15. Cigna also wins and loses business in Indiana to TPAs. [redacted]

275. Anthem's Indiana Plan President testified that his "biggest competitive concern is the vertically integrated hospital products," primarily IU Health Plans. Hillman (Anthem) Dep. 211:16-212:16, 213:4-213:7, 213:11-214:2. Prof. Dranove's failure to properly assess the competitive significance of provider sponsored plans such as IU Health Plans — the health plan owned by the largest provider in Indiana — is particularly troubling. Dranove Tr. 3941:8-13. Despite IU Health's prominence in Indianapolis, and in Indiana generally, and IU Health Plans' recent rapid growth, Prof. Dranove improperly dismissed the importance of IU Health Plans on the grounds that it did not rise to the level of a "systematic change in the fundamentals of the market." Dranove Tr. 3931:14-3932:15.

276. As a PSP, along with the prestige of the IU name, IU Health Plans offers a value proposition of (1) [redacted] and (2) [redacted] Parker (IU Health Plans) Dep. 21:8-20, 26:5-10, 26:17-27:5. IU Health Plans has approximately 200,000 members, including approximately 105,000 commercial members. Berfiend (IU Health) Tr. 2860:6-11. Per HealthLeaders data, IU Health Plans' membership grew 3,201% between 2015 and 2016. Dranove Tr. 3931:14-3932:15. [redacted] Berfiend (IU Health) Tr. 2881:10-13. In Indianapolis alone, IU Health Plans offers access to six hospitals at low rates.

Berfiend (IU Health) Tr. 2857:24-2858:8. IU Health Plans regularly wins business away from Anthem. Parker (IU Health Plans) Dep. 32:16-17, 32:19-23; DX0445 ([redacted]). IU Health Plans expects continued growth and part of its growth strategy [redacted]. Parker (IU Health Plans) Dep. 39:4-17.

277. In addition to IU Health Plans, SIHO and PHP are PSP competitors that each have a significant competitive presence, and compete for ASO and fully-insured business. Hillman (Anthem) Dep. 213:15-214:2; Cahill (PHP) Dep. 56:3-21 (PHP has [redacted] members).

278. In recent years, "hospital systems approaching and directly contracting with employers for . . . their networks, [has become] much, much more prevalent." Hillman (Anthem) Dep. 211:16-213:1, 253:1-16.

279. Regulatory hurdles to servicing ASO clients are low, and regulatory requirements for fully-insured plans are not difficult to satisfy. Gray (Key Benefits Administrators) Dep. 43:20-44:16. IU Health Plans, for example, successfully entered the commercial business in 2015 after initially offering a plan to its employees in 2012, and currently has revenues of approximately $400 million a year. Parker (IU Health Plans) Dep. 12:2-9; Berfiend (IU Health) Tr. 2860:6-11 (estimating 105,000 commercial members), 2905:19-2906:8.

280. Additionally, rental networks are readily available in Indiana. Hillman (Anthem) Dep. 237:22-238:23, 239:2-24. Key Benefits Administrators, for example, utilizes seven Indiana-focused networks, in addition to seven national networks. *See* DX0233; *see also* DX0472 (illustrating the Indiana-specific network marketed by Encore).

281. Due to these low regulatory hurdles and the ready availability of rental networks, competitors can rapidly expand their presence in Indianapolis-Carmel-Anderson and elsewhere

in Indiana. Providers and competitors in Indiana and nearby states (such as Medical Mutual of Ohio) can also service ASO and fully-insured clients in Indiana. *See e.g.*, DX0434 at ¶¶ 17-20.

b. Anthem And Cigna Are Not Close Competitors In Indiana

282. Anthem and United aggressively compete with one another in Indiana with United appearing "almost across the board" bidding for business. Cahill (PHP) Dep. 66:9-21; Hillman (Anthem) Dep. 210:17-211:14, 212:17-22. By contrast, Cigna only appears "every once in a while" and its presence is limited to its existing large employer customers. Cahill (PHP) Dep. 66:9-21; Hillman (Anthem) Dep. 222:9-12, 233:15-234:19; Dranove Tr. 3850:24-3851:5 (acknowledging that more than 90% of Anthem's large group losses in Indiana are to competitors other than Cigna). Indiana employers have testified that Cigna has refused to participate in recent bids and is not thought of as "another health insurer" from whom Indiana employers can "receive comparable high-quality insurance at competitive prices." Record (Steel Dynamics) Dep. 35:18-36:19.

283. The data confirms that Cigna's presence in Indiana is dependent on a very small number of accounts. Fowdur Tr. 4247:14-4249:21 (discussing DDX0493 at 31). [redacted]

5. Maine

284. Plaintiffs allege that Anthem's acquisition of Cigna would harm large group employers in four CBSAs in Maine. Compl. ¶ 41. However, the evidence demonstrates that there is substantial competition for the sale of commercial health insurance and that substantial competition will continue to exist post-merger. Burke (MEA Trust) Tr. 4025:8-15, 4027:25-

4028:13. Indeed, in two of the alleged Maine CBSAs, Augusta-Waterville (about fifty-five miles from Portland) and Lewiston-Auburn (about thirty-five miles from Portland), the HHI of the combined Anthem-Cigna company is below presumptively anti-competitive levels using Prof. Dranove's own calculations when Anthem is properly treated separately and not aggregated with other Blues. *See* Dranove Tr. 3943:2-8; DDX0410 (highlighted Maine CBSAs).

285. Maine health insurance customers are very concerned about rising healthcare costs. Burke (MEA Trust) Tr. 4019:19-4020:2. The only customer to testify at trial, Maine Education Association Benefits Trust Executive Director Christine Burke, testified that some Maine public school workers pay more in premiums (due to rising healthcare costs) than they earn in wages. Burke (MEA Trust) Tr. 4022:9-4023:1.

286. At least ten health plan companies currently serve Maine residents today: Aetna, Anthem, Cigna, EBPA LLC, Geisinger, Group Benefit Services, Harvard Pilgrim, Key Benefits Administrators, Community Health Options ("CHO"), and United. Corcoran (Anthem) Dep. 159:7-160:11; Burke (MEA Trust) Tr. 4025:8-15, 4027:25-4028:13; Fowdur Tr. 4261:20-4262:4; Gray (Key Benefit Administrators) Dep. 48:24-49:13, 50:2; DX0468; DX0469. Maine employers can also directly contract with Maine providers. Fowdur Tr. 4261:20-4262:4.

a. Maine Is A Competitive Market With Several Carrier Options And Low Barriers To Entry

287. Aetna, Harvard Pilgrim, and United are currently operating in Maine. Corcoran (Anthem) Dep. 159:7-160:11; Schumacher (United) Dep. 294:12-14; Fowdur Tr. 4261:20-4262:4. They and Anthem face competition from CHO, and from TPAs such as EBPA, Geisinger, Group Benefit Services, and Key Benefit Administrators. Corcoran (Anthem) Dep. 158:14-159:1, 159:7-160:5; DX0468; DX0469. Ms. Burke, who heads the plan for single largest

Maine health insurance customer, testified that she "absolutely" would be satisfied with her healthcare options post-merger and that she sees the merger as "win-win", especially given Cigna's current lack of a significant presence. Burke (MEA Trust) Tr. 4027:25-4028:20. In Ms. Burke's view, the consolidation of large hospital systems is a far larger concern for Maine residents than this merger. Burke (MEA Trust) Tr. 4028:21-4029:17.

288. Plaintiffs offer no evidence that the remaining competitors will not serve as competitive constraints post-merger. Harvard Pilgrim is already bidding on large group business in 2016-2017, such as the MEA Trust, that it did not bid on before. Burke (MEA Trust) Tr. 4026:25-4027:8. [redacted]: DX0612 at HPHC-ANTHEMDOJ-001486. Similarly, United competes for Maine-based business. Butler (Cigna) Dep. 150:15-19. And EBPA, a TPA, regularly bids on Maine business, including against carriers like Aetna and Anthem, as well as Group Benefit Services — another TPA that serves Maine accounts. DX0469.

289. There are few, if any, regulatory barriers to servicing ASO clients, and regulatory requirements for fully-insured plans are easily addressed. Gray (Key Benefit Administrators) 43:20-44:22 (noting that Key Benefits Administrators only needs licensing to administer fully-insured products); [redacted]. Insurer licensing is on a statewide basis, such that once a company is licensed, it can write anywhere in the state. DX0434 at 3-4.

290. Maine has seen new carrier entry in recent years. One recent entrant is CHO, a startup health insurance cooperative. Drozdowski (Anthem) Dep. 88:10-89:1. CHO is the leader in individual insurance in Maine, and also has won large group Anthem accounts.

Corcoran (Anthem) Dep. 105:4-10, 178:21-179:6. Despite any prior financial issues, CHO has continued to compete in Maine. Corcoran (Anthem) Dep. 105:4-10, 178:21-179:6.

291. Within the last two years**,** Geisinger has begun serving as a TPA for the health insurance needs of Eastern Maine Healthcare Systems ("EMHS"). Corcoran (Anthem) 261:2-10. Anthem believes that the Geisinger-EMHS relationship may lead to EMHS itself becoming a "new entrant in the near future." Corcoran 185:9-21; Fowdur Tr. 4261:20-4262:4. Existing TPAs such as EBPA continue to compete in Maine using rental networks like First Health and MultiPlan. DX0468. Although EBPA rents Anthem's network, (Corcoran (Anthem) Dep. 190:5-20), EBPA has won business from Anthem. Corcoran (Anthem) Dep. 181:13-22.

b. Anthem And Cigna Are Not Close Competitors In Maine

292. Anthem's "primary competitors" in Maine are Harvard Pilgrim and Aetna. Corcoran (Anthem) Dep. 166:15-167:6; 192:11-21. Aetna has the "leading market share for large group self-insured accounts," and Harvard Pilgrim has an "aggressive" presence in the "large group space." Corcoran (Anthem) Dep. 104:2-13, 105:4-10. Aetna and Harvard Pilgrim have "comparable capabilities" to Anthem and "price aggressively to win groups away from Anthem." Corcoran (Anthem) Dep. 104:2-105:10, 255:21-256:20.

293. Overall, Harvard Pilgrim's [redacted] Roberts (Harvard Pilgrim) Dep. 108:19-22. Harvard Pilgrim achieved [redacted] Roberts (Harvard Pilgrim) Dep. 109:9-14.

294. Cigna, by contrast, is "targeted," and "not considered very aggressive" for large group, fully-insured business. Corcoran (Anthem) Dep. 166:19-167:6; *see also* Burke (MEA Trust) Tr. 4027:25-4028:13. For example, Cigna declined to bid for the MEA Trust's business

(the largest account in Maine) for 2017. Burke (MEA Trust) Tr. 4026:21-4027:8. On the other hand, Aetna and Harvard Pilgrim have submitted "aggressive, very exciting proposals" during the Request for Information stage. Burke (MEA Trust) Tr. 4026:25-4027:8.

295. Plaintiffs' basis for asserting that Cigna and Anthem are close competitors in Maine is data that Cigna lost more Maine business to Anthem than Cigna did to Aetna or Harvard Pilgrim. Dranove Tr. 3946:24-3947:3. However, Prof. Dranove admits that Cigna actually lost more Maine business to Geisinger, a smaller competitor, than it did to Anthem. Dranove Tr. 3950:6-10; DDX0434.

296. Prof. Dranove admits that the use of small data samples, such as data from smaller states like Maine, can overstate the relationship between two competitors. Dranove Tr. 3730:22-3731:20, 3952:8-24. A few anecdotes of head-to-head competition over several years do not accurately portray Maine's competitive environment. Fowdur Tr. 4261:20-4262:4 (noting that there are companies capable of entering Maine); *see also* Burke (MEA Trust) Tr. 4027:25-4028:13 (Cigna's "footprint in Maine" is not big enough for its absence to make a huge difference). Indeed, Maine's recent entrants have accumulated sufficient shares such that they may act as a significant constraint to a post-merger price increase. Willig Tr. 4570:15-4572:3.

5. Missouri

297. Plaintiffs have alleged that the merger would harm large group employers in the St. Louis CBSA. Compl. ¶ 41. However, Prof. Dranove's own market share calculations show that the merger is not presumptively unlawful in the St. Louis CBSA when Anthem is properly treated as a separate company and not aggregated with other Blue licensees. PX0751 at 2.

298. Plaintiffs characterize St. Louis as part of a CBSA that encompasses parts of Missouri and Illinois; however, because Anthem is not the BCBS licensee for Illinois, it cannot

and does not market or sell insurance to employers headquartered in Illinois. Compl. ¶ 41; Martenet (Anthem) Dep. 114:10-115:1.

a. Missouri Is A Competitive Market With Several Carrier Options And Low Barriers To Entry

299. Competition is "fierce" in St. Louis, Missouri. Martenet (Anthem) Dep. 115:6-116:9. There are over twenty carriers who compete for large group employers in the state of Missouri, including United, Aetna, Centene, Cigna and Humana. *Id.* at 17:13-18:4, 20:14-21:8, 53:19-54:19.

300. Anthem also competes against an "alphabet soup" of TPAs in Missouri, including Key Benefits Administrators, Meritain, UMR, HealthSCOPE, HealthSource, [redacted], HealthSmart, and BAS that are able to rent networks from other carriers and that obtain stop loss insurance from a wide variety of insurers. *Id*. at 26:4-27:2, 115:6-116:9, 117:8-25; [redacted]. Anthem has lost large groups to both HealthSCOPE and HealthSmart. Martenet (Anthem) Dep. 50:20-51:20; DX0446 at ANTM004117917, 2-6 of 7 [redacted]. TPAs are not restricted by geography and do not have to be located in Missouri to compete in Missouri. Martenet (Anthem) Dep. 93:6-20, 116:10-22. TPAs have access to networks which span across all fifty states. *See e.g.*, Gray (Key Benefit Administrators) Dep. 57:17-19; Horvath (CoreSource) Dep. 53:14-15; 53:17. For instance, Key Benefits Administrators markets itself in every state, competing for large groups in eighteen, including Missouri. Gray (Key Benefit Administrators) Dep. 45:13-46:3, 46:5-10, 46:12-13, 48:24-49:13, 50:2, 50:8-51:4; DX0309 at 1-16.

301. There are also formidable PSPs operating in Missouri. These include SSM/Dean, Cox Health Plans, and a Cox and Barnes-Jewish Hospital (BJC Healthcare) collaborative. Martenet (Anthem) Dep. 53:19-54:19. Additionally, SoutheastHEALTH, a hospital system in Missouri recently launched its own health insurance option. Edwards (HealthSCOPE) Dep. 43:11-17, 43:20.

302. Missouri is also seeing competition from providers in the form of disintermediation or direct contracting. For example, Cox Health Plan, Mercy Health System, Southeast Health, St. Francis, Barnes-Jewish, and others will "go out and they will approach employer groups in the area, in Springfield, Missouri area, as well as third-party administrators to offer a . . . direct contract to that customer or to that third-party administrator." Martenet (Anthem) Dep. 74:9-23, 115:6-116:9.

303. Further, there are several expansion and entry threats in Missouri. Anthem anticipates expansion from SSM/Dean and Cox Health Plan's and BJC's collaborative into other areas of Missouri. Martenet (Anthem) Dep. 115:6-116:9. Anthem also anticipates expansion from carriers already licensed in Missouri that are offering other types of health insurance coverage, including Centene and Essence Health. *Id.*

b. Anthem And Cigna Are Not Close Competitors In Missouri

304. Anthem considers United, Aetna, and BCBS of Kansas City to be its largest competitors in Missouri. *See* Martenet (Anthem) Dep. 20:14-21:8. In addition, Anthem's win-loss reports show that United, and not Cigna, is Anthem's strongest competitor in Missouri. *Id.*; DX0442 at 137. [redacted]. DX0446 at ANTM004117919, 1 of 7. [redacted]. *Id.*

[redacted]. *Id.* at 2-7 of 7; Martenet (Anthem) Dep. 55:10-12.

6. New York

305. Plaintiffs allege harm in a single New York CBSA — New York-Newark-Jersey City, NY-NJ-PA — which spans parts of New Jersey and Pennsylvania as well as New York. Compl. ¶¶ 41, 68; Dranove Tr. 3872:3-6. Anthem competes as Empire in New York and its BCBS license only covers ten New York City metropolitan and surrounding counties plus a few upstate counties. PX0701 at 78. Anthem does not operate as a BCBS licensee in either New Jersey or Pennsylvania and therefore cannot compete throughout the entire alleged CBSA. PX0125 at 48-49; Compl. ¶ 41; Schreiber (Anthem) Dep. 267:12-18. A couple of large accounts make up a substantial portion of Empire's (Anthem's) membership in New York. *See e.g.*, Schreiber (Anthem) Dep. 52:25-53:3, 53:6-54:20 (noting that the City of New York and the State of New York accounts have approximately 900,000 and 1.1 million members respectively); PX0758 at 2; Soumakis (Anthem) Dep. 96:20-97:16 ([redacted]).

306. Although Prof. Dranove's market share calculations were completed without receiving CID data from several significant New York competitors, including MVP, (Dranove Tr. 3903:16-3904:11), his calculations still show that the proposed merger is not presumptively unlawful for the New York City CBSA under the Merger Guidelines when Anthem is properly considered separately from other Blue licensees. Dranove Tr. 3912:10-23 (discussing PDX033 at slide 32); PX0751 at 2. The same is true on a statewide level. PX0751 at 6.

a. New York Is A Competitive Market With Several Carrier Options And Low Barriers To Entry

307. New York "historically has been a hyper competitive, very aggressive marketplace." Schreiber (Anthem) Dep. 32:1-22. Prof. Dranove's own calculations show that Cigna is only the [redacted] largest carrier in the New York City CBSA, [redacted]. PX0751 at 2. Anthem also faces competition in New York from MVP, CareConnect, Capital District Physicians' Health Plan (CDPHP), Crystal Run Healthcare, Oscar, and various TPAs.

308. Given the large population of the New York City area, many customers in New York slice their health insurance among multiple carriers. *See e.g.*, Schreiber (Anthem) Dep. 382:12-383:4, 383:17-19, 383:22-384:6; Fitzgibbon (EmblemHealth) Dep. 19:24-25, 20:2, 20:11-18; DX0277. Anthem has over one hundred large groups that slice accounts in New York. Schreiber (Anthem) Dep. 383:5-16. For instance, the City of New York account is sliced between Anthem and EmblemHealth and the State of New York account is sliced between Anthem and United. Schreiber (Anthem) Dep. 52:25-53:3, 53:6-54:20; *see also* Fitzgibbon (EmblemHealth) Dep. 180:12-17. Regional carriers such as EmblemHealth and [redacted] serve New York employees [redacted] through slicing. *See e.g.*, Fitzgibbon (EmblemHealth) Dep. 64:2-17; DX0497; [redacted].

309. EmblemHealth covers [redacted] Fitzgibbon (EmblemHealth) Dep. 61:3-16. *See* Phase I Findings ¶ 91.

310. MVP covers [redacted] Austen (MVP) Dep. 16:6, 16:9-25, 33:22-25, 34:2-25, 35:2, 35:18-20, 36:4-9; DX0637 at MVP_004196; *see also* Phase I Findings ¶ 98. MVP [redacted]. Austen (MVP) Dep. 140:16-22.

311. Northwell Health (formerly North Shore/LIJ) is [redacted] DX0540 at ANTM000141314-15. Northwell Health's PSP, CareConnect, [redacted]. Soumakis (Anthem) Dep. 83:8-16; DX0540 at ANTM000141315 (Northwell Health is [redacted]). CareConnect [redacted]. Soumakis (Anthem) Dep. 84:14-85:13. While Plaintiffs asserted that CareConnect is only in the individual and small group space, (Dranove Tr. 3744:18-3745:8), Northwell (CareConnect) [redacted]. DX0486.

312. CDPHP is another PSP that Empire (Anthem) competes against in the large group space. Schreiber (Anthem) Dep. 412:25-413:12. CDPHP is one of Empire's (Anthem's) "main competitor[s]" in upstate New York. Schreiber (Anthem) Dep. 413:13-415:10.

313. Many TPAs compete for New York ASO business, including UMR, [redacted], HealthSmart, [redacted], and [redacted]. Schreiber (Anthem) Dep. 86:2-3, 86:5-12, 86:14-87:22, 87:24-25, 88:2-3, 88:5-11, 88:13-90:24; [redacted];

Archer (HealthSmart) Dep. 30:6-8; [redacted]; *see* Soumakis (Anthem) Dep. 84:14-85:13, 237:19-238:2.

314. New York has low barriers to entry and expansion. New York insurance licensure is statewide so a competitor operating in one area of the state is licensed to expand its service area to other parts of the state. [redacted]; DX0434 at ¶¶ 17-20. MVP and CDPHP, two competitors in upstate New York, face "no barriers" to expanding downstate. Schreiber (Anthem) Dep. 413:13-414:10. [redacted] Fitzgibbon (EmblemHealth) Dep. 174:19-25, 175:2-4.

315. [redacted] and Crystal Run. Soumakis (Anthem) Dep. 83:8-16, 85:22-86:5; Austen (MVP) Dep. 105:22-25, 106:2-6; Fitzgibbon (EmblemHealth) Dep. 39:12-18; DX0486. Anthem views the "[t]he threat of [PSPs]" as "increasingly viable." DX0540 at ANTM000141307. Oscar is also a new entrant in New York. [redacted]; *see also* Dranove Tr. 3742:22-3743:20 (admitting that Oscar recently entered New York and New Jersey "successfully in terms of enrollment"). Oscar is now considering expanding into large group business. Soumakis (Anthem) Dep. 83:8-16.

b. Anthem And Cigna Are Not Close Competitors In New York

316. Anthem does not consider Cigna to be a "day-in and day-out" competitor in New York. Schreiber (Anthem) Dep. 97:15-17, 97:19-98:4 ("[I]n New York, they're really not that competitive [in providing commercial ASO services] . . . I don't view them as a key competitor in New York."), 187:25-188:4, 188:9-189:9. Other competitors, such as [redacted] and

[redacted], also do not consider Cigna to be a competitor for large groups. [redacted]; [redacted].

317. Anthem's "immediate threats" for large groups in the New York City area are "United, Aetna, Emblem, [and] Cigna as well to a lesser degree." Schreiber (Anthem) Dep. 460:21-22, 461:2-462:15; *see also* [redacted]; Austen (MVP) Dep. 62:9-25, 63:2-13.

318. "Aetna is right now probably the single biggest competitive threat that we have, with United being a close second in New York." Schreiber (Anthem) Dep. 106:11-107:17, 416:17-24. Anthem recently lost 93,000 Metro Transit Authority members to Aetna. Schreiber (Anthem) Dep. 137:5-11, 137:14-139:13. In January 2016, "[f]or the most part," all of Empire's (Anthem's) losses were "to Aetna and for price." Schreiber (Anthem) Dep. 419:16-420:5.

VI. THE MERGER WILL NOT HARM INNOVATION

319. As in Phase I, Plaintiffs again contend in Phase II that the merger will harm "innovation." Dranove Tr. 3685:8-12. Plaintiffs, however, failed to establish that Cigna is a "maverick" firm playing a uniquely disruptive role in the healthcare solutions industry that constrains pricing. *See* Phase I Findings ¶ 423. Moreover, Prof. Dranove has not even attempted to quantify any harm stemming from his assertion that incentives to innovate will be decreased post-merger. Dranove Tr. 1164:10-23. On the contrary, Dr. Israel showed — including through quantitative analysis — that the merger will *increase* innovation. Israel Tr. 2027:21-2036:11.

320. The evidence also shows that the combination of Anthem and Cigna will enable new, innovative offerings not possible for either company individually. While Cigna has various strengths not possessed by Anthem, such as its wellness programs, Anthem excels at reducing the total cost of care. Phase I Findings ¶ 431. In addition to Anthem and Cigna, many entities

offer health and wellness programs, engage in provider collaborations, or explore new types of payment arrangements with providers. Phase I Findings ¶¶ 423-425, 435-438. Plaintiffs have offered no evidence in either trial phase to suggest that these entities will stop innovating if the transaction closes.

321. Furthermore, the confirmed activities of these other competitors and general trends in the industry will continue to make it imperative for the combined firm to innovate. Phase I Findings ¶¶ 433-34. For example, despite its higher membership and smaller geographic dispersion, Anthem has been a successful innovator for many years. *See e.g.*, DX0160 at ANTM-DDC-001575576. Plaintiffs have not shown that combining Anthem with Cigna would reduce these strong incentives to innovate. In fact, Mr. Drozdowski, with more than twenty years at Anthem, is not aware of any value-based program that Anthem started in response to a similar Cigna program. Drozdowski (Anthem) Tr. 1640:12-1641:4. And notwithstanding Prof. Dranove's belief that Anthem's Q-HIP program was developed in response to competition from other insurers (Dranove Tr. 2299:21-2300:22), Anthem actually developed it — "the first program of its kind in the nation" — fifteen years ago in response to hospital cost increases that persistently outpaced inflation. Drozdowski (Anthem) Tr. 1640:12-24, 1634:25-1635:5.

322. In Phase II, Plaintiffs have advanced three arguments to support their theory that innovation may be lessened due to the merger: (1) Cigna offers a unique level-funded product that has caused other carriers to respond with similar products; (2) Anthem tends to be more innovative in areas where it has lower market share or a discount disadvantage; and (3) Cigna tends to be more flexible in collaborating with providers. As discussed below, Plaintiffs again fail to support these theories with sufficient evidence. In addition, Plaintiffs have not shown that even if this supposed innovation were lost, such loss would constitute anticompetitive harm.

A. Plaintiffs Have Not Offered Sufficient Evidence To Support Their Contention That The Merger Will Harm Innovation

323. **First**, the evidence shows that Cigna's level-funded product is not unique, but instead was acquired through Cigna's purchase of a rival insurer, Great West. Phase I Findings ¶ 441; *see also* Mahoney (SML) Tr. 3677:5-16; Bailey (Cigna) Dep. 75:22-76:7. Plaintiffs have offered no evidence that the combined firm will jettison the level-funded product, rather than making it available to additional customers. *See* Mifsud (Melita) Tr. 3262:14-3263:5 (explaining that he viewed Cigna's acquisition of Great West's level-funded product as something that was "going to expand their market"). In any event, many companies offer such hybrid or level-funded products, including Aetna, United, Blue Shield, Humana, TPAs such as HealthSmart, and even Kaiser on a limited basis. *See* Schreiber (Anthem) Dep. 40:12-42:10; [redacted]; Archer (HealthSmart) Dep. 59:8-10, 60:7-19 (explaining that other TPAs also offer level-funded plans).

324. **Second**, Plaintiffs are incorrect that Anthem's larger shares and discount advantages in places like Virginia and New Hampshire cause Anthem to innovate less, as these states are precisely where Anthem pioneered value-based contracting. In Virginia, Anthem "introduced the first hospital-based incentive program in the nation," despite having "the best discount" and being one of the largest payers there. Drozdowski (Anthem) Tr. 1667:12-1668:1. In New Hampshire, Anthem piloted a program that was rolled out nationwide as EPHC and has done "amazingly well on provider innovation, reimbursement innovation, [and] provider collaboration." Guertin (Anthem) Tr. 3573:3-3574:2 (testifying that it has also made care coordination payments sufficient to hire 100 care managers and implemented quality incentives for more than ten years that have saved "self-insured customers millions of dollars").

325. Likewise, in Indiana, Plaintiffs' suggestion that Anthem is less innovative because some customers "loathe" Anthem takes the cited testimony out of context (Hillman (Anthem) Dep. 193:13-194:5), and ignores Anthem's record of collaboration and innovation. *See e.g.*, PX0514 at ANTM003872796, ANTM00382798. Anthem has "deep, trusting provider relationships" in Indiana, including value-based contracts with almost 70% of primary care physicians. *Id*. at ANTM00382797, ANTM00382799. For example, Anthem has a [redacted]. *Id.* at 2802.

326. Anthem's innovation has not been limited to Virginia, New Hampshire, or Indiana, but has been pursued in each Anthem state. In California, Anthem created Vivity, a unique partnership with providers that even Prof. Dranove concedes was "something that nobody else has offered." Dranove Tr. 983:6-10. Plaintiffs have suggested that Anthem developed Vivity to keep pace with Cigna's development of a similar product with St. Joseph (Phase II Opening Arguments 2753:1-10), but the evidence shows that Anthem developed it in response to Kaiser, not Cigna. Rothermel (Anthem) Tr. 4115:1-4116:16. Cigna similarly developed its delivery system alliance ("DSA") with St. Joseph in response to Kaiser, not Anthem. Rapisardi (Cigna) Dep. 192:21-194:14 ("[I]t was never really my concern so much about competing against [Anthem's] Vivity or [Blue Shield's] Trio. What I really wanted to compete against was Kaiser."). Other carriers have also formed DSAs in response to Kaiser, including Oscar, Aetna, and Blue Shield. Rapisardi (Cigna) Dep. 144:21-145:13, 146:20-147:11.

327. Furthermore, despite Cigna's efforts to innovate and focus more on total cost of care, the joint Anthem-Cigna integration team concluded that Anthem's programs lower claims utilization and reduce total cost of care more than Cigna's programs, even after adjusting for

Anthem's discount advantage. Phase I Findings ¶ 431. In any case, Prof. Dranove has conducted no empirical analysis suggesting that healthcare quality will be reduced by the merger. Dranove Tr. 3999:22-4000:4. As Mr. Berfiend explained, even when IU Health has experienced lower payments for its services, "the quality [of care IU offers] would be the same." Berfiend (IU Health) Tr. 2892:6-12.

328. **Third**, Plaintiffs have suggested that Cigna is more willing to engage in provider collaborations than Anthem. For instance, Plaintiffs elicited that in 2012 Granite formed a collaboration with Cigna that requires Cigna to send raw claims data to Granite each month, whereas neither Anthem nor any other payers have entered into a similar arrangement. Rowe (Granite) Tr. 2811:21-2813:23, 2820:14-16, 2828:14-21, 2835:1-3 (noting the arrangement is for upside-only shared savings). But Anthem already has value-based arrangements with each of the Granite member hospitals. Guertin (Anthem) Tr. 3574:22-3576:4. [redacted] DDX0215 at GH 00385. As a result of this lawsuit, however, Ms. Rowe decided to pause discussions concerning the Anthem-Granite agreement. Rowe (Granite) Tr. 2846:1-12; *see also* Guertin (Anthem) Tr. 3574:22-3576:4 (explaining that Anthem originally refused to share sensitive commercial data for each Granite member with Granite because they did not resolve Anthem's concerns that the hospital-competitors might have access to each other's data).

B. The Evidence Shows That The Merger Will Enhance Innovation

329. Rather than diminishing innovation as Plaintiffs suggest, the evidence shows that the merger will enable the combined firm to offer the best aspects of Anthem's and Cigna's

programs to their customers in the form of new, improved products that combine Anthem's discount advantage with Cigna's customer-facing product components that those customers tend to find most attractive. Phase I Findings ¶¶ 4, 43, 292-93, 303. As discussed in more detail below, this combined product is not likely to exist absent the merger. *Infra* § VII.

330. On the provider side, the combined firm will be able to accelerate the shift from fee-for-service arrangements to true value-based care arrangements. One goal of the integration team was to "make sure that we were delivering the most robust provider engagement programs that we possibly could." Matheis (Anthem) Tr. 1465:25-1466:11, 1466:20-1467:14 ("Cigna has some very nice programs" and the merged firm can offer the "best of both practices" with providers). The combined firm will bring expertise from both companies "that can be quite complementary to trying to accelerate [provider collaborations] across multiple markets." Guilmette (Cigna) Dep. 286:1-287:11; *see also* Phase I Findings ¶¶ 294-97. There is no dispute that these improved collaborative relationships with providers will benefit patients as well.

331. Further, the post-merger company will be able to offer higher patient density to providers, which can be crucial in establishing credible, effective provider collaborations. Phase I Findings ¶¶ 296-97, 433-34; *see also* Drozdowski (Anthem) Tr. 1675:24-1676:11 (testifying that "in many markets Cigna lacks substantial size, which is essential to build and grow and maintain a provider collaborative relationship," and that combining the companies "will enhance the ability to expedite provider collaboration"). Granite's Rachel Rowe, which has had a value-based overlay with Cigna for years, testified that Cigna does not have enough patient volume in order for it to do value-based care effectively, noting that "Cigna's much smaller than Anthem," and "the more lives that you have in a data warehouse when you're doing analytics, the better it is." Rowe (Granite) Tr. 2807:2-9, 2826:2-18.

332. The merger will not reduce incentives to collaborate because such collaboration is a necessity to reduce overall healthcare spending. Hayes (Aetna) Dep. 258:4-10, 12-22 (noting that Aetna's goal is to reach 75% of medical spend in value-based contracting by 2020); Wheeler (Bon Secours) Tr. 3421:2-4 (value-based reimbursement is an industry-wide trend); Marchesini (HCA) Dep. 125:12-126:11 (stating there is "no doubt that the health plans are finding ways to fund improving the care coordination with members of the marketplace").

333. Employers in the industry have expressed a preference toward moving from fee-for-service arrangements to value-based contracts. *See e.g.*, Hayes (Aetna) Dep. 221:8-14, 221:16-222:3; Kilmartin (Mercer) Dep. 157:25-158:1, 158:3-9, 158:11-22, 158:25-159:4, 159:6-12 (affirming that clients are supportive of the shift from volume-based to value-based arrangements); Abbott (WTW) Tr. 95:6-97:22; Pogar (Anthem) Dep. 202:19-23.

334. The improved discounts created by the merger will increase incentives to enter into provider collaborations. Schumacher (United) Dep. 251:1-4, 251:7-252:3 ([redacted]); Drozdowski (Anthem) Tr. 1666:17-1667:8 (insurers are incentivized to rapidly enter into collaborative relationships with providers as a way to make up for discount disadvantages). Thus, there is no tension between pursuing discount advantages and continuing to collaborate with providers. Cheslock (Anthem) Dep. 88:10-19 (noting that "they can be complimentary"); *see also* Israel Tr. 2031:9-2032:5 (stating that there is no tension between innovation and lower pricing if they enable "better discounts and a faster transition to value based care").

335. Finally, provider collaboration enables reductions in cost of care and generates other savings. Goulet (Former Anthem) Dep. 54:9-55:14; Welch (Cigna) Dep. 99:23-100:2 (agreeing that Cigna's provider collaborations have resulted in savings for Cigna's customers);

see also Goulet (Former Anthem) Dep. 68:7-69:3 (stating that, as Anthem began to implement provider collaboration strategies, the cost of care trend slowed compared to cohort groups that did not have those collaborative programs). Thus, insurers are incentivized to keep engaging in provider collaboration, independent of discount advantages. Goulet (Former Anthem) Dep. 61:23-64:5 (stating that providers were "very happy" with Anthem's programs and that Anthem's programs had "helped them make their practice more efficient"); Wenners (Anthem) Dep. 119:18-120:19.

VII. MERGER-SPECIFIC EFFICIENCIES WILL GENERATE COST SAVINGS THAT SWAMP ANY ALLEGED ANTICOMPETITIVE EFFECTS

A. The Best-Of-Best Shows That The Merger Will Result In Substantial Cost Savings For Large Group Customers

336. Dr. Israel presented a model of post-merger, buy-side negotiations between insurers and providers, based on the uncontested economic theory that larger firms get better prices. Israel Tr. 4413:2-14, 1846:20-1849:14. The model accepts that post-merger — as is true today and as Plaintiffs' witnesses agree will happen — insurers and providers have a duty to negotiate for the best terms they can. *See Id.* at 4391:16-4393:9; Wheeler (Bon Secours) Tr. 3415:24-3416:5. Dr. Israel's best-of-best methodology is a conservative implementation of this negotiation model. Israel Tr. 4413:2-14; *see also* Phase I Findings § VII.A.5.

337. The best-of-best methodology predicts that the effect of the merger is that the combined firm, with its additional volume, will obtain pricing from providers no worse than — and perhaps better than — the individual firms could achieve on their own (*Id.* at 2145:14-25, 1854:19-1855:24); this is true even if the new entity sometimes does better than or worse than (i.e., does not "close the gap") the best-of-best. *Id.* at 4498:19-4499:2.

338. Using the best-of-best methodology, Dr. Israel calculated that the merger will generate $2.4 billion in medical cost savings nationwide. *See id.* at 1830:22-1832:7. In Phase II, Dr. Israel quantified the medical cost savings Anthem and Cigna will achieve at the state level: $1.4 billion in the ten states that contain a CBSA at issue. *Id.* at 4364:21-4365:4. This broad benefit to consumers outweighs any theoretical harm.

339. The logic of the best-of-best calculation, reflecting the discount gap between Anthem and Cigna at specific providers, is confirmed by the statewide results. In areas where Cigna has a small share and a relatively weak cost position, such as in Indiana, the best-of-best model results in large medical cost savings for Cigna customers because Cigna benefits to a larger degree from the increased volume. Israel Tr. 4365:5-21 (discussing DDX0498 at 2-3).

340. Testimony in Phase II confirms that using discount differentials is an appropriate way to estimate the potential effect of the merger. *See e.g.*, Wheeler (Bon Secours) Tr. 3427:16-3428:3, 3428:18-3429:2; Harlin (Wells Fargo) Tr. 3360:7-3361:1 (discount differentials used to compare the strength of insurers' offerings); Phase I Findings § VII.A.6.

341. The spread of discount differentials between Anthem and Cigna across different providers reflected in Dr. Israel's best-of-best results is corroborated by provider testimony about real world discount differentials. Israel Tr. 4368:9-4369:9; Brendt (Sutter) Dep. 84:1-24 (testifying that Anthem, Blue Shield, and Aetna have comparable rates, but rates are [redacted] Gorse (Patient First) Tr. 3180:6-12 (discussing DX0775) (describing a [redacted] differential in average reimbursements for Virginia locations); Wheeler (Bon Secours) Tr. 3439:18-3440:4 (discussing DDX0394) (describing a [redacted] differential in Richmond); Berfiend (IU Health) Tr. 2859:9-17 (discussing PDX0024) (showing a [redacted]

differential in Indianapolis); *see e.g.,* Israel Tr. 1862:7-24 (discussing DX0714) (estimating that Anthem's discounts are approximately [redacted] lower than Cigna's).

342. Dr. Israel's efficiencies analysis is not dependent on the merged firm using the affiliate clause to achieve savings; if the company determines not to invoke the clause with some providers, renegotiations will happen soon enough in the ordinary course of business. Israel Tr. 2106:18-23, 4381:10-4383:10; Drozdowski (Anthem) Tr. 1656:1-1656:25, 1660:23-1661:13. The principle remains that the merged firm will do no worse than whichever firm had the better discount pre-merger. Israel Tr. 1846:20-1849:14.

343. But by invoking the affiliate clause, the combined firm can rapidly achieve the vast majority of these savings. *See* DX0153 at ANTM-DDC-000677256 (showing that 80% of medical cost savings can be achieved solely by unilaterally invoking the affiliate clause); *see e.g.*, Berfiend (IU Health) Tr. 2886:4-8 (calculating moving Cigna to Anthem rates would reduce medical network costs by more than $50 million per year), 2889:24-2890:9 (noting IU Health has an affiliate clause with Anthem that Anthem can exercise unilaterally on January 1); DX0391 (containing affiliate clause); DX0392 (same); DX0393 (same); DX0395 (draft enterprise contract with affiliate clause); DX0396 (same); *see also* Drozdowski (Anthem) Tr. 1659:4-15 (discussing DX0153 at slide 6) (showing the new firm expects to achieve 90% of value capture within two years, and between 51% and 77% of the total within one year). And customers that use Cigna outside of the Anthem states will still benefit from the lower Anthem rates within the Anthem states, if they have employees there. Schlegel (Anthem) Tr. 1433:16-24 (such customers would have access to Anthem's networks); *see also* Phase I Findings ¶¶ 337-38 (showing that customers could choose to use Anthem in the Anthem states and Cigna everywhere else).

B. The Merger's Efficiencies Will Not Harm Providers

344. The merger will not adversely affect providers, including small physician groups and solo practitioners. First, the vast majority of medical cost savings come from hospitals and large physician groups: hospital and hospital groups account for 70% of the cost savings and large physician groups account for 24%. Israel Tr. 1979:17-1981:3. Only 6% of these savings come from small physician groups or solo practitioners. *Id.* at 1979:17-1981:3.

345. Second, medical cost savings do not come from providers without market power. A discount gap between Anthem and Cigna is present where a provider has market power that allows them to charge one firm higher rates than another; providers with no market power will charge the competitive price to all insurers. *Id.* at 4443:20-4444:15. Therefore, for providers without market power, the best-of-best calculation finds no savings because there is no discount gap to close. Instead, the best-of-best computes medical cost savings only if a provider has market power (e.g., where a provider is able to charge differential rates to Anthem and Cigna (*Id.*), in which case, the merger will allow the merged firm, with its combined volume, to offset the providers' market power and move the price towards the competitive price increasing consumer welfare. *Id.* at 1961:9-18, 4418:23-4420:12; *see also infra* § VIII.C.1.

C. The Calculated Efficiencies Are Cognizable And Merger-Specific

346. A merger-specific efficiency is one that is unlikely to be accomplished absent the merger. Israel Tr. 4372:9-4373:2, 4376:1-8; Merger Guidelines § 10; *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 150 (D.D.C. 2004). Here, Plaintiffs agree the medical cost savings cannot be achieved absent the merger; indeed, it is the basis of their monopsony claim. Compl. ¶ 71 ("*As a result of the merger*, Anthem likely would reduce the rates that both types of providers earn by providing medical care to their patients." (emphasis added)); Dranove Tr. 2449:14-19 ("Q. [The

evidence] also indicates that *the merger will result* in lower provider rates . . . correct? A. Yes." (emphasis added)).

347. It is undisputed that insurers with greater volume are able to obtain better reimbursement rates from providers. *See* Dranove Tr. 2448:22-2449:13. There is similarly no dispute that the combined company will bring additional volume to the negotiating table compared to Anthem and Cigna individually.

348. While the merger will lower rates on the provider side, the ability to achieve the medical cost savings is not contingent upon forcing Cigna customers to accept Anthem's current products, nor does the integration team's plan require Cigna customers to do so. Schlegel (Anthem) Tr. 1417:24-1418:1; Singhal (McKinsey) Tr. 1790:2-1791:8; Matheis (Anthem) Tr. 1533:7-15. Instead, the merger will allow Anthem and Cigna to create a new, more attractive product that includes Cigna's customer-facing features with a stronger cost position. Dranove Tr. 4791:19-22 (admitting that a lower-priced Cigna product would be a new, merger-specific product); Cordani (Cigna) Tr. 510:10-511:21; DeVeydt (Former Anthem) Tr. 1697:14-1698:1; Israel Tr. 4372:9-4373:2; *see also* Phase I Findings ¶¶ 1-10. The new product will be branded "Blue." The development of a new product not available today will entice current Cigna customers to voluntarily switch to Anthem, but ultimately, it will be the customer's choice. Schlegel (Anthem) Tr. 1417:9-16, 1418:11-17; Drozdowski (Anthem) Tr. 1656:9-16; Mathai (Anthem) Tr. 1275:5-15. The fact that the NewCo will seek to brand this new product "Blue" to comply with the Best Efforts rules is not inconsistent with the fact that the product will be a new offering. DeVeydt (Former Anthem) Tr. 1697:14-1698:1; Israel Tr. 4379:12-4380:18.

349. For years, Cigna has generally obtained less favorable discounts than Anthem, and Cigna does not have the volume needed to achieve Anthem's discounts absent the merger.

Israel Tr. 1862:7-16 (discussing DX0714), 1871:13-1872:2, 4373:5-21; *see also* Dranove Tr. 4784:20-24; DX0747. Similarly, Anthem has been unable to replicate Cigna's customer-facing products. Israel Tr. 4373:22-4374:11; Dranove Tr. 4784:17-19. The merger will allow NewCo to combine the "best of both," including by combining networks and leveraging the areas where each company is strongest to create a more attractive product that will make NewCo a fiercer competitor in the sale for health insurance. Israel Tr. 4376:10-23; Burke (MEA Trust) Tr. 4028:14-20 (describing the merger as a "win-win" because it would allow Anthem to take advantage of some of Cigna's products such as their wellness programs); Gorse (Patient First) Tr. 3190:9-13 (agreeing that a combined firm adopting the best practices of Anthem and Cigna's value-based arrangements would be beneficial for Patient First).

350. This has always been the goal of the merger. *See* DX0235 at slide 16; DX0240 at slides 15, 24; DX0241; DX0057. Plaintiffs' attempt to define rebranding by quoting a leading question in cross-examination does not change the record evidence that customers will benefit from a new product post-close. *Compare* Matheis (Anthem) Tr. 1599:20-25 (the leading question and answer cited by Plaintiffs), *with Id.* at 1605:13-1606:21 (answering the Court's question as to what rebranding means), *and Id.* at 1519:9-1520:11 (describing the combination).

351. The merger will also provide benefits to providers by accelerating the move to value-based care arrangements. Israel Tr. 1881:12-1882:7; DX0160 at ANTM-DDC-001575562; DX0689 at ANTM-DDC-000533147-149, 179-186; *see also* [redacted]. Increased density is the key to value-based reimbursement programs. Drozdowski (Anthem) Tr. 1675:24-1676:11; Singhal (McKinsey) Tr. 1791:11-23; Cordani (Cigna) Tr. 514:12-515:15; [redacted]. The combined firm, with a larger volume of patients and more reliable

patient flow, will make it more profitable and less risky for a provider to enter value-based reimbursement arrangements with the combined firm. Willig Tr. 4598:16-4599:5.

D. Dr. Israel's Merger Simulation Shows Efficiencies Outweigh Any Potential Anticompetitive Effect

352. Dr. Israel presented an economic model of post-merger, sell-side negotiations between insurers and employers, using a merger simulation negotiation model that balances the benefits consumers receive from a strengthened Anthem and Cigna against the potential harm resulting from the merger, and he found the merger to be procompetitive in all ten states at issue in the local large group case. Israel Tr. 4402:4-19 (discussing DDX0498 at 5-6).

1. Dr. Israel's Negotiation Model Is The Appropriate Framework Here

353. The negotiation mode — not the auction model — is the appropriate model to use given the back-and-forth negotiations that occur during the RFP process. *Id.* at 4404:6-4406:2 ("[W]hat is happening here is not an auction. . . . We have heard there is back and forth and multiple rounds and some sharpening of pencils at the end. So it really is a negotiation."); Abbott (WTW) Tr. 87:15-88:6, 161:8-21; Hawthorne (Scott Insurance) Tr. 2991:7-2992:17; Harlin (Wells Fargo) Tr. 3362:10-3363:8, 3364:11-13; De Rosa (Cigna) Dep. 157:11-160:6; Dahms (Anthem) Dep. 253:2-254:1.

354. The second score auction model that Prof. Dranove uses has faulty assumptions that render its results inapplicable to the proposed merger. First, the model assumes that customers do not negotiate with insurers at the final negotiation stage. Israel Tr. 4406:17-4408:10, 4448:22-4449:2. Yet, here, customers utilize brokers who negotiate with payers in order to obtain the best deal for their clients. Mifsud (Melita) Tr. 3223:10-17, 3233:17-3235:2; Mahoney (SML) Tr. 3651:11-20, 3660:13-20; Hawthorne (Scott Insurance) Tr. 2991:7-2992:13;

Abbott (WTW) Tr. 65:11-66:8; Fowdur Tr. 1360:7-1361:1, 1362:18-1363:1. Second, the auction model assumes *zero* pass-through of medical cost savings. Israel Tr. 4406:17-4408:10, 4448:22-4449:2. However, the merged firm will pass through the vast majority of the savings it achieves.

355. Dr. Israel calculated that medical costs savings for self-insured customers are passed through 98% (*Id.* at 1953:19-1954:25, 4360:8-4361:3), and that variable cost savings are passed through 86%. *Id.* at 1953:19-1954:25, 4415:8-15. For fully-insured customers, medical costs are a variable cost, therefore passed through at 86%. *Id.* at 1953:19-1954:25, 4438:11-16. Dr. Israel's negotiation model is therefore conservative when it assumes 50% pass-through. *Id.* at 2026:2-2027:20 (referencing DDX0015 at 50), 4360:18-4361:16.

2. Dr. Israel's Merger Simulation Shows The Merger Is Procompetitive

356. In Phase II, Dr. Israel ran his merger simulation for local large groups by using statewide efficiencies calculated using the best-of-best methodology and statewide shares. *Id.* at 4400:21-24, 4401:11-14, 4402:4-15 (discussing DDX0498 at 2-3); *see also* Dranove Tr. 3726:3-22 (using statewide diversion ratios due to insufficient data at the CBSA level). Dr. Israel used a statewide analysis because CBSAs are too narrow due to the ease of entry and repositioning across CBSAs. Israel Tr. 4402:20-4404:4. As Dr. Fowdur and Dr. Willig showed, CBSAs are unsupportable geographic markets; the relevant markets are at least regional or statewide. *Supra* § III. Moreover, shares based on employee location are inappropriate because employers make the purchasing decisions. Israel Tr. 4402:20-4404:4.

357. Dr. Israel's simulation shows a net benefit from the merger in every state, which is a conservative result, as merger simulations overstate potential harm because they cannot account for entry and repositioning by competitors in response to a price increase. Israel Tr.

4402:20-4404:4. This is particularly true at the CBSA level due to entry and repositioning that takes place at the localized level. Israel Tr. 4402:20-4404:16; see supra §§ V.E-F.

358. Prof. Dranove *never* ran a merger simulation or UPP analysis incorporating medical cost savings. Dranove Tr. 4781:1-4. Rather, at the eleventh hour, on the last day of trial, during his fourth trial examination testimony, Prof. Dranove presented a chart purporting to compare Dr. Israel's efficiencies against Prof. Dranove's harms by CBSA. Dranove Tr. 4736:6-4738:18 (discussing PX0760). PX0760, however, is neither the result of a merger simulation incorporating efficiencies, nor an apples-to-apples comparison; instead, it compares Dr. Israel's statewide efficiencies against Prof. Dranove's alleged CBSA-level harms calculated by using improper market shares that combine Anthem and the Blues. Dranove Tr. 4736:6-18, 4798:4-4801:5; *see also supra* § IV.A.3. Prof. Dranove's last-ditch effort to rectify the fact that he did not run a proper analysis incorporating efficiencies is highlighted by the inconceivable characterization of certain "feature market" CBSAs as those where "*no amount of cost savings could offset employer harm*" — a conclusion that Prof. Dranove himself could not explain or justify, despite the fact that PX0760 had been created under his supervision and produced only one day prior to his testimony. Dranove Tr. 4803:4-9. Dranove Tr. 4803:4-4804:3. This analysis laid bare the flaws in Prof. Dranove's model. Unlike Dr. Israel's model, which fairly balances upward and downward pricing pressure, Prof. Dranove's model is rigged to find harm.

E. Response To The Court's Questions On Merger Savings And Harms

359. At the January 4, 2017 closing session, the Court requested that the Parties provide record cites for each Party's quantifications of savings and harms (Trial Tr. 4859:1-11), and the Court separately raised a question as to whether, according to Dr. Israel's analysis, the merger would result in anticompetitive harm absent efficiencies (Trial Tr. 4919:12-18).

360. The Anthem-Cigna integration team, assisted by McKinsey, calculated $2.6-3.3 billion medical network efficiencies and $2.2-2.36 billion general and administrative (G&A) efficiencies, of which $515 million is variable cost savings. Phase I Findings § VII.B; Drozdowski (Anthem) Tr. 1649:7-11; Matheis (Anthem) Tr. 1460:17-21, 1481:21-1483:7, 1500:24-1508:16; Singhal (McKinsey) Tr. 1801:8-24.

361. Dr. Israel calculated $2.4 billion in medical network savings. Israel Tr. 1830:22-1832:7. He also conducted multiple permutations of the merger simulations — for different sizes of employers across various geographies, in response to the Complaint — to quantify the expected competitive effect of the merger. Israel Tr. 2017:18-2019:2 (National Account, 14-state), 2022:9-2023:12 (National Account, 50-state), 4399:14-4402:14 (local large group, 10 state). The base model of the simulation, presented in Phase I, showed a net benefit of $4.50 per member per month (PMPM). Israel Tr. 2017:18-2019:2 (discussing DDX0015 at 47). The $4.50 PMPM figure is the balancing of $5.26 PMPM of passed-through efficiencies against $0.77 PMPM, which is the model's expected effect from lost competition based on upward pricing pressure to a very small percentage of members (while the $0.77 PMPM figure is not in the trial record, it was included in Dr. Israel's opening report at Table 9). The $0.77 PMPM figure does *not* represent Dr. Israel's estimate of harm as a result of the merger. Indeed, when asked at trial about the merger's competitive effects *absent efficiencies,* Dr. Israel testified that the merger would not lead to higher prices. As he explained, because merger simulations, by definition, show harm when no efficiencies are input (Israel Tr. at 4411:3-5), running the simulation without efficiencies, as Prof. Dranove did, does not provide a meaningful prediction about the impact of the merger. Moreover, because merger simulations overstate harm because they do not account for entry and repositioning, the better way to assess the extent to which the merger will cause

higher prices, regardless of efficiencies, is through econometric analysis of whether the presence of Anthem or Cigna on a bid affects the other's ASO fee bid pricing. Israel Tr. 4411:6-18. Dr. Israel conducted this analysis and found that such presence had no statistically significant effect on ASO fee bids, which shows that Anthem and Cigna are not key competitive pricing constraints on each other. Israel Tr. 4411:6-18, 2007:13-2008:5. Therefore, even without any efficiencies, the merger will not harm consumers.

362. Prof. Dranove never provided a calculation for G&A savings, and he expressly disclaimed being an efficiency expert. Dranove Tr. 4723:6-21. Although Prof. Dranove first asserted a figure of $100 to $500 million in Cigna medical costs savings based on a regression using Dr. Israel's original data (Dranove Tr. 3802:16-3803:5), Prof. Dranove later admitted that his $100 million estimate (based on an inverted U-shaped Cigna function) was unsupported by factual testimony. Dranove Tr. 4797:3-10. Although he criticized Dr. Israel's regression of Cigna medical cost savings, Prof. Dranove said that when Dr. Israel modified his regression to incorporate Prof. Dranove's criticisms, Dr. Israel's medical cost savings rose to $2.7 billion. Dranove Tr. 4795:6-4796:2; DDX0582. Prof. Dranove's own regressions using the updated data estimated Cigna medical cost savings of $700 million to $1.1 billion. Dranove Tr. 4794:10-4796:1. Prof. Dranove's harm estimates ranged from about $450 to $880 million (Dranove Tr. 3737:16-3738:18; PDX0033 at Slide 45), but those figures are unreliable because they were made by inappropriately combining Anthem and the Blues. Dranove Tr. 3862:19-3863:18.

VIII. THE ADMITTED MEDICAL COST SAVINGS ARE NOT MONOPSONY HARM

A. Plaintiffs' Alleged Product Market For The Purchase Of Healthcare Services By Commercial Health Insurers Fails

363. Plaintiffs allege that "the purchase of healthcare services by commercial health insurers" is a relevant product market because "[f]or doctors, hospitals, and other health care providers, there are no reasonable substitutes for the sale of their services to commercial health insurers. Compl. ¶¶ 65, 67. "In response to a reduction in reimbursement rates from those insurers, few providers would be able to compensate for the loss of revenue by selling more services to government programs such as Medicare Advantage, Medicare, or Medicaid." Compl. ¶ 67. Plaintiffs also allege that "government programs generally reimburse providers at far lower rates than do commercial health insurers." Compl. ¶ 67.

364. Plaintiffs' alleged product market excludes government payers and therefore is too narrow. Government payers purchase the same product (healthcare services) from providers, yet Plaintiffs' alleged product market does not account for the substantial amount of payments that providers receive from government payers through the Medicare and Medicaid programs. *See* Dranove Tr. 2445:2-13 (nationally, total hospital spending is 57% government and 43% private payor); DDX0177; *see also* Berfiend (IU Health) Tr. 2909:15-22 (72.4% of IU's gross patient revenue is from Medicare and Medicaid, and only 15% is from Anthem); DX0619 at BonSecours0000000021.0006, DDX0396 ([redacted]); DX0619 at BonSecours0000000021.0008, DDX0397 ([redacted]); Lipman (LRG) Tr. 3319:13-16 (referencing PDX020) (47% of LRG's total revenue is from Medicare and

Medicaid). [redacted]. *See* Rowe (Granite Health) Tr. 2802:7-15; Berfiend (IU Health) Tr. 2873:22-25. Thus, government payors — which can account for the majority of purchases of healthcare services — must be considered in the alleged market.

365. Plaintiffs' opinion that government purchases can be ignored because they are not profitable for providers (Dranove Tr. 3779:9-3780:18), contradicts statements previously made by Plaintiffs. For example, Plaintiffs acknowledge that "public payors (*e.g.*, Medicare and Medicaid) and private payors (*e.g.*, commercial health insurers) do not compete in output markets, but do compete in the market for the purchase of health care providers," and patients using both private and government payers "contribute to the demand that's placed on the physician's time." FTC & DOJ, Improving Health Care: A Dose of Competition Ch.6, at 15 & n.95 (2004), available at https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf. Further, Plaintiffs previously admitted that "in analyzing competitive effects, the Division's analysis took into account all payers for medical services from hospitals and physicians, including government payers, such as Medicare and Medicaid." Dep't of Justice, Background to Closing of Investigation of UnitedHealth Group's Acquisition of Oxford Health Plans (July 20, 2004), available at https://www.justice.gov/archive/atr/public/press_releases/2004/204676.htm.

366. Further, Prof. Dranove's SSNRP test considered only one option available to providers — replacing commercial insurer patients with government patients. Dranove Tr. 3777:22-3779:23. This approach ignores the numerous self-help options that providers can, and do, exercise that could defeat a potential SSNRP such as directly contracting with employers

(Phase I Findings § III.G), launching a provider-sponsored insurance plan (*id.* at III.E), entering joint ventures with insurers (*see e.g.,* Granite Health and Tufts (*see* §V.E.2.a) and Inova and Aetna (*see* §§ V.E.3.a.i, V.E.3.a.iii)), collaborating with TPAs (*supra* § V.E.3.a.i (describing Bon Secours' collaboration with TPA to launch Value Network health plan), [redacted] Wheeler (Bon Secours) Tr. 3398:25-3399:6 (testifying that Bon Secours granted favorable rates to carrier "to stimulate competition"); Berfiend (IU Health) Tr. 2885:23-2886:3; *see also* Dranove Tr. 2315:5-15, 2417:11-14. Similarly, individual physician practices are able to merge, [redacted], which increases their bargaining power as well.

B. The Division Ignores Its Own Guidelines And Prof. Dranove Does Not Conduct A SSNRP Test For The Thirty-Five CBSAs To Show That All Of Them, Or Even Any Of Them, Are Relevant Geographic Markets For The Purchase Of Healthcare Services

367. Prof. Dranove testified that a CBSA is a relevant geographic market for the purchase of commercial health insurance because hospitals would not move to another CBSA in response to a SSNRP, and therefore the alleged markets pass the hypothetical monopsonist test. Dranove Tr. 3783:13-3784:5 (discussing PDX033 at slide 60). However, Prof. Dranove did not conduct a SSNRP test for each of the thirty-five CBSAS. *Id.* at 3985:19-23; Fowdur Tr. 4236:1-9. Nor did Prof. Dranove conduct quantitative analysis of average provider rates for the thirty-five CBSAs. Dranove Tr. 3987:1-5. Instead, Prof. Dranove's entire basis for concluding that a CBSA is a proper geographic market is that a provider would not be able to "pick themselves up and move to another CBSA" or to forego patients. *Id.* at 3783:13-3784:14.

368. However, this is not the appropriate question. *Supra* § III.A. By assuming that full replacement is the only option, Prof. Dranove fails to take into account slicing and other

competitive alternatives. Fowdur Tr. 4214:6-16; *see also* Dranove Tr. 3792:23-3793:19 (noting that providers can refuse demands for lower rates or convince patients to switch to a different carrier, giving them "the ability to punish Anthem downstream if they fail to get a reasonable offer upstream"). He also fails to acknowledge that because many provider systems have facilities both inside and outside of the alleged markets, those systems can punish a hypothetical monopsonist outside of the geographic area where the hypothetical monopsonist operates.

369. As Dr. Fowdur put it, "[t]here are no specific analys[e]s to each of the thirty-five CBSAs that he has done; so we cannot just accept them as being obvious boundaries." Fowdur Tr. 4236:1-9. In addition, Plaintiffs have not explained why CBSAs should be relevant buy-side geographic markets despite the fact that contracting for provider reimbursement rates occurs on a much broader basis, generally across an entire health system regardless of where its facilities are located. *See e.g.*, [redacted].

370. For the reasons discussed above, Plaintiffs have not shown that the thirty-five CBSAs at issue are relevant geographic markets. *Supra* § III.

C. The Merger-Specific Efficiencies Created By Lowering Provider Rates Are Not The Result Of Unlawful Monopsony Power

371. Plaintiffs' witnesses recognized that pooling purchases (including via acquisition) to realize cost savings is commonplace and desirable. *See* Rowe (Granite) Tr. 2795:22-2796:2 ("As a group of six hospitals, we leverage our scale to gain operational efficiencies by jointly purchasing services."); Gorse (Patient First) Tr. 3184:21-3185:6 (explaining that by purchasing centrally, Patient First obtains lower prices). Plaintiffs themselves recognize the procompetitive benefits of combined volume that lead to lower prices when analyzing group purchasing arrangements. *See* Pls.' Proposed Conclusions of Law (Dec. 15, 2016), ECF No. 401, ¶ 61.

372. Despite this broad recognition, Prof. Dranove asserts that acquisitions resulting in increased buying leverage are anticompetitive. By this logic, nearly every horizontal merger (in which the firms purchase common inputs and can pool their purchasing thereafter) would be anticompetitive. Prof. Dranove cited no economic support for such an extreme standard.

373. By contrast, as Dr. Israel testified, it is well established that there are two distinct types of buyer power: monopsony power and bargaining power. Israel Tr. 4416:22-4417:13, 4424:18-4425:10 (discussing DDX0498 at 9), 4496:11-21 (discussing DX0824). The welfare implications, and thus the appropriate enforcement policies, of the two types of buyer power are very different: although both result in lower input prices, monopsony power usually results in higher prices to customers, whereas bargaining power does not. *Id.* at 4424:18-4425:10; DX0825 at 1. The exercise of *bargaining power* by health insurers to get better prices for their customers is procompetitive. *Id.* at 4425:18-4426:6 (discussing DDX0498 at 11).

374. Antitrust law is concerned with adverse competitive effects on *consumers*. Therefore, the default is that lower prices are *procompetitive* and to be encouraged. *See* Israel Tr. 4418:23-4420:12 (economic literature on healthcare insurance supports the view that moving prices toward the competitive level is an economically efficient outcome).

375. Lower prices are anticompetitive *only* in isolated cases where prices are the result of monopsony power, which occurs when (1) prices are being pushed below the competitive level, (2) output is reduced, *and* (3) the lower prices are not passed through to consumers. Israel Tr. 4416:22-4418:22; *see also* Phase I Findings § VII.D. These three conditions all fit together: "[T]he source of the lower prices is that a monopsonist reduces the amount of the input that it purchases . . . in order to shade down the demand and get a better price. And then, as a result of

that, it creates scarcity. There is less of the product being made; and so prices go up in the downstream market. . . . [Cost savings] are not passed through." Israel Tr. 4418:23-4420:12.

1. The Merger Will Move Prices Toward The Competitive Level

376. In economics, the competitive price covers a supplier's cost, plus a reasonable return on capital. *Id.* at 1966:5-1967:10, 4418:23-4420:12. Industries where sellers earn returns above the competitive level will continue to attract investment. *Id.* at 4426:19-4427:23.

377. In both economics and the law, a monopsonist is able to profitably pay less than the competitive price for its purchases. *Id.* at 4490:11-23 (discussing DX0825 at 246). Here, the merger will result in lower provider prices that are closer to, but not below, the competitive level.

378. First, the reduction in provider revenue that will result from the merger is a small fraction of total revenue. Dr. Israel testified that the best-of-best savings constitute 0.5% of the total medical spend in the ten states where Plaintiffs allege monopsony harms. *Id.* at 4417:15-4418:2, 4420:23-4421:10; *see also* Willig Tr. 2229:1-2231:1; Phase I Findings ¶ 324. This small impact was confirmed by Plaintiffs' own witnesses. Henry Lipman of LRG testified that moving Cigna to lower Anthem rates post-merger will result in a 0.7% reduction in LRG's net revenue. Lipman (LRG) Tr. 3289:22-3290:7. [redacted]. Gorse (Patient First) Tr. 3180:6-3181:3 (discussing DX0775), 3183:1-12 (discussing DDX0317). Such a small proportional reduction cannot be deemed to drive prices below the competitive level.

379. Second, there is no evidence that the projected medical cost savings will drive prices below the competitive level for any particular provider, let alone *across* all hospitals in the Anthem footprint. Moreover, notwithstanding the Court's December 20, 2016 ruling on the scope of monopsony testimony going forward, Anthem maintains that it is relevant that the

Parties have stipulated that Medicare prices are intended to cover the cost of care furnished by a reasonably efficient hospital, which comports with public statements made by CMS. *See* Pls.' Stipulation ¶ 8 (Oct. 21, 2016), ECF No. 200 (stipulating that Medicare payments "reflect[] the expected relative costliness of inpatient treatment for patients"); *see also* Israel Tr. 1966:5-1967:10 (noting on DDX0015 at 26 that "Discharge base rates, also known as standardized payment amounts, for operating payments and the Federal rate for capital payments are set for the operating and capital costs that efficient facilities are expected to incur in furnishing covered inpatient services."). Anthem's average reimbursement rates are currently 191% of Medicare rates, and the merged firm will pay estimated average reimbursement rates at 188% of Medicare rates. Israel Tr. 1968:6-1969:6 (discussing DDX0015 at 27). Therefore, the Court need not determine whether Medicare rates perfectly cover costs in every instance. Unless Medicare rates are off by nearly 90%, prices will move toward, not below, the competitive level.

380. Third, as a matter of economics, providers will not agree to accept prices below their marginal cost. Dranove Tr. 3790:15-3792:7 ("marginal cost . . . is the lowest price that any provider would ever accept"). The medical cost savings calculated by taking advantage of the best cost position already obtained by Anthem or Cigna individually therefore will not push prices below the competitive level. Israel Tr. 4421:13-4422:12.

2. Output Will Not Decrease As A Result Of The Merger

a. The Correct Measure Of Output Is Utilization

381. Utilization of medical services is the proper measure of output. In order to obtain lower input prices, a monopsonist decreases its demand for the input in question. Israel Tr. 4423:7-25. In this case, the input is medical services provided by hospitals and physicians. *Id.*

at 4423:7-25. The test for monopsony is, therefore, whether the cost savings will lead to a reduction in medical services (e.g., a reduction in utilization). *Id.* at 4423:7-25.

382. The economic literature confirms that utilization is the proper metric for measuring output in the healthcare industry. *Id.* at 4423:7-25 (referencing economic literature showing that larger insurers are associated with *increased utilization*).

383. Indeed, although Prof. Dranove initially contended that quality rather than utilization is the appropriate measure of output, (*see* Dranove Tr. 2319:20-2320:2), in his third report, he conceded the proper measure of output is the number of office hours and staffing for physicians (i.e., utilization). Israel Tr. 4431:6-19. As Dr. Israel explained, if fewer physicians are available (or available less often) then utilization of physician services, by definition, would go down. *Id.* at 4427:24-4430:1, 4431:6-19.

b. The Merger Will Not Adversely Affect Output

384. Dr. Israel empirically analyzed whether Anthem or Cigna's market share has an effect on utilization (e.g., the number of incidences of care). *Id.* at 1969:21-1971:1, 4422:13-4423:6; *see also* Phase I Findings, § VII.D.2. He found that where Anthem and Cigna have higher shares, patients utilize medical services *more* often, not less. *Id.* at 4422:13-4423:6.

385. Dr. Israel's testimony stands unrebutted because Prof. Dranove conducted no quantitative analysis of output. *See* Dranove Tr. 1164:3-23.

c. Even If Quality Is The Correct Measure, The Merger Will Not Adversely Affect Quality

386. Even if the quality of healthcare services is the proper metric, Dr. Israel determined the merger will not reduce quality. He analyzed the relationship between an

insurer's market share and four well-established quality metrics, and found no statistically significant relationship between shares and healthcare quality. Israel Tr. 1978:18-1979:16.

387. No provider has testified that it has reduced quality of care in response to a reduction in reimbursement rates. [redacted].

388. Moreover, David Cutler, a leading healthcare economist, has stated that 30% of cost in the U.S. healthcare system could be eliminated with no effect on quality. Israel Tr. 1974:19-1975:16.

389. Indeed, testimony during Phase II of the trial confirms the substantial amount of waste, fraud, and abuse present in the industry. *See* Burke (MEA Trust) Tr. 4018:5-17 ("The amount of waste in the system is calculated to be about 40 percent—or, 40 cents on every dollar goes to the wrong care or inappropriate care, mistakes."); Guertin (Anthem) Tr. 3570:24-3572:1 (hospitals overcharge for care by purchasing free-standing outpatient sites and submitting for reimbursement at the higher hospital price); *see also* Phase I Findings ¶ 319 (discussing additional evidence of waste in today's healthcare system).

390. Again, Dr. Israel's analysis stands unrebutted because Prof. Dranove did no empirical analysis of the effects of the merger on healthcare quality. Dranove Tr. 1164:10-23.

3. Cost Savings Generated By The Merger Will Be Passed Through To Customers

391. The hallmark of monopsony power is that lower costs generated on the buy-side are not passed through to consumers on the sell-side. Israel Tr. 4424:1-17. Anthem-Cigna integration planning documents are premised on passing on medical cost savings to consumers. DX0240 at slide 14 (noting the deal's value for employers is "[a]ffordable premiums/reduced

total **cost of care**") (emphasis in original), 23 (identifying "full pass through of lower network costs"); DX0241 at slide 7, 10 (SteerCo presentation defining "Affordability" as "Lower claims PMPM / improved product pricing").

392. Anthem's decision to pass through savings to consumers is a profit-maximizing choice: passing on savings allows the firm to be more competitive, increasing its sales volume and profits. *Cf.* Israel Tr. 1955:10-1956:5. This is Anthem's business model generally and its plan for the combined firm. *See* Matheis (Anthem) Tr. 1519:9-1520:11 (noting that combining Cigna's member engagement with Anthem's lower cost model and better medical management "creates a really nice opportunity" and will generate incremental growth); *see also* DX0057 at slides 6, 8-10 ([redacted]); Matheis (Anthem) Tr. 1465:2-16, 1478:8-15 (discussing DX0240).

393. Dr. Israel performed a regression where he determined the relationship between lower variable administrative costs and ASO fees. Israel Tr. 1953:19-1954:12, 4363:1-5, 4415:8-15. He found that for each $1 decrease in variable administrative costs, insurers pass through 86% of the savings. *Id.* at 1954:13-17, 4415:8-15; *see also* Phase I Findings ¶ 248.

394. Medical cost savings are automatically passed through to self-insured consumers. While there may be some incentive to keep a portion of the savings, Dr. Israel modeled the relationship between a decrease in medical cost savings and the ASO fee charged to consumers and found that for each $1 decrease in medical cost, insurers pass through 98% of the savings to customers. Israel Tr. 1953:19-1954:25, 4360:8-4361:16; *see also* Phase I Findings ¶ 248.

395. For fully-insured customers, Dr. Israel explained that medical costs are variable costs that the insurance company must bear. Israel Tr. 4359:15-4360:7. As such, Dr. Israel's analysis showing that 86% of variable costs are passed through also applies to full-insurance

medical cost savings. *Id.* at 4359:15-4360:7. Additionally, the MLR provision of the ACA mandates that insurers spend at least 85% of premium dollars on medical care, consistent with Dr. Israel's findings. *Id.* at 4497:21-4498:5.

D. Providers Have High Margins And Substantial Market Power In The Sale of Healthcare Services

1. Providers, Including Non-Profit Providers, Have High Margins And High Levels Of Profitability, And Medical Costs Are Only Rising

396. Healthcare providers, including non-profit providers, have high margins and high levels of profitability, and the cost of healthcare is rising each year 5.6% over inflation. Dranove Tr. 2439:17-2440:1. On direct examination of its provider witnesses, and through Prof. Dranove, Plaintiffs elicited testimony on the effect of the merger on provider profitability. On cross-examination, the Plaintiffs' witnesses admitted to high levels of profitability, even post-merger. *See e.g.*, Berfiend (IU Health) Tr. 2908:1-5 (stating that IU Health's total operating income was $324 million); DX0575 at IUH0001188; Marchesini (HCA) Dep. 10:12-19 (HCA's current net income is over $2 billion); Carley (Centura) Dep. 114:19-23 (Centura Health's net revenue is around $2.8 billion). [redacted], (Wheeler (Bon Secours) Tr. 3429:10-3431:8 (discussing DX0620 at 10 and DDX0391)), [redacted] (Taheri (Yale Medicine) Dep. 53:6-14, 61:1-16), and Southern New Hampshire Health System, whose revenue for the 2015 fiscal year totaled approximately $303 million, with a net operating income of $9.7 million. Wilhelmsen (Southern New Hampshire) Dep. 173:21-174:13.

2. Providers Will Retain Substantial Bargaining Power And The Ability To Reject Any Purportedly Anticompetitive Reimbursement Rates

397. Providers' substantial market power is increasing as the trend towards provider consolidation continues. *See* DX0586 at ANTM015513475 [redacted], at ANTM015513477 ("Hospital consolidation activity is up 60% during the most recent 5 year period."); Burke (MEA Trust) Tr. 4028:21-4029:17 (explaining that the consolidation of large hospital systems has "really restrict[ed] the negotiating power of the purchasers" and is much more concerning than the Anthem-Cigna merger); Ramseier (Anthem) Dep. 20:23-21:17; Martenet (Anthem) Dep. 136:15-137:15; DeLacey (WBS) Dep. 36:16-37:23; Roberts (Harvard Pilgrim) 283:2-11, 279:7-280:4; Boudreau (Minuteman) Dep. 61:13-14, 61:16-62:5; DX0563 at PHC_AnthemProd001_0002546; Hurst (Piedmont Healthcare) Dep. 65:1-3; PX0519 at ANTM003921220; Aumock (DaVita) Dep. 145:22-146:20.

398. In many regions, providers' market power is so substantial that they exercise near monopoly power. DX0036 at 19 (some providers have "near monopolies that could result in diminished bargaining power on our part"); DX0547 at ANTM013143718 ([redacted]); DX0541 at ANTM000132230; Papouchian (Blue Shield) Dep. 19:19-20:1, 20:3-4, 20:6-7, 21:9-14, 21:9-17; Martenet (Anthem) Dep. 136:15-137:15; Adams (Centra) Dep. 24:15-26:14, 26:16-27:11.

399. Provider systems are often so dominant that a carrier cannot have a competitive network unless it contracts with that system. King (Anthem) Tr. 3087:1-7 (several hospitals in Virginia are "must-haves"); Martenet (Anthem) Dep. 138:3-139:1, 136:15-137:15; Pogar

(Anthem) Dep. 40:6-21, 103:21-104:15; Brown (Arthur J. Gallagher) Dep. 81:25-82:13; Taheri (Yale Medicine) 94:16-18, 94:21; Schreiber (Anthem) Dep. 433:14-436:15.

400. [redacted]. Carley (Centura) Dep. 26:3-27:3; DX0345 at CHCO0002400; Torcom (Sentara) Dep. 80:25-81:18; DeLacey (WBS) Dep. 52:16-18, 52:20-24, 53:1; Edwards (HealthSCOPE) 85:21-22, 86:3; Van Etten (Kaiser) Dep. 35:3-36:13, 36:15; Papouchian (Blue Shield) Dep. 19:15-20:1, 20:3-4, 20:6-7; Goulet (Former Anthem) Dep. 213:20-24, 214:3-215:18; Aumock (DaVita) Dep. 65:21-66:18.

401. In some cases, provider consolidation has resulted in an imbalance of bargaining power when contracting. [redacted]. Wheeler (Bon Secours) Tr. 3435:9-3436:9, 3408:8-3409:15; King (Anthem) Tr. 3087:1-3088:19, 3094:17-3096:8; Pogar (Anthem) Dep. 36:14-37:22, 294:24-297:10 (insurers are "price takers" in Colorado; Anthem does not "have a lot of negotiating clout" because of provider "consolidation" and because they may "walk away"); DX0631 at ANTM013773720; McCreary (UCHealth) Dep. 47:11-48:12 , 36:23-37:6, 37:15-39:4, 39:6-18; [redacted]; Cavin (Denver Health) Dep. 26:15-28:5; Brendt (Sutter) Dep. 41:7-22, 42:4-14.

402. When negotiating with providers, carriers face not only pressure to maintain a competitive network, but also pressure from customers to keep providers "in-network." King (Anthem) Tr. 3090:4-3092:21, 3093:4-19 (Bon Secours gave notice it was terminating its Anthem contract, which created anxiety with Anthem's customers and required Anthem to make

concessions); Brendt (Sutter) Dep. 77:12-23; Benton (New West Physicians) Dep. 50:14-52:6; Schreiber (Anthem) Dep. 433:14-436:15; Papouchian (Blue Shield) Dep. 49:20-50:5, 50:7-9.

403. [redacted] Wheeler (Bon Secours) Tr. 3415:24-3416:5; Carley (Centura) Dep. 36:2-37:12, 39:1-9; Brendt (Sutter) Dep. 87:24-88:2, 88:4-6; Aumock (DaVita) Dep. 74:14-75:3.

3. Plaintiffs Have Not Proven That The Medical Cost Savings Will Result In Lower Quality Healthcare

404. [redacted]. *See e.g.*, Berfiend (IU) Tr. 2891:14-2892:12 [redacted]; Schumacher (United) Dep. 297:21-298:6, 298:9-10, 298:12-15, 298:18; [redacted]. "[T]here is no consistent relationship between lower spending and lower quality." Israel Tr. 1974:16-1975:16. Dr. Israel's rigorous, empirical analyses also prove that healthcare quality will not be reduced on account of the merger.

405. Ultimately, Prof. Dranove did no empirical analysis to determine if (1) prices will move below the competitive price, (2) output will be reduced, or (3) lower prices will not be passed through. Dr. Israel is the *only* expert to empirically analyze monopsony, and his work stands unrebutted. The medical cost savings are not the result of monopsony power, but rather a procompetitive reduction of costs that directly benefits customers, and should thus be credited.

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Respectfully submitted,

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