ORAL ARGUMENT SCHEDULED MARCH 24, 2017

No. 17-5024

United States Court of Appeals
for the District of Columbia Circuit

UNITED STATES OF AMERICA, *et al.*,

Plaintiffs-Appellees,

v.

ANTHEM, INC.,

Defendant-Appellant

On Appeal from the United States District Court
for the District of Columbia
Civil Action No. 1:16-CV-01493-ABJ (HON. AMY BERMAN JACKSON)

AMICUS CURIAE BRIEF OF AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF APPELLEES AND AFFIRMANCE

Melinda Reid Hatton
AMERICAN HOSPITAL ASSOCIATION
800 Tenth Street, N.W.
Two City Center, Suite 400
Washington, D.C. 20001
(202) 638-1100

Douglas C. Ross*
David A. Maas
Davis Wright Tremaine LLP
1919 Pennsylvania Avenue NW
Suite 800
Washington, D.C. 20006-3402
(202) 973-4200
douglasross@dwt.com
davidmaas@dwt.com

March 16, 2017

**Counsel of Record for American Hospital Association*

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to Circuit Rule 28(a)(1), counsel for American Hospital Association hereby certify:

(A) Parties.

All parties appearing in this Court and before the district court are listed in the Brief for Plaintiffs-Appellees.

(B) Rulings Under Review

References to the ruling at issue appear in the Brief for Plaintiffs-Appellees.

(C) Related Cases

American Hospital Association adopts the statement of related cases presented in the Brief for Plaintiffs-Appellees.

CORPORATE DISCLOSURE STATEMENT

The American Hospital Association (AHA) has no parent company and no publicly held company holds more than a ten percent interest in AHA. AHA is a trade association as that term is used in CR 26.1(b). AHA represents hospitals, health care systems, networks, and other providers of care, as well as individual members.

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I. INTRODUCTION AND INTEREST OF AMICUS CURIAE[1]

The American Hospital Association (AHA) is a national organization that represents nearly 5,000 hospitals, health care systems, networks, and other providers of care, as well as 43,000 individual members. Hospitals and health systems operate in a health care market that is continually evolving. The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 accelerated structural changes that have produced an unprecedented realignment in the provision of health care. This realignment will continue regardless of the changes that may be effected in the ACA.

Hospitals and their physician partners are in the midst of a shift from the traditional fee-for-service payment system to new and innovative reimbursement models that reward providers for improving patient outcomes and controlling the total cost of care provided. This change requires that providers and payers think differently about their usual places on opposite sides of the negotiating table. Historically, providers and payers have negotiated over the price at which services are offered. But the total cost of caring for a patient depends on what services are provided to the patient and the quality of the care provided. More services do not always lead to better outcomes—as has been documented repeatedly, often the

[1] No counsel for a party authored this brief in whole or in part, and no person or entity other than *amicus curiae* or its counsel contributed funds toward the preparation or submission of this brief.

reverse is true. *See, e.g.*, J. Michael McWilliams, M.D., et al., *Performance Differences in Year 1 of Pioneer Accountable Care Organizations*, New Engl. J. Med. 2015; 372:1927-36 (May 14, 2015)[2]; Alliance of Community Health Plans, *Rewarding High Quality: Practical Models for Value-Based Physician Payment*, 2014 Report (Apr. 20, 2016).[3] Increasingly, hospitals, physicians, and some payers, have recognized that to ensure the right care is provided to a patient, payment systems should focus on patient outcomes. A payment system that rewards good outcomes, obtained through efficient delivery of appropriate health care tailored for an individual patient, aligns the interests of patients, providers, and payers alike.

The success of such "value-based" reimbursement models depends critically on the willingness of payers to experiment, innovate, and collaborate with hospitals and physicians to develop new payment methodologies that go beyond the old fee-for-service system. The record in this case suggests Anthem has been less willing than Cigna to innovate to develop value-based reimbursement systems. The district court highlighted substantial evidence that underscores Cigna's particular reliance "upon innovation to compete," and "its focus on ways to improve member health and employer cost outcomes." Opinion at 90. If Anthem acquires Cigna, that focus on innovation will be lost, to the detriment of health care consumers.

[2] http://www.nejm.org/doi/full/10.1056/NEJMsa1414929#t=article.
[3] https://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf.

Anthem disagrees, claiming it is committed to innovation too. But, as the district court recognized, resolution of the Government's challenge to the pending acquisition does not require that "the Court … decide who was first to move in a particular direction or which company innovates more. The question to be decided is whether the transaction would reduce the new firm's incentive to innovate in the relevant market …." Opinion at 89. Because the proposed acquisition would "reduc[e] the number of national carriers from four to three," Opinion at 65, the acquisition "would reduce the new firm's incentive to innovate in the relevant market," Opinion at 89. Any loss of innovation in this market would have far-reaching consequences: As the district court found, relying on testimony from an Anthem witness, "national accounts in particular are considered to be the 'innovation incubators' for the entire industry. *Id.* (quoting Kendrick (Anthem) Tr. 1180). "They push carriers to enhance plan design, customer service, technology, and data security, and the innovations they spur are often deployed to other customers and segments." *Id.*

The district court's findings are consistent with the realities that hospitals and health systems experience every day. Hospitals understand that when payer markets are competitive, payers are more willing to work with hospitals (and physicians) to design innovative solutions to encourage and reward the delivery of better care at a competitive price. When payer markets are concentrated, payers—

and in particular, this often specifically means Anthem—are slow to shift from traditional fee-for-service reimbursement to systems that reward the ability to deliver better outcomes. If Anthem were permitted to acquire Cigna the pace of innovation would slow, to the detriment of providers and consumers. The injunction issued by the district court, stopping the acquisition, prevents significant consumer harm that would follow the acquisition, and so should be affirmed.

II. ARGUMENT

A. The Acquisition Will Reduce Innovation at a Time When Innovation Is Most Needed

1. Innovative Payment Models Are Critical to Sustainable Health Care

The American health care system is undergoing substantial transformation. The way consumers and insurers pay for care is changing; so is the way insurers and providers work together to deliver care. Tangible examples of that transformation were included in the ACA. That law included an emphasis on developing alternatives to volume based reimbursement. Prior to its enactment, one observer commented:

> Serious problems exist with the quality and cost of health care today. One major cause of these problems is that current payment systems encourage volume-driven care, rather than value-driven care.… [C]urrent payment systems often penalize providers financially for keeping people healthy, reducing errors and complications, and avoiding unnecessary care. Fortunately, alternative payment systems exist that encourage both higher quality and lower costs by giving providers greater responsibility for the factors driving health care costs.

Harold D. Miller, *From Volume To Value: Better Ways To Pay For Health Care*, 28 Health Aff. 5, 1418, 1418 (Sept./Oct. 2009) (footnote omitted).[4]

One of the early experiments with alternatives to volume driven care was the capitation model—where a fixed payment is made on behalf of an insured person in return for a promise that medically necessary services will be delivered to the insured. The incentive this system may create was bitingly described by Judge Posner two decades ago in *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995). He suggested that the incentive created for an entity accepting capitation "is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible." *Id.* at 1410.

Newer, more sophisticated, payment models provide incentives for providers and payers to accelerate their migration from fee-for-service systems that incentivize the provision of unneeded services, or pure capitation models that incentivize the withholding of needed services, to innovative models that focus on what the patient needs, while actively encouraging appropriate cost control. So, for example, the ACA included "critical" value-based reimbursement "initiatives, including the Medicare Shared Savings Program, value based payments to hospitals, and others." *See, e.g.*, Bruce Fried & David Sherer, *Value Based*

[4] http://content.healthaffairs.org/content/28/5/1418.full.pdf+html.

Reimbursement: The Rock Thrown into the Health Care Pond, Health Aff. Blog (July 8, 2016).[5] More recently, "Congress doubled down on the value-based reimbursement bet," enacting changes to the Medicare program designed to increase the use of value-based reimbursement in the provision of services to Medicare beneficiaries. *Id.* The Centers for Medicare and Medicaid Services (CMS) have a dedicated Center for Medicare and Medicaid Innovation, which was created "for the purpose of testing innovative payment and service delivery models to reduce program expenditures… while preserving or enhancing the quality of care provided to individuals." CMS Report to Congress (Dec. 2016) at 1–2 (internal quotation marks omitted).[6] The Medicaid program encourages value-based solutions, and plans offered on health benefit exchanges incorporate value-based reimbursement models as well. Vernon K. Smith, et al., *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*, Kaiser Commission on Medicaid and the Uninsured (Oct. 13, 2016)[7] (Medicaid); Fried & Sherer, *supra* (health benefit exchanges).

Value-based reimbursement models include episode-of-care payments—"that is, paying a single price for all of the services needed by a patient during an

[5] http://healthaffairs.org/blog/2016/07/08/value-based-reimbursement-the-rock-thrown-into-the-health-care-pond/.
[6] https://innovation.cms.gov/Files/reports/rtc-2016.pdf.
[7] http://kff.org/medicaid/report/implementing-coverage-and-payment-initiatives-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2016-and-2017.

entire episode of care." Miller at 1419. Payment on this basis "gives the provider responsibility for one additional factor in the health cost equation: the number and types of services within an episode. For example, once a patient has a heart attack, a single payment would be made to a provider for all care needed by that patient to treat that heart attack." *Id*. at 1420. This model creates an incentive "to eliminate any unnecessary services within the episode." *Id*. Although payments for episodes of care may represent an advance over traditional fee-for-service payment, payment on this basis alone "does not create any constraint on the number of episodes of care." *Id.* Capitation creates an incentive to reduce episodes but, as noted above, by placing the financial risk for sick patients on providers, may create the perverse incentives described by Judge Posner in *Marshfield Clinic*. But if capitation payments are adjusted according to the health status of the patients under the care of a provider, "a provider gets paid more for taking care of sicker patients but not for providing more services to the same patients." *Id*. at 1420–21. Other models with which providers and payers are experimenting would pay more (or less) depending on a patient's outcome. *See* Rob Houston, *Maintaining the Momentum: Using Value-Based Payments to Sustain Provider Innovations*, Ctr. for Health Care Strategies (Mar. 14, 2016).[8] Such models can create incentives for providers to hire care coordinators to manage the health needs of patients and to

[8] http://www.chcs.org/maintaining-the-momentum-using-value-based-payments-to-sustain-provider-innovations/.

hire nurses who will visit patients after discharge from the hospital to ensure they are taking their medications and have appropriate home care. *See, e.g.*, Richard B. Salmon, et al., *A Collaborative Accountable Care Model In Three Practices Showed Promising Early Results On Costs And Quality of Care*, 31 Health Aff. 11, 2379, 2380 (Nov. 2012)[9] (describing successes of innovative value-based care including Cigna's Collaborative Accountable Care initiative). These simple steps can promote patient wellbeing while simultaneously lessening the chance of expensive readmissions to the hospital. *Id.*; *see also* Aparna Higgins, et al., *Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers*, 30 Health Aff. 9, 1718, 1727 (Sept. 2011)[10] (finding quality improvements under accountable care model around ten percent, readmissions and total inpatient days decreased by fifteen percent, and annual savings of over $300 per patient).

These and other similarly creative solutions work only if providers and payers are both willing participants—it takes two to tango. Innovation requires an investment of time and money to succeed. Providers seek payers who are willing to work with them to control costs while improving quality. Large national insurers can be either good or poor partners in this dance. They can be good partners because they have the resources and scale to experiment. *See* Trial Tr.

[9] http://content.healthaffairs.org/content/31/11/2379.full.pdf+html.
[10] http://content.healthaffairs.org/content/30/9/1718.full.pdf+html.

11/29/16,1180:6–20 (Kendrick); PX 94. But they can be poor partners if they are not spurred on by aggressive competitors to change old habits.

The market cannot rely on small players and new entrants to provide the competition needed to spur incumbents to adopt innovative solutions, nor can these small and new entrants consistently develop innovative and workable solutions on their own. Innovative, value-based reimbursement models frequently require large numbers of lives, making it all but impossible for new entrants to compete with the large, national players like Anthem and Cigna. Even tech darling Oscar—one of the few startups on the payer side to make any headway in recent years—has posted massive losses while it tries to succeed in the marketplace. *See* Zachary Tracer, *Losses Mount for Obamacare Startup Oscar as Repeal Looms*, Bloomberg News, Feb. 28, 2017.[11]

Employers, who pay for most commercial health insurance in the U.S., are demanding more innovative, value-based options. As a consultant to Fortune 500 companies testified at trial, there is growing interest among large employers in adopting sophisticated technology and continuing innovation to reduce health care costs and improve employee health. *See* Trial Tr. 11/21/16, 73:24–77:9 (Abbott). National insurers have focused on innovation as a way to compete for these accounts. In this environment, Anthem has been challenged to win business

[11] www.bloomberg.com/news/articles/2017-02-28/losses-mount-for-obamacare-startup-oscar-as-law-s-repeal-looms.

because its "account teams … were not really being consultative, not really helping [the clients] understand what was driving their costs, not bringing new solutions or innovation to them." Trial Tr. 11/28/16, 780:3–15 (Smith).

While Anthem remains resistant to value-based reimbursement, especially in markets where it has substantial share, hospitals and healthcare providers are embracing the new world of value-based care. New collaborations are the product of tremendous investments of time, money and effort by hospitals. Permitting an acquisition that will reduce the market for national insurers from four to three will lessen the incentive of all players in the market to innovate—to the detriment of patients.

2. The Antitrust Laws Are Intended to Promote Innovation, Including by Preventing Acquisitions that Would Harm Innovation

The Supreme Court has emphasized that the antitrust laws must "safeguard the incentive to innovate." *Verizon Commc'ns Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 407 (2004). It is no surprise, then, that innovation plays an important role in merger analysis. The district court understood this. Quoting the Horizontal Merger Guidelines (§ 6.4), the court observed, "A merger can substantially lessen competition by diminishing innovation if it would 'encourag[e] the merged firm to curtail its innovative efforts below the level that would prevail in the absence of the merger.'" Opinion at 89. Other district courts

within this Circuit similarly have recognized the importance of innovation in merger analysis. *See, e.g.*, *United States v. H&R Block*, 833 F. Supp. 2d 36, 79 (D.D.C. 2011) (relied on by the district court below: anticompetitive harm would follow from the loss of an "aggressive competitor" with an "impressive history of innovation").

The focus on innovation in merger cases "has become an increasingly important focus … over the past twenty-five years." Howard A. Shelanski, *Information, Innovation, and Competition Policy for the Internet*, 161 U. Pa. L. Rev. 1663, 1670 (2013); *see also* Michael L. Katz & Howard A. Shelanski, *Mergers and Innovation*, 74 Antitrust L.J. 1 (2007) (collecting merger cases in which the impact on innovation was considered). As the Sixth Circuit wrote in a hospital merger case, relying (as did the district court here) on the Horizontal Merger Guidelines, increased market power (the harm merger law seeks to prevent) permits a firm to "raise price, reduce output, ***diminish innovation***, or otherwise harm consumers as a result of diminished competitive constraints or incentives." *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 565 (6th Cir. 2014) (quoting Horizontal Merger Guidelines § 1) (emphasis added); *see also C.R. Bard, Inc. v. M3 Sys., Inc.*, 157 F.3d 1340, 1372 (Fed. Cir. 1998) ("antitrust jurisprudence has well understood that the enforcement of the antitrust laws is self-defeating if it chills or stifles innovation").

Innovators often are smaller firms that must find different ways to compete if they are to succeed against entrenched incumbents. An acquisition that eliminates a "maverick" firm—"a firm that plays a disruptive role in the market to the benefit of customers"—may lessen competition in violation of Section 7. Horizontal Merger Guidelines § 2.1.5 (U.S. Dep't of Justice & FTC) (Aug. 19, 2010).[12] The district court in *H&R Block* identified the target firm in that merger as a maverick that played "a special role" in the market, finding that its elimination would harm competition. 833 F. Supp. at 79–80. Similarly, the district court in *FTC v. Staples, Inc.*, 970 F. Supp. 1066 (D.D.C.1997) held the merger there "would result in the elimination of a particularly aggressive competitor in a highly concentrated market" and this was "certainly an important consideration when analyzing possible anticompetitive effects." *Id.* at 1083*; see also FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 146 (D.D.C. 2004) ("An important consideration when analyzing possible anticompetitive effects is whether the acquisition would result in the elimination of a particularly aggressive competitor in a highly concentrated market.") (citation and internal quotation marks, alteration omitted); Commentary on the Horizontal Merger Guidelines § 2 (U.S. Dep't of Justice and FTC) (Mar. 2006)[13] ("The Agencies may find that a proposed merger would be likely to cause significant anticompetitive effects with respect to innovation or

[12] https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf.
[13] https://www.justice.gov/atr/file/801216/download.

some other form of non-price rivalry. Such effects may occur in addition to, or instead of, price effects.").[14]

3. Anthem's Acquisition of Cigna Would Harm Competition by Reducing Innovation in the Market for the Sale of Health Insurance to National Accounts in the Fourteen Anthem States

The district court carefully considered the evidence when it found Anthem's acquisition of Cigna "will reduce innovation in the market." Opinion at 89. The court's analysis of the acquisition's impact on innovation strongly supports its conclusion that the effect of this acquisition may be substantially to lessen competition. The court's innovation analysis is supported by a large body of evidence and is consistent with the experience of hospitals and health systems who have opposed this acquisition as a significant blow to their efforts to work to implement value-based payment models that encourage providers and payers to focus on patients.

A witness from a prominent health care consulting firm testified that when it comes to selling to large national accounts, there are only four significant players: "Aetna, Anthem, Cigna, and UnitedHealthcare …. We don't tend to include anyone else in that list." Opinion at 37 (quoting Sharp (Aon Hewitt) Dep. 91). Anthem's own documents describe the market as "consolidated," Opinion at 66 (citing PX 121), and show that Anthem (together with other Blues), United, Cigna,

[14] https://www.justice.gov/atr/file/801216/download.

and Aetna control 83% of the market for commercial health plans sold to national accounts, Opinion at 66 (citing PX 63).

If the "list" of significant players is reduced from four to three, as it would be should Anthem acquire Cigna, Anthem's incentive to innovate—never substantial—would decline precipitously and Cigna—the more innovative of the two—would disappear as an independent competitor. Anthem trumpets its claim to "have the best overall discount position in the market" but admits that as a result, its "competitors have a strong incentive to be more aggressive and flexible" with value-based programs. Trial Tr. 11/30/16 1666:13–24 (Drozdowski) (quoting PX 374).

The evidence at trial showed that Cigna, one of those competitors, is known for being more dynamic, value-centric, and customer-focused. Guilmette 5/3/16 Dep. 48:22–49:16; Phillips 4/14/16 Dep. 174:3–8, 175:22–176:5. Cigna differentiates itself from Anthem and the other large national carriers by being ahead of the curve on innovative, value-based solutions that align the incentives of insurers, providers, employers, and patients. Trial Tr. 11/22/16, 401:23–402:22, 415:7–421:5 (Cordani); Muney 4/6/16 Dep. 151:3–152:9; Manders 6/2/16 Dep. 267:18–21. Cigna often has led the way in offering programs and plans designed to "[k]eep[] the healthy and at risk from becoming sicker." DX 324 at -237. Cigna separates itself by fostering collaborative, value based partnerships with health care

professionals and hospitals. Trial Tr. 11/23/16, 711:8–712:21 (Thackeray); 781:20-782:7 (Smith). Cigna has adopted an organization-wide strategy to strengthen its provider collaborations through value-based care programs. Manders 6/2/16 Dep. 37:19–38:5; Evanko 3/29/16 Dep. 25:18–26:13, 28:6–30:8. Cigna has more than "300 hospital collaboratives and nearly 100 specialty collaboratives, like oncology, orthopedics." Trial Tr. 11/28/16, 779:14–18 (Smith). Evidence at trial showed Cigna has had important successes in provider collaboration: "78 percent of [Cigna's provider collaborations] showed improvements in quality under a pay-for-value model." Trial Tr. 11/28/16, 772:23–774:1 (Smith); Trial Tr. 11/28/16, 779:19–23 (Smith) (Cigna's provider collaborations "are doing extremely well on their financial and quality metrics.").

By focusing on better health outcomes and innovative patient-centric programs, Cigna can compete with Anthem, even when Anthem has lower rates. As the district court found, "Cigna's innovation in the market, in turn, spurred even those carriers with strong provider discounts to improve their products." Opinion at 91. Cigna has actually monetized its more innovative approach to compete directly with, and take market share from, Anthem. *See*, *e.g.*, PX 617 (internal Cigna email discussing targeting Anthem to take market share). With a clear leg up on Anthem in innovation, the testimony at trial showed Cigna's efforts to

collaborate with providers are stronger and more flexible than Anthem's. Trial Tr. 11/28/16, 982:11–21 (Dranove).

Without this acquisition, Cigna will remain an independent and aggressive competitor through innovation and renewed focus on value-based care. Trial Tr. 11/22/16, 444:17–447:13, 454:6–8, 456:2–8 (Cordani). Cigna also will be positioned to continue its trajectory as a market leader in provider collaborations. And Cigna will continue to spur Anthem—and other insurers—to innovate more in an effort to keep market share.

If Anthem acquires Cigna, it will put a quick end to these significant consumer benefits.

4. Post-Acquisition, Anthem Would Be Even Less Likely to Innovate Than It Is Today

Before the district court, and now on appeal, Anthem promises that after the acquisition of Cigna it will become more innovative. Appellant's Br. at 28; Trial Tr. 11/30/16 1670:17–20 (Drozdowski); Anthem's Proposed Findings of Fact, Dkt. 417 at 295–97. The promise is a curious one. Nothing prevents Anthem from embracing value-based billing and becoming an innovator ***without*** this acquisition. Testimony at trial, however, showed that Anthem has been prodded to innovate only in markets where sufficient competition exists—from firms such as Cigna—that compel it to innovate. Anthem admitted it is less responsive to customers and providers in markets where it has a dominant position. Hillman Dep. (5/5/2016)

193:21–22 (Plan President of Indiana—one of Anthem's strong, established markets, writing, "there are some customers, some prospects who loathe us"). By contrast, where Anthem has a smaller market share, it has been more likely to work with providers on innovative, value-based solutions. Anthem's Plan President of Colorado stated as much in an internal email:

> ***As you know, we do not have market share like other states nor a significant discount advantage. As a result, we need to create "value" in other ways.*** For example, we have focused on a strong provider collaboration strategy, member engagement and service strategy (which includes well-being), and a more competitive mid market ASO strategy. The Cigna acquisition is extremely complementary to these initiatives.

PX 554 (emphasis added).

Anthem's behavior is consistent with basic economic principles that predict the more dominant a firm is, the less likely it is to innovate. As one noted health care economist observed:

> [T]here is no evidence that larger insurers are more likely to implement innovative payment and care management programs.… [and there is] a countervailing force offset[ting] the incentive to invest in … [reform]: … [more] dominant insurers in a given insurance market are less concerned with the possibility of ceding market share.

Leemore S. Dafny, *Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience*,1845 The Commonwealth Fund 33 at 7–8 (Nov. 2015).[15] The proposed acquisition would allow Anthem to retreat from its

[15] http://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-insurance-industry-consolidation.

participation in the value-based care movement in markets where Cigna's presence has compelled Anthem to offer such care to compete. The Court recognized that if Anthem proceeds with the acquisition, the "planned movement of Cigna members to the Blue brand that will be necessary … will also inhibit Cigna's incentive to innovate." Opinion at 91.

Anthem's promise to become more of an innovator when Cigna is taken firmly under its wing seems especially unlikely given the uneasy relationship between the two companies displayed before, during, and since trial. In a lawsuit Cigna filed immediately after the trial, Cigna claims actions Anthem took after the acquisition agreement was signed impair Cigna's ability to innovate and compete. *See* Complaint, *Cigna Corp. v. Anthem Inc. et al.*, No. 2017-0109-JTL (Del. Ch. Ct. Feb. 14, 2017) (public version filed Feb. 23, 2017). Cigna alleges that "in its post-trial proposed findings of fact, Anthem abandoned any pretense of seeking to acquire Cigna for its innovative offerings or its pioneering value-based care." *Id.* ¶ 70. Instead, Anthem's proposed findings stated that ***it*** "led the competition in value-based initiatives and that Cigna was unable to do value-based care effectively, called Cigna a second tier competitor, and sought to discredit Cigna's growth model." *Id.* Cigna charges that Anthem's changed tune "reinforce[es] the government's argument that Anthem had pursued the transaction with the aim of eliminating an innovative competitor in the industry." *Id.* (alteration omitted).

Anthem wasted no time filing a caustic countersuit, alleging Cigna sabotaged the acquisition. *See* Complaint, *Anthem, Inc. v. Cigna Corp.*, No. 2017-0114-JTL (Del. Ch. Ct. Feb. 17, 2017) (public version filed Feb. 23, 2017).

While the now-bitter rivals' cross-claims have not been adjudicated, the very fact they were made underscores the improbability, should the acquisition occur, that anything will remain of the Cigna way of doing business.

III. CONCLUSION

The transformation from fee-for-service to value-based reimbursement will improve patient outcomes and better control health care costs. Hospitals and health systems cannot deliver these innovations unless insurers are willing to partner with them to develop more collaborative reimbursement models. The market for the sale of health insurance to national accounts in the fourteen Anthem states is already highly concentrated. The acquisition will have serious anticompetitive effects in this market, as detailed at length in the district court opinion. A particularly pernicious anticompetitive effect will be to harm innovation. Hospitals and health systems have a particular interest in working to maintain and even accelerate the momentum hospitals have developed to improve quality, while making care more affordable for patients. But providers cannot go it alone. Hospitals need payers willing to collaborate to deliver better quality care

for less. Permitting Anthem to acquire Cigna will cause tremendous damage to innovation and so to health care consumers.

The AHA respectfully requests that the district court order enjoining the proposed acquisition be affirmed.

Dated: March 16, 2017

Respectfully submitted,

/s/ Douglas C. Ross

DOUGLAS C. ROSS
DAVID A. MAAS
Davis Wright Tremaine LLP
1919 Pennsylvania Avenue N.W., Suite 800
Washington, D.C. 20006-3402
(202) 973-4200
douglasross@dwt.com
davidmaas@dwt.com

-and-

Melinda Reid Hatton
AMERICAN HOSPITAL ASSOCIATION
800 Tenth Street, N.W.
Two City Center, Suite 400
Washington, D.C. 20001

Counsel for Amicus Curiae American Hospital Association

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7) because it contains 4,321 words, excluding the parts of the brief exempted by Circuit Rule 32(a), as determined by the word-counting feature of Microsoft Word.

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman.

Dated: March 16, 2017

/s/ Douglas C. Ross
Douglas C. Ross

Counsel for Amicus Curiae American Hospital Association

CERTIFICATE OF SERVICE

I hereby certify under Circuit Rule 25(a), that on this 16th day of March, 2017, I electronically filed the foregoing Brief for *Amicus Curiae* American Hospital Association with the Court using the CM/ECF system. All participants in the case are registered CM/ECF users and will be served by the appellate CM/ECF system as follows:

Scott Anthony Westrich
James Joseph Fredricks
Kristen Ceara Limarzi
Mary Helen Wimberly
U.S. Department of Justice
(DOJ) Antitrust Division
Appellate Section
scott.westrich@usdoj.gov
james.fredricks@usdoj.gov
kristen.limarzi@usdoj.gov
maryhelen.wimberly@usdoj.gov

Counsel for Plaintiff-Appellee,
United States of America

Paula Lauren Gibson
CA Office of the Attorney General
paula.gibson@doj.ca.gov

Counsel for Plaintiff-Appellee,
States of California

Rachel Olivia Davis
CT Office of the Attorney General
rachel.davis@ct.gov

Counsel for Plaintiff-Appellee,
States of Connecticut

Loren L. AliKhan
D.C. Office of the Attorney General
Loren.AliKhan@dc.gov

Counsel for Plaintiff-Appellee,
District of Columbia

Daniel Stephen Walsh
GA Office of the Attorney General
dwalsh@law.ga.gov

Counsel for Plaintiff-Appellee,
State of Georgia

Layne Marshall Lindebak
IA Office of the Attorney General
Layne.Lindebak@iowa.gov

Counsel for Plaintiff-Appellee, State of Iowa

Ellen Schiff Cooper
MD Office of the Attorney General
ecooper@oag.state.md.us

Counsel for Plaintiff-Appellee, State of Maryland

Irina Cristina Rodriguez
NY Office of the Attorney General
irina.rodriguez@ag.ny.gov

Counsel for Plaintiff-Appellee, State of New York

Tyler Timothy Henry
VA Office of the Attorney General
thenry@oag.state.va.us

Sarah Oxenham Allen
VA Office of the Attorney General
SOAllen@oag.state.va.us

Counsel for Plaintiff-Appellee, Commonwealth of Virginia

Christina M. Moylan
ME Office of the Attorney General
christina.moylan@maine.gov

Counsel for Plaintiff-Appellee, State of Maine

Jennifer Lynne Foley
NH Office of the Attorney General
Jennifer.Foley@doj.nh.gov

Counsel for Plaintiff-Appellee, State of New Hampshire

Devin Laiho
CO Attorney General's Office
devin.laiho@coag.gov

Counsel for Plaintiff-Appellee, State of Colorado

Victor J. Domen, Jr.
Office of the TN Attorney General & Reporter
vic.domen@ag.tn.gov

Cynthia Elaine Kinser
TN Office of the Attorney General
cynthia.kinser@ag.tn.gov

Counsel for Plaintiff-Appellee, State of Tennessee

Christopher Mark Curran
J. Mark Gidley
Noah A. Brumfield
Matthew Sterrett Leddicotte
George Lovell Paul
White & Case LLP
ccurran@whitecase.com
mgidley@whitecase.com
nbrumfield@whitecase.com
mleddicotte@whitecase.com
gpaul@whitecase.com

Counsel for Defendant-Appellant, Anthem, Inc.

Craig Aaron Benson
Charles F. Rule
Paul, Weiss, Rifkind, Wharton & Garrison LLP
cbenson@paulweiss.com

Counsel for Defendant-Appellee, Cigna Corporation

Steven G. Bradbury
Paul T. Denis
Brian Rafkin
Dechert LLP
bradbury@dechert.com

Counsel for Amici Curiae: Michael Akeman, Dr Benoît Durand, Jerry A. Hausman, Dr. Gregory K. Leonard, Prof. Will Mitchell, Prof. Melissa A. Schilling, J. Douglas Zona Ph.D.

Richard A. Levie
JAMS
rlevie@jamsadr.com

Special Master

Joe R. Whatley, Jr.
Whatley Kallas, LLP
jwhatley@whatleykallas.com

Counsel for Amici Curiae American Medical Association and Medical Society of the District of Columbia

Pursuant to Circuit Rule 31(b), an original and eight copies of the Brief of

will be delivered to the Clerk's Office.

Dated: March 16, 2017

/s/ *Douglas C. Ross*
Douglas C. Ross