MERGER ANTITRUST LAW

Unit 17: UnitedHealth/Change

Class 25

Professor Dale Collins
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UnitedHealth/Change

OptumInsight and Change Healthcare Combine to Advance a More Modern, Information and Technology-Enabled Health Care Platform

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- **Accelerates work to improve outcomes and experiences and lower the cost of health care**

EDEN PRAIRIE, Minn. and NASHVILLE, Tenn.: Optum, a diversified health services company and part of UnitedHealth Group (NYSE: UNH), and Change Healthcare (NASDAQ: CHNG), a health care technology leader, have agreed to combine. Change Healthcare will join with OptumInsight to provide software and data analytics, technology-enabled services and research, advisory and revenue cycle management offerings to help make health care work better for everyone.

This combination unites two technology and service companies focused on serving health care. Their combined capabilities will more effectively connect and simplify core clinical, administrative and payment processes - resulting in better health outcomes and experiences for everyone, at lower cost. Change Healthcare brings key technologies, connections and advanced clinical decision, administrative and financial support capabilities, enabling better workflow and transactional connectivity across the health care system. Optum brings modern analytics, comprehensive clinical expertise, innovative technologies and extensive experience in improving operational and clinical performance.

“Together we will help streamline and inform the vital clinical, administrative and payment processes on which health care providers and payers depend to serve patients,” said Andrew Witty, President of UnitedHealth Group and CEO of Optum. “We’re thrilled to welcome Change Healthcare’s highly skilled team to create a better future for health care.”

“This opportunity is about advancing connectivity and accelerating innovations and efficiencies essential to a simpler, more intelligent and adaptive health system. We share with Optum a common mission and values and importantly, a sense of urgency to provide our customers and those they serve with the more robust capacities this union makes possible,” said Neil de Crescenzo, President and CEO of Change Healthcare. Upon closing, Mr. de Crescenzo will serve as OptumInsight’s chief executive officer, leading the combined organization.

Some of the key opportunities to enhance the health care system include:

- The combined company will help clinicians make the most informed and clinically advanced patient care decisions, more quickly and easily. Change Healthcare brings widely adopted technology for integrating evidence-based clinical criteria directly into the clinician’s workflow, while Optum’s clinical analytics expertise and Individual Health Record can strengthen the evidence base needed to deliver effective clinical decision support at the point of care. This can ensure appropriate sites of care and consistently achieve the best possible health, quality and cost outcomes.

- Complexities across the health system result in significant levels of administrative waste. The combined company will be well positioned to make health care simpler, more efficient and more effective. A key opportunity is to enhance with insights drawn from billions of claims transactions using Change Healthcare's intelligent health care network, combined with Optum's advanced data analytics. This will support significantly faster, more informed and accurate services and processing.

- Change Healthcare's payment capacities combined with Optum's highly automated payment network will simplify financial interactions among care providers, payers and consumers and accelerate the movement to a more modern, real-time and transparent payment system. This will ensure physicians get paid more quickly, accurately and reliably, and provide consumers the same simplicity and convenience managing their health care finances they experience with other transactions. Change Healthcare brings deep patient communication capabilities, engaging more than 200 million unique individuals each year. Integrating these engagements with people's health financial benefits will make it simpler for consumers and enhance alignment with incentive programs which reward healthy behaviors.

"Change Healthcare has made significant progress executing its strategic objectives, including advancing innovation, accelerating growth and improving the effectiveness of the U.S. health system," said Howard Lance, Chairman of the Board of Directors of Change Healthcare. "We are delighted to have in Optum a partner that shares a common vision of creating a better future for health care for the people and communities we serve and see this combination as in the best interests of all of our stakeholders."

The agreement calls for the acquisition of Change Healthcare's common stock for $25.75 per share in cash and is expected to close in the second half of 2021, subject to Change Healthcare shareholders' approval, regulatory approvals and other customary closing conditions. Private equity funds affiliated with The Blackstone Group, which own approximately 20% of the common stock of Change Healthcare, have agreed to vote the shares they control in favor of the combination.

The acquisition is expected to be accretive to UnitedHealth Group's net and adjusted earnings per share by approximately $0.20 and $0.50 respectively in 2022, advancing strongly in subsequent years, inclusive of investments to accelerate technology, system and product integration and development activities to more quickly deliver the value of this combination to all health care system stakeholders. Adjusted earnings exclude from net earnings only the after-tax non-cash amortization expense pertaining to acquisition-related intangible assets.

About Optum

Optum is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone. With more than 190,000 people worldwide, Optum delivers intelligent, integrated solutions that help to modernize the health system and improve overall population health. Optum is part of UnitedHealth Group (NYSE: UNH). For more information, visit www.Optum.com .

About Change Healthcare

Change Healthcare (NASDAQ: CHNG) is a leading independent healthcare technology company, focused on accelerating the transformation of the healthcare system through the power of the Change Healthcare Platform. We provide data and analytics-driven solutions to improve clinical, financial, administrative, and patient engagement outcomes in the U.S. healthcare system. Learn more at www.changehealthcare.com .

Contacts

Media Contacts

Gwen Holliday
202-549-3429
gwen.m.holliday@Optum.com

Katherine Wojtecki
630-624-9142
Katherine.Wojtecki@changehealthcare.com

Investor Contacts

Brett Manderfeld
952-936-7216
brett_manderfeld@uhg.com

Evan Smith, CFA
404-338-2225
Evan.Smith@changehealthcare.com

Additional Information and Where to Find It

The proposed transaction will be submitted to the stockholders of CHNG for their consideration. This communication may be deemed to be solicitation material in connection with the proposed transaction. UNH and CHNG intend to file materials relevant to the proposed transaction with the SEC, including CHNG's proxy statement on Schedule 14A. This communication is not a substitute for the proxy statement or any other documents that CHNG may send to its stockholders in connection with the proposed transaction. BEFORE MAKING ANY VOTING DECISIONS, CHNG's STOCKHOLDERS ARE URGED TO READ ALL RELEVANT DOCUMENTS FILED WITH THE SEC WHEN THEY BECOME AVAILABLE, INCLUDING THE PROXY STATEMENT FOR THE PROPOSED TRANSACTION, BECAUSE THEY WILL CONTAIN IMPORTANT INFORMATION ABOUT THE PROPOSED TRANSACTION. Copies of the proxy statement and other relevant materials, when filed, will be available free of charge on the SEC's web site at http://www.sec.gov or on CHNG's website at ir.changehealthcare.com .

Non-GAAP Financial Information

This press release presents non-GAAP financial information provided as a complement to the results provided in accordance with accounting principles generally accepted in the United States of America ("GAAP"). A reconciliation of the non-GAAP financial information to the most directly comparable GAAP financial measure is included with the above earnings per share disclosure**.**

Cautionary Statement Regarding Forward-Looking Statements

This press release may contain statements, estimates, projections or guidance that constitute "forward-looking statements" as defined under U.S. federal securities laws about the proposed transaction. Generally, the words "believe," "expect," "intend," "estimate," "anticipate," "plan," "project," "should," "will" and similar expressions identify forward-looking statements, which generally are not historical in nature. These statements are based on current plans, estimates and expectations that are subject to risks and uncertainties. We caution that actual results could differ materially from expected results,

depending on the outcome of certain factors, including (i) the failure to satisfy the conditions to the completion of the proposed transaction, including approval of the proposed transaction by CHNG's stockholders and the receipt of regulatory approvals on the terms expected or on the anticipated schedules; (ii) the occurrence of any event, change or other circumstance that could give rise to the termination of the merger agreement; (iii) there may be a material adverse change regarding CHNG or its business; (iv) the failure to complete or receive the anticipated benefits from the proposed transaction, including due to the failure to successfully integrate the businesses and technologies; (v) revenues following the proposed transaction may be lower than expected; (vi) operating costs, customer loss and business disruption (including, without limitation, difficulties in maintaining relationships with employees, customers, clients or suppliers) may be greater than expected; (vii) the retention of certain key employees at CHNG; (viii) the parties' ability to meet expectations regarding the timing, completion and accounting and tax treatments of the proposed transaction; (ix) risks related to diverting management attention from ongoing business operations; (x) the risk that any regulatory approval, consent or authorization that may be required for the proposed transaction is not obtained or is obtained subject to conditions that are not anticipated; (xi) the outcome of any legal proceedings that may be instituted against UNH or CHNG related to the proposed transaction; (xii) there may be changes in economic conditions, financial markets, interest rates, political conditions or changes in federal or state laws or regulations; (xiii) there may be changes in the market price of CHNG's common stock; (xiv) risks associated with public health crises, large-scale medical emergencies and pandemics, such as the COVID-19 pandemic; and (xv) the other factors relating to UNH and CHNG discussed in "Risk Factors" in their respective Annual Reports on Form 10-K for the most recently ended fiscal year and in their other filings with the Securities Exchange Commission (SEC), which are available at http://www.sec.gov . The effects of the COVID-19 pandemic may give rise to risks that are currently unknown or amplify the risks associated with many of these factors. Neither UNH nor CHNG assumes any obligation to update or revise this communication as a result of new information, future events or otherwise, except as otherwise required by applicable law. Readers are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof.

Participants in Solicitation

Change Healthcare and its directors and executive officers, and UnitedHealth Group and its directors and executive officers, are deemed to be participants in the solicitation of proxies from stockholders of Change Healthcare in connection with the proposed merger. Information about Change Healthcare's directors and executive officers and their ownership of Change Healthcare's common stock can be found in its Annual Report on Form 10-K for the year ended March 31, 2020 filed with the SEC on June 4, 2020, in its Definitive Proxy Statement for its 2020 Annual Meeting of Stockholders filed with the SEC on July 16, 2020 and on Change Healthcare's website at www.changehealthcare.com . Information about UnitedHealth Group's directors and executive officers can be found in its Annual Report on Form 10-K for the year ended December 31, 2019 filed with the SEC on February 14, 2020, in its Definitive Proxy Statement for its 2020 Annual Meeting of Stockholders filed with the SEC on April 17, 2020 and on UnitedHealth Group's website at http://www.unitedhealthgroup.com. Investors may obtain additional information regarding the interest of such participants by reading the proxy statement and other materials to be filed with the SEC in connection with proposed merger when they become available.

Optum

Benefits of Combination with Change Healthcare

- By combining our products and expertise with those of Change Healthcare, we can increase efficiency and reduce friction in health care, producing a better experience and lower costs.
- Simply put, with this new combination, Optum will help improve the quality of health care delivery, automate claims transactions, and accelerate payment between provider and payer. We will accomplish this through aligning clinical decision making, improving claims accuracy, and simplifying payment.
- The combination of capabilities can improve healthcare by:
  - Helping health care providers and payers better serve patients by more effectively connecting and simplifying key clinical, administrative and payment processes.
  - Promoting better patient outcomes.
  - Reducing the high costs and inefficiencies that plague the health system by improving decision-making processes and putting the right data in the right hands at the right time.
  - Decreasing claims denials. Today, 90% of claim denials are avoidable and create extra work on the back end for everyone involved. By combining with Change Healthcare, we aim to create a system that can help reduce this figure.
- The combination will help us to substantially reduce the estimated $267 billion the U.S. health care industry wastes annually on simply ensuring that health care providers submit valid and properly documented claims and that insurers pay the correct amount for the services provided.
- With the distinct and complementary capabilities and skills of Change Healthcare, Optum will advance anew and more modern foundation to support the next generation health system.
- Our frictionless platform will help patients get a simplified consumer experience, lower costs, and get better point-of-care delivery due to improved adherence to best clinical evidence.
- This is the health care system of the future, and Optum's combination with Change Healthcare will help make it a reality.

Government's Flawed Case in Opposition to this Combination

The theories of competitive harm advanced by the Department of Justice (DOJ) have no basis in fact or law, and do not provide any basis for blocking what is clearly a pro-competitive, pro-consumer transaction.

- The Government's case rests entirely on speculation and theories unsupported by any past conduct, i.e., that Optum will somehow exploit Change Healthcare's products and services to secure an unfair advantage for UnitedHealthcare's health insurance business.
- There is no reason to believe Optum will misuse the competitively sensitive information ("CSI") that passes through Change's EDI (Electronic Data Interchange) network to benefit UnitedHealthcare's health insurance business. This is because Optum's business model and financial success is dependent on providing products and services to external customers, not just UnitedHealthcare. Put simply, anymisuse of customer CSI would be economic suicide for Optum because its sophisticated external customer base would simply cease using Optum's services and turn to any number of Optum competitors.

- Optum already has access to the CSI of UnitedHealthcare's competitors, through services that Optum currently provides to some of the largest insurance companies in the nation. Optum invests extraordinary time, money, and resources into safeguarding that information and keeping it walled off from UnitedHealthcare. UnitedHealth Group's existing firewalls and data-security policies prohibit employees from improperly sharing external-customer CSI.
- The Government's theory that Optum will raise prices, degrade quality, or withhold innovations from its rivals—through manipulating Change Healthcare's EDI network—has no basis in rational economic or financial logic. Optum has no incentive to discriminate against health insurers with respect to EDI services, which constitute less than 1% of a payer's cost structure and are sometimes provided for free.
- Instead, Optum has every incentive to do just the opposite -- continuing to offer high quality products and services, including EDI. There is no support for the Government's speculation that the combination with Change Healthcare will lead to Optum hoarding the product and service innovations that could result. Optum has served third-party payers for years and has consistently shared innovations with the marketplace. Indeed, the returns associated with sharing innovations with the marketplace are the driver of Optum pursuing this combination in the first place.
- Optum's long-standing real-world practices with respect to the treatment of customer data and competitively sensitive information will be applied to Change Healthcare's customer data post-close, and Optum believes that its long-standing policies and practices address DOJ's stated concerns. Nevertheless, to provide further assurance to DOJ and to Change Healthcare's customers and partners, Optum agreed to codify those commitments to both Optum's and Change Healthcare's customers and the Government to fully address those concerns.

Summary of Commitments to DOJ and Customers

To address the Government's speculative concerns, Optum agreed to a series of commitments in support of Optum's and Change Healthcare's customers. First, in response to DOJ's claim that the Optum's combination with ChangeHealthcare would create a "monopoly in first-pass claims-editing solutions," Optum agreed to divest Change Healthcare's claims-editing business. Final bids are being received for this business. We expect a signed agreement with a strong buyer fully replicating Change Healthcare's competitive position in first-pass claims editing to be completed within a matter of weeks.

Effective upon closing the transaction, and in addition to the divestiture, Optum has agreed to make the following commitments to Optum's and Change Healthcare's customers and the Government that fully address those concerns.

- Data
  - Optum will not alter Change Healthcare's current practices of making certain aggregated, de-identified data available to the marketplace.
- Firewalls
  - Optum will maintain robust firewall processes and extend them to Change Healthcare's business—to protect sensitive customer data and provide information to customers to allow them to verify those firewall processes.
- Performance Guarantees
  - Optum will continue to process EDI transactions consistent with industry standards and in the most efficient, contractually available manner.
- Non-discrimination Related to Innovations
  - Consistent with its current business practices, Optum will make any new products or services developed using medical EDI transaction data available to the marketplace.

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Optum

Optum + Change Healthcare Fact Sheet

Benefits of the combination

The combination between Optum and Change Healthcare is good for all participants in the health system, especially consumers.

- This combination will advance our ability to create products and services that improve the delivery of health care and reduce the high costs and inefficiencies that plague the health system.
- We will share these innovations broadly to benefit those who engage with the health system today and well into the future.

The combination of Change Healthcare and Optum adds value for those we serve.

- **For patients** who are at the center of everything we do, the combination will drive better experiences and outcomes before, during, and after episodes of care. We can also provide a simple, convenient experience managing health care finances similar to other consumer transactions, including a clearer understanding of price at the point of service.
- **For providers** we can reduce the administrative burden by accelerating e-billings and payments, in part enabled by an automated claims submission process allowing providers to be paid promptly. We can also provide advanced clinical decision and care coordination support tools to improve patient outcomes.
- **For payers** we can enable a more comprehensive view of the patient to improve health outcomes and operational processes, while reducing cost. We can also enable health care payers to more clearly and effectively convey critical benefit information, including deductible status and payment obligation, at the point of care.

Our team members work tirelessly every day to advance our goals of administrative efficiency, clinical alignment, and payment simplification.

- Across Optum, we operate with the highest ethical standards in protecting confidential data and information of our clients and adhere to the safeguards we have had in place for more than a decade to ensure data is accessed and used only for permissible purposes.
- We will not be distracted by the DOJ's complaint and will continue to honorably serve our clients and consumers and those that engage in the health system.

Opposition to Department of Justice decision to sue to block improvements to the health system

We strongly disagree with the Department's decision to attempt to block this combination, and we look forward to presenting the merits of our case.

- The theories at the core of the Department's case are completely without merit, as they are based on speculation about UnitedHealth Group's future motives and are entirely inconsistent with how we have always conducted business.

Our track record of safeguarding our customers' proprietary information speaks for itself. We have best-in-class firewalls and compliance programs that maintain the integrity of our customers' data and information, and prevent unauthorized access and misuse. Combining with Change Healthcare alters none of those fundamentals.

- Today, Optum successfully serves all stakeholders in the healthcare system, including the largest health plans in the country. Our customers have trusted our ability to maintain the safety and integrity of their data for more than a decade, a key to the success of our long-standing multi-payer business.

Optum facts

We are grateful to serve and partner with:

- 4 out of 5 health plans
- 9 out of 10 Fortune 100 companies
- Over 100 Federal, State and municipal agencies including 24 states and Washington D.C.
- 9 out of 10 U.S. hospitals
- Federal, state, and municipal agencies across 40 states and D.C.
- Over 127 million consumers including military, veterans, Medicare and Medicaid beneficiaries

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA
U.S. Department of Justice
Antitrust Division
450 Fifth Street, NW, Suite 4100
Washington, DC 20530,

STATE OF MINNESOTA
445 Minnesota Street, Suite 1400
St. Paul, Minnesota 55101-2131,

and

STATE OF NEW YORK
28 Liberty Street
New York, NY 10005,

Plaintiffs,

v.

UNITEDHEALTH GROUP INCORPORATED
9900 Bren Road East
Minnetonka, MN 55343,

and

CHANGE HEALTHCARE INC.
3055 Lebanon Pike
Nashville, TN 37214,

Defendants.

COMPLAINT

UnitedHealth Group (United), which owns the largest health insurer in the United States, proposes to acquire Change Healthcare (Change), the leading source of key technologies that

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Thursday, February 24, 2022

Justice Department Sues to Block UnitedHealth Group's Acquisition of Change Healthcare

Acquisition Would Allow Health Care Giant to Use Competitively Sensitive Claims Data of Hundreds of Millions of Americans to Reduce Competition and Innovation to the Detriment of Health Insurance Consumers

The Department of Justice, together with Attorneys General in Minnesota and New York, filed a civil lawsuit today to stop UnitedHealth Group Incorporated (United) from acquiring Change Healthcare Inc. (Change). The complaint, filed in the U.S. District Court for the District of Columbia, alleges that the proposed $13 billion transaction would harm competition in commercial health insurance markets, as well as in the market for a vital technology used by health insurers to process health insurance claims and reduce health care costs.

"Quality health insurance should be accessible to all Americans," said Attorney General Merrick B. Garland. "If America's largest health insurer is permitted to acquire a major rival for critical health care claims technologies, it will undermine competition for health insurance and stifle innovation in the employer health insurance markets. The Justice Department is committed to challenging anticompetitive mergers, particularly those at the intersection of health care and data."

"The proposed transaction threatens an inflection point in the health care industry by giving United control of a critical data highway through which about half of all Americans' health insurance claims pass each year," said Principal Deputy Assistant Attorney General Doha Mekki of the Justice Department's Antitrust Division. "Unless the deal is blocked, United stands to see and potentially use its health insurance rivals' competitively sensitive information for its own business purposes and control these competitors' access to innovations in vital health care technology. The department's lawsuit makes clear that we will not hesitate to challenge transactions that harm competition by placing so much control of data and innovation in the hands of a single firm."

As alleged in the complaint, the proposed transaction would give United, a massive company that owns the largest health insurer in the United States, access to a vast amount of its rival health insurers' competitively sensitive information. Post-acquisition, United would be able to use its rivals' information to gain an unfair advantage and harm competition in health insurance markets. The proposed transaction also would eliminate United's only major rival for first-pass claims editing technology — a critical product used to efficiently process health insurance claims and save health insurers billions of dollars each year — and give United a monopoly share in the market.

The proposed acquisition would eliminate an independent and innovative firm, Change, that today provides a variety of participants in the health care ecosystem, including United's major health insurance competitors, with vital software and services. This includes electronic data interchange (EDI) clearinghouse services, which transmit claims and payment information between insurers and providers, and first-pass claims editing solutions, which review claims under the health insurer's policies and relevant treatment protocols. Indeed, Change markets itself as a valuable partner for insurers, working closely with them to innovate and problem-solve. United's acquisition of this neutral player would allow United to tilt the playing field in its favor, harming current competition and allowing United to control and distort the course of innovation in this industry for the foreseeable future.

UnitedHealth Group Incorporated is headquartered in Minnetonka, Minnesota. United is an integrated health care enterprise that includes, among other subsidiaries, UnitedHealthcare, the largest health insurer in the United States; Optum Health, a large network of health care providers located throughout the country; OptumRx, a large pharmacy benefit manager; and OptumInsight, a health care technology business. United's revenues were $288 billion in 2021.

Change Healthcare Inc. is headquartered in Nashville, Tennessee. Change is a leading independent health care technology company providing health care analytics, software, services and data to health care providers, health insurers and other software and services firms in the health care industry. Change's revenues were $3.4 billion in 2021.

Attachment(s):
Download United Change Complaint.pdf

Topic(s):
Antitrust

Component(s):
Antitrust Division
Office of the Attorney General

Press Release Number:
22-159

Updated February 24, 2022

United's health insurance rivals rely on to compete with United. By ensuring accuracy, avoiding overpayments, and reducing administrative waste, Change's technologies save United's rivals tens of billions of dollars each year and reduce healthcare costs for American families. Through these technologies, Change also has access to vast amounts of competitively sensitive data about United's rivals—data that reveals how their plans are designed and how they calculate payments to providers, for example—and holds "unfettered" rights to use much of this information. United is keenly aware of Change's data rights; its former CEO viewed acquisition of these rights as an essential reason for the acquisition of Change. Indeed, United recognized that it could use this data to extract intelligence about its health insurance rivals, despite acknowledging that this would trigger "Payer and provider sensitivity and competitive concerns." Tellingly, while United has long coveted its rivals' claims data, it has gone to great lengths to safeguard its own claims data from competitors, recognizing that "someone specifically going out and getting all of that information" on "how the plans work" is "not a good thing from a competitive standpoint."

Because Change's products are so widely used, including by many healthcare providers, United's health insurance rivals would not be able to prevent their data from being routed through Change post-transaction. Therefore, United's proposed acquisition of Change, with its rivals' competitively sensitive data, would allow United to co-opt its rival insurers' innovations and their competitive strategies and reduce their incentives to pursue those innovations and strategies in the first place. The proposed acquisition would also allow United to use its control over Change's technologies to disadvantage its health insurance rivals by raising their costs and denying or delaying their access to innovations and quality improvements to products and services supplied by Change.

Ultimately, this substantial lessening of competition would result in higher cost, lower quality, and less innovative commercial health insurance for employers, employees, and their families.

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I. INTRODUCTION

1. Health insurance helps protect American families from the financial risks associated with sickness and injury. It also facilitates access to the U.S. healthcare system, thereby improving health outcomes and affecting the lives of hundreds of millions of people living in the United States. Each year, Americans visit a doctor or hospital more than one billion times and spend more than four trillion dollars on healthcare—almost one-fifth of the U.S. gross domestic product. Roughly 155 million people, or almost half of all Americans, get their health insurance through an employer. Employers count on competition between health insurers to provide affordable, high quality, and innovative health plans to meet the needs of employees and their families. United's proposed acquisition of Change threatens this competition.

2. United is a behemoth in the healthcare industry. A serial acquirer that has purchased more than 35 healthcare companies over the last 10 years, United operates, among other things: the largest health insurance company in the United States; a large network of physician groups, outpatient surgical centers, and other healthcare providers, including over 53,000 physicians across 15 states; a pharmacy benefit manager (PBM) that handles over a billion prescriptions every year; and a healthcare technology business that facilitates, among other things, the transmission, analysis, and review of health insurance claims.

3. Change is the leading independent supplier of technologies used by healthcare providers to submit health insurance claims, and by health insurance companies to evaluate and process these claims. It is not owned by any healthcare provider or health insurer. Change operates the nation's largest electronic data interchange (EDI) clearinghouse, which transmits data between healthcare providers and insurers, allowing them to exchange insurance claims, remittances, and other healthcare-related transactions. The claims and remittances are referred to

as "claims data." The claims data shows, among other things, the treatment an individual receives and the insurance coverage that they have, and provides a window into the inner workings of the health insurers and their plans. Change also sells a license to its separate state-of-the-art claims editing technology that enables health insurers to process, in real time, millions of healthcare claims each day to ensure compliance with their health insurance policies.

4. Nearly all of United's major health insurance rivals rely on Change's EDI clearinghouse and claims editing technology to compete with United's commanding health insurance business, and they have leveraged these tools to save billions of dollars each year. Change's technologies are critical tools that allow United's health insurance rivals to keep healthcare costs down for their members and pay providers' claims quickly so they can compete more effectively with United and one another for health insurance customers.

5. Change is the leading independent provider of technology used to transmit and review health insurance claims. As Change told analysts in 2019 "the SCALE, size, and independence of our business is a competitive advantage." It has access to a vast trove of competitively sensitive claims data that flows through its EDI clearinghouse—over a decade's worth of historic data as well as billions of new claims each year. According to United, 50 percent of all medical claims in the United States pass through Change's EDI clearinghouse. Change's self-described "pervasive network connectivity," including approximately "900,000 physicians, 118,000 dentists, 33,000 pharmacies, 5,500 hospitals and 600 laboratories," means that even when United's health insurer rivals choose not to be a Change customer, health insurers have no choice but to have their claims data pass through Change's EDI clearinghouse. Not only does Change process vast amounts of competitively sensitive claims data, but it also has secured "unfettered" rights to use over 60 percent of this data for its own business purposes including, for

example, using claims data for healthcare analytics. Additionally, through its claims editing product, Change has access to the proprietary plan and payment rules for all of United's most significant health insurance competitors.

6. Change has access to claims data and health insurers' proprietary plan and payment rules. Health insurers consider this information to be competitively sensitive. This data is especially valuable because it can be used to understand how an insurer designs its plans for particular employers, and glean insights into the plans' payment and operational rules.

7. United operates its own EDI clearinghouse and offers a competing claims editing technology through OptumInsight, its healthcare technology business. But United's major rival health insurers rely on Change for its innovative, high-quality products, including claims editing technology and EDI clearinghouse, avoiding United's claims editing and clearinghouse products to protect their competitively sensitive data from their largest rival. United is well aware of its rivals' reluctance to use United's EDI clearinghouse and claims editing products. OptumInsight euphemistically refers to this reluctance as the "'U'-factor,"—a reference to United's insurance business. An internal strategy document discussing the competitive perception of OptumInsight's claims editor put it bluntly: "health plans don't typically want to go with Optum because Optum is a competitor."

8. United, for its part, actively avoids placing its own competitively sensitive claims data in the hands of its actual or potential health insurance competitors. United requires its business units to limit the disclosure of data outside of United "to the minimum necessary." And its internal policies reflect the competitive importance of claims data to UnitedHealthcare (United's health insurance business) and to the commercial health insurance industry generally. For example, United will not permit its business units to license claims data to a third-party

unless it is justified "as being in the best interests of the Enterprise [United] (taking into account all business segments)." United also restricts data licenses to third-parties if they are "primarily for the benefit of a significant competitor." United implements these policies to protect its financial interests.

9. Although it carefully safeguards its own claims data, United covets its rivals' claims data and has long sought to acquire Change for this reason. United executives repeatedly expressed in ordinary course business documents that a purchase of Change was motivated by the desire to acquire Change's access to claims data. For example, in evaluating whether to acquire Change, the "primary question" from United's then-CEO concerned Change's "data rights." He viewed Change's rights to proprietary claims data as "the foundation" to the business case for acquiring Change. United's consultants from McKinsey & Company (McKinsey) confirmed Change's extensive rights to claims data, reporting that Change "connects to over 70% of all payers, providers, pharmacies, and physician organizations"; it enjoys the "broadest and deepest datasets in several categories"; and it "has unrestricted access under HIPAA guidelines." McKinsey also pointed to Change's "High volume of claims," "Breadth across multiple networks," and "Direct customer contracts" as particularly advantageous.

10. United saw similar advantages to acquiring Change's claims editing technology. An early United analysis of the deal shows that it understood that by acquiring Change it would gain access to the proprietary plan and payment rules of rival health insurers, specifically the "claim edits of a large number of non-UHC payers (Humana, Anthem, Aetna, Cigna, Blues)."

11. United's proposed $13 billion acquisition of Change would fundamentally alter the health insurance industry, reducing its competitiveness. Unless enjoined, the proposed transaction would give United access to and control of sensitive business information about its

health insurance rivals. In particular, United would gain unprecedented access to a vast trove of its health insurance rivals' competitively sensitive claims data through Change's secondary-use rights, something United wants but has not attained previously. By acquiring Change, United will have the ability to diminish competition in the health insurance industry by applying machine learning to rival insurers' claims data, stealing rival insurers' best ideas, and reducing its rivals' incentives to innovate, among other things. Such competitive harm, including harm to innovation, reduces the American public's access to high-quality, affordable health insurance plans that meet their healthcare needs.

12. Post-transaction, United also would have a strong incentive to use this data to weaken its health insurance rivals' competitiveness. The competitive insights that United would obtain by acquiring Change would allow United to slow its rivals' innovations, reverse-engineer its rivals' proprietary plan and payment rules, preempt their competitive strategies, and compete less vigorously for certain customers by understanding which employer groups pose more risk and have higher costs of treatment. This course would prove profitable to United while harming competition.

13. United's own deal documents validate these concerns. For example, in conducting due diligence on the deal for United, McKinsey concluded that United could "Utilize transactions intelligence (*i.e.*, clinical utilization) from multiple [healthcare] providers / payers to optimize benefit design" for its own health insurance business. In later documents, United's deal team reiterated this point and observed that United could use Change's "multipayer claims data to track procedure pricing," acknowledging the antitrust risk with this opportunity by stating that United would likely need to "closely assess antitrust concerns on use/sharing of pricing information."

14. United's proposed acquisition of Change also would allow United to use its control over Change's technologies to disadvantage its health insurance rivals by raising their costs and reducing or withholding quality improvements and innovations from rivals that rely on Change's technologies. For example, Change sees potential value to incorporating certain claims editing functionality into its EDI clearinghouse. If United acquires Change, it would have a powerful incentive to deny such innovations to its health insurance rivals, depriving them of Change's technologies, as part of a strategy to disadvantage its health insurance rivals and expand its already large base of health insurance customers. Even modest increases in the number of customers, or members, have big implications for a health insurer's profitability. According to United, gaining 100,000 new health plan enrollees means tens of millions of dollars in profits for United. For these reasons, this transaction violates Section 7 of the Clayton Act because it may likely substantially lessen competition in the market for the sale of commercial health insurance to national accounts and large group employers.

15. United's proposed acquisition of Change also would eliminate significant head-to-head competition between United and Change to supply first-pass claims editing solutions, which are software and services health insurers use to help adjudicate claims. Today, United and Change compete to supply first-pass claims editing solutions to health insurers. As the United pricing team explained, "[Change] is our big competitor for this product. We have been approving 20%-25% discounts consistently when [Change] is in the mix." But United's proposed acquisition of Change would give United over 75 percent share of the market for first-pass claims editing solutions and eliminate this competition, leaving insurers at the mercy of a vertically integrated monopolist that has every incentive to raise prices and reduce quality and

innovation. This transaction violates Section 7 of the Clayton Act because it tends to create a monopoly in the market for the sale of first-pass claims editing solutions.

16. In sum, by placing Change's EDI clearinghouse and first-pass claims editing tools, including the accompanying competitively sensitive data, in United's hands, United's acquisition of Change is likely to substantially lessen competition in the markets for commercial health insurance and claims editing solutions. The proposed acquisition threatens to reduce competition among U.S. commercial health insurers, thereby harming health insurance customers (employers) and their individual members, all of whom rely on competition between United and its rivals to keep healthcare affordable. For the reasons set forth below, United's proposed acquisition of Change is unlawful and must be stopped.

II. DEFENDANTS AND THE PROPOSED TRANSACTION

UnitedHealth Group and its Subsidiaries

17. United is one of the ten largest companies by revenue in the United States. Today, United is a vertically integrated healthcare enterprise with a portfolio of wholly owned subsidiaries comprising a massive healthcare ecosystem. These subsidiaries include, but are not limited to: (a) the largest U.S. health insurer, UnitedHealthcare; (b) one of the largest PBMs, OptumRx; (c) a significant provider network, Optum Health; and (d) an advanced healthcare technology business, OptumInsight. United generated $288 billion in revenue in 2021. It is headquartered in Minnetonka, Minnesota and incorporated under Delaware law.

18. UnitedHealthcare is the largest commercial health insurer in the United States. It provides health insurance to employers in all 50 states and the District of Columbia. In 2021, UnitedHealthcare recorded $223 billion in revenue. That same year, UnitedHealthcare's national

accounts and large group employer commercial health insurance plans had about 23 million members and generated an estimated $31 billion in revenue.

19. United's OptumRx subsidiary markets itself as "one of the three largest participants in the pharmacy benefit management (PBM) sector." In 2021, it filled 1.4 billion prescriptions. In 2021, OptumRx generated $91 billion in revenue.

20. United's Optum Health subsidiary employs or manages healthcare providers, mostly focused on primary care. Optum Health's network included 53,000 providers serving over 19 million individuals in 2021, and it continues to grow through the acquisition of physician groups. In 2021, Optum Health generated approximately $54 billion in revenue.

21. United's OptumInsight subsidiary provides healthcare analytics, technology, and services. OptumInsight supplies many of UnitedHealthcare's healthcare technology needs. In 2021, OptumInsight generated $12 billion in revenue, the majority of which was from products and services sold to UnitedHealthcare.

22. United's OptumInsight subsidiary sells a first-pass claims editing solution called Claims Edit System (CES) that is used by UnitedHealthcare as well as some small and midsize insurers. United's major health insurance competitors in the markets for large group employers and national accounts generally do not use CES, because they do not want to expose their proprietary plan and payment rules to a United-owned company. OptumInsight also has an EDI clearinghouse that primarily processes insurance claims and other transactions for UnitedHealthcare. OptumInsight's EDI clearinghouse is UnitedHealthcare's managed gateway, meaning it is the exclusive EDI clearinghouse through which UnitedHealthcare accepts claims.

Change Healthcare

23. Change is a leading independent healthcare technology company. It provides healthcare analytics, software, services, and data to providers, insurers, and other software and services firms in the healthcare industry. Change markets itself as a valuable partner for insurers, working together "hand-in-glove" to innovate and problem-solve. In a 2021 filing with the Securities and Exchange Commission, Change stated that it provides "collaborative benefits of a mission-critical partner to the healthcare industry" and offers a "consistent track record of innovation." In 2021, Change generated $3.4 billion in revenue. Change is headquartered in Nashville, Tennessee and incorporated under Delaware law.

24. Change sells the market-leading first-pass claims editing solution, called ClaimsXten. Health insurers have realized a collective $12 billion in savings per year from using ClaimsXten.

25. Change also operates the nation's largest EDI clearinghouse, which connects approximately 5,500 hospitals, 900,000 physicians, and 2,400 government and commercial health insurers. Change's internal business documents recognize that it "offers the largest medical EDI network in the U.S." and that "over two-thirds of transactions are managed by our clearinghouse solutions." In light of its vital technology, Change has concluded that the "healthcare system, and how payers and providers interact and transact, would not work without Change Healthcare." Change captures the claims data that flows through its EDI clearinghouse, and maintains data going back to 2012 representing 211 million unique patients covered by many different health insurers.

The Proposed Transaction

26. United has considered an acquisition of Change for many years. As early as 2015, United recognized that "All Paths Lead to [Change]." On January 5, 2021, United agreed to acquire Change for approximately $13 billion (the Proposed Transaction). At the same time as they agreed to the Proposed Transaction, United and Change entered into a side agreement, requiring United to immediately increase its purchases of products and services from Change, ensuring that even if this transaction fails to proceed, United will pay Change approximately $60 million more per year than it did before the agreement was signed.

III. BACKGROUND

A. Commercial Health Insurance

27. Most Americans obtain commercial health insurance from their employers, which contract with health insurers to offer health insurance plans to their employees. Employees, and their covered spouses and dependents, that receive health insurance through an insurer's plan are called the health insurer's members.

28. Health insurers routinely categorize employer-customers based on the employer's number of employees. In the vast majority of U.S. states, "large group" insurance is health insurance that is sold to employers with more than 50 employees (under the laws of four states, the threshold for large group insurance is employers with more than 100 employees). Within large group employers, insurers recognize a subset of the largest employers, those with employees spread across more than one state, as "national accounts."

29. When selling commercial health insurance to national accounts and large group employers, health insurers compete on many factors, such as price, cost containment, claims adjudication (including claims editing and processing speed), clinical programs, customer service, care management, wellness programs, and reputation. Insurers also compete on the

breadth and quality of their network of healthcare providers, including doctors and hospitals, because most people seek medical care close to where they live or work.

30. UnitedHealthcare is the nation's largest commercial health insurer. It has the largest market share among national accounts, covering approximately one out of every five Americans insured through a national accounts employer. It is also one of the largest health insurers serving large group employers in many local markets throughout the United States.

B. Overview of Claims Submission and EDI Clearinghouses

1. Claims Data and EDI Clearinghouses

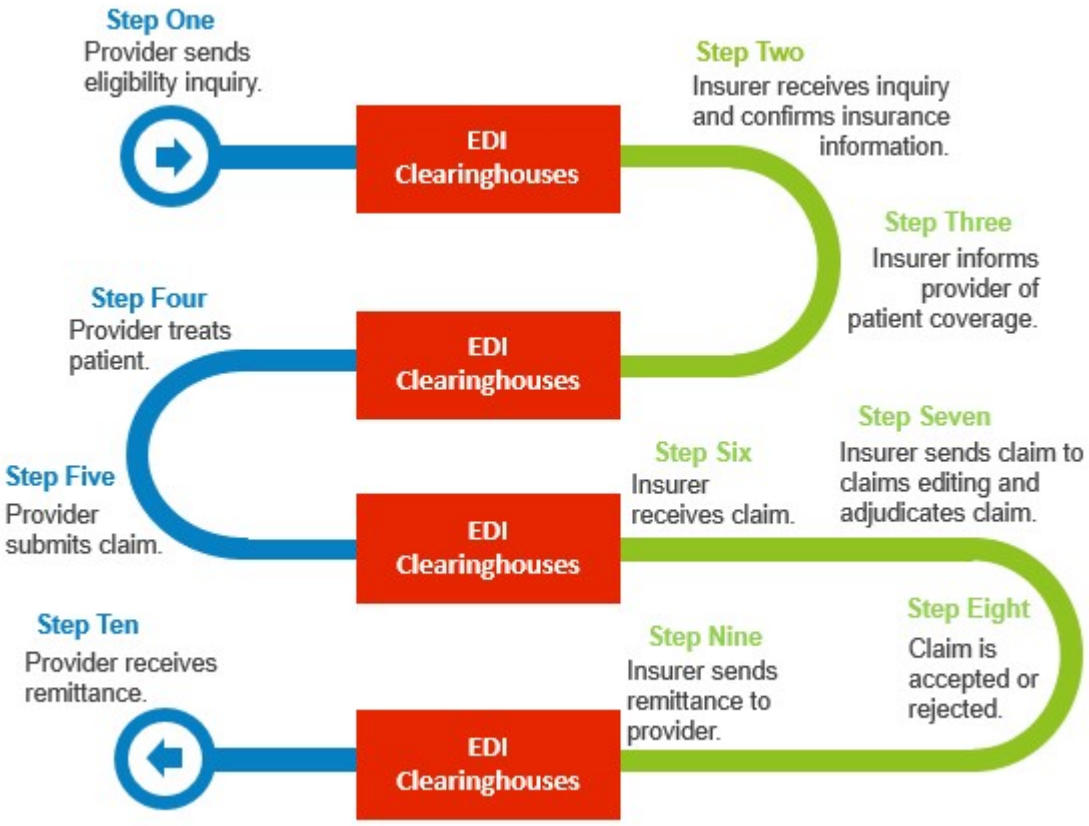
31. EDI clearinghouses enable providers and health insurers to transmit claims data electronically. EDI clearinghouses are sometimes described as the data "pipes" that connect providers and insurers.

32. Claims processing typically involves a series of data transmissions between providers and health insurers. When an insured individual goes to a healthcare provider to receive care, the provider will generally first confirm the individual's health insurance coverage by sending an eligibility inquiry to the insurer. Once the insurer verifies the individual's insurance policy, the provider treats the individual (the patient) and then submits a medical claim to the insurer to receive payment. The claim contains information about the treatment, including the facility where the patient was treated, the patient's diagnosis, the services provided, and the provider's charge for the service.

33. Upon receipt, the health insurer "adjudicates the claim" and determines what services are covered by applying its claims editing process. The claims editing process uses software to review the claim against the provider's contract with the insurer, clinical guidelines, and the patient's health plan policies to determine whether to accept the claim. If the health

insurer accepts the claim, it determines the amount it will pay and sends the provider a remittance.

34. Each of the foregoing transactions is typically transmitted via an EDI clearinghouse, as depicted below:



35. Historically, providers and health insurers used paper claims, faxes, and phone calls to communicate about eligibility, claims, and remittances. This approach was time consuming, error prone, labor intensive, and costly. Large national health insurers receive millions of claims every day, making it infeasible for most insurers to rely on paper claims submissions.

36. EDI clearinghouses eliminate the high costs and delays of paper claims and telephone calls. They significantly reduce the time it takes health insurers to receive claims and

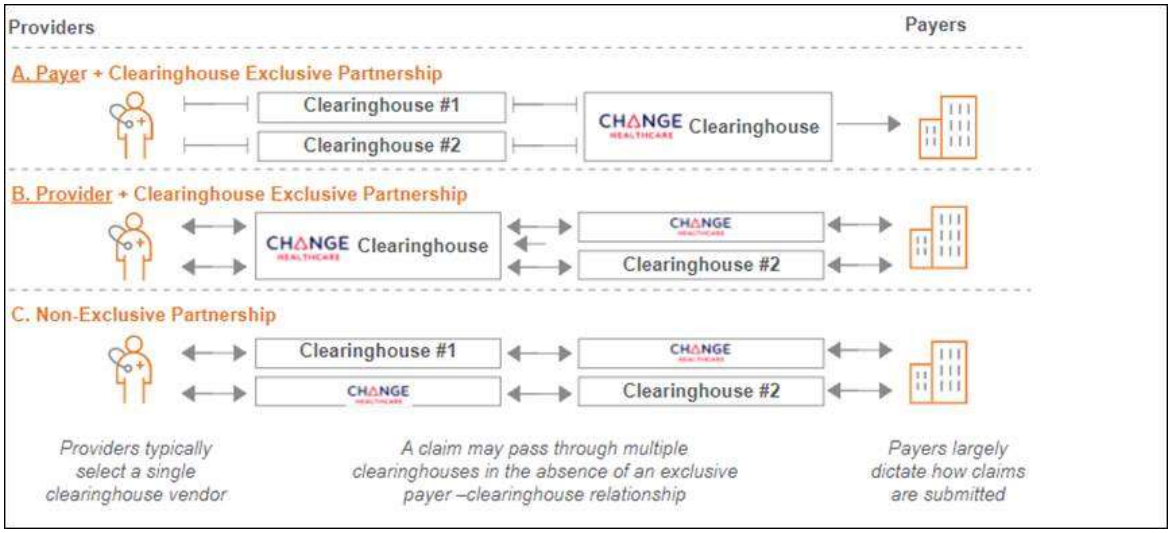
send remittances, leading to faster reimbursement for providers. Today, over 95 percent of all medical claims are transmitted electronically through EDI clearinghouses.

37. Healthcare providers often use a single EDI clearinghouse that is integrated with the provider's other software, such as claims management, billing, or electronic health records software. Providers want their claims to be transmitted quickly and accurately to health insurers. A provider can sometimes connect directly to an insurer, without using an EDI clearinghouse. Because most providers submit claims to multiple insurers, however, establishing a direct connection with each insurer is less efficient and imposes more administrative burden than using a single EDI clearinghouse to submit claims to all insurers.

38. Some health insurers use a single clearinghouse as a "managed gateway" that serves as the exclusive access point through which all of an insurer's claims data must pass. Other insurers establish relationships with multiple EDI clearinghouses. Health insurers want their EDI clearinghouse(s) to transmit data in a cost-effective manner and to give providers a quick and seamless exchange of claims data.

39. When a provider's EDI clearinghouse is not directly connected with a patient's health insurer, claims data must flow through more than one EDI clearinghouse. The industry

calls this transmission between clearinghouses a "hop." United depicted how hops occur, and the difficulties of disintermediating Change's EDI clearinghouse, in an internal document:



40. Each EDI clearinghouse through which claims data passes has access to all of the information contained in the claims data. To use that data, a clearinghouse must have "secondary-use" data rights. A clearinghouse can obtain secondary-use rights from *either* the health insurer *or* provider. The data can then be analyzed to learn about an insurer's plan and policy design, the costs of claims it pays, its provider network, and its proprietary payment rules.

2. Change's EDI Clearinghouse Has Unmatched Breadth, Providing a Vital Avenue for Transmission of Health Insurers' Claims and Claims Data to Providers

41. Change operates the largest EDI clearinghouse in the nation, transmitting over 14 billion total transactions (medical and other) through its EDI clearinghouse every year. According to United, over 50 percent of U.S. medical claims pass through (or touch) Change's EDI clearinghouse, making it a vital link between providers and insurers. In 2019, Change told potential investors that the "Change Healthcare network is by far the broadest and deepest network in the country." In that same presentation, Change explained that it achieves "flywheel effects" through its scale and data, creating compounding value.

42. Change's EDI clearinghouse is thought to be used by more providers than any rival clearinghouse. Thus, even if a health insurer does not have a direct connection to Change's EDI clearinghouse, a significant portion of that insurer's claims and claims data will "hop" to Change's EDI clearinghouse because of Change's extensive provider connections.

43. As an independent EDI clearinghouse that is not owned by a health insurer, Change works closely with its health insurer customers to improve healthcare technology and reduce costs. For example, Change is developing a tool that would give providers faster confirmation of claim acceptance. Providers would be paid faster, and health insurers would spend fewer resources and adjudicate claims more quickly. Health insurers are projected to realize significant additional savings by implementing this tool. Change also has a "Strategic Advisory Council" that maintains its close relationships with its insurer customers. But for the Proposed Transaction, Change would continue to have strong incentives to develop innovations that benefit its provider and health insurer customers alike, and the healthcare system more broadly.

3. Change's Broad Data Repository and Data Rights Are at the Heart of the Proposed Transaction

44. Change sees and collects the claims data that flows through its EDI clearinghouse. Change has accumulated a massive data set of claims data, unique in its breadth, going back to 2012. Its data set includes claims data from virtually all of UnitedHealthcare's most significant rivals and is growing rapidly. In 2019, for example, Change's executives told their board that three billion new claims are added each year. As United has recognized, Change "maintains the highest volume of claims and penetration across EDI companies" and its access to United's health insurance rivals' data "differentiates" Change from United.

45. Change also has secured from providers and health insurers the right to use much of this claims data for its own business purposes, provided that certain personally identifiable information has been removed. The claims data that flows through Change's clearinghouse includes competitively sensitive information about health insurers' plans and policies.

46. United's desire to acquire this wealth of claims data from Change was a driving motivation for the Proposed Transaction. In the period leading up to the acquisition, United executives repeatedly expressed in ordinary course business documents that the Change purchase was motivated by the desire to acquire Change's rights to claims data. United's due diligence led it to conclude that Change had secondary-use rights to over 60 percent of the claims data that passes through its EDI clearinghouse.

47. While United desires claims data from its rivals, it closely guards its own claims data to ensure that competitors cannot gain access. United requires its business units to limit the disclosure of data outside of United "to the minimum necessary" and restricts data licenses to third parties if the licenses primarily benefit a significant competitor. Indeed, OptumInsight's CEO testified that OptumInsight would continue its policy of licensing UnitedHealthcare's claims data only to non-competitors, such as pharmaceutical companies. United's internal policies reflect the competitive importance of data to UnitedHealthcare and to the commercial health insurance industry generally.

4. United Operates Its Own EDI Clearinghouse Primarily for Its Own Use

48. United owns an EDI clearinghouse through its OptumInsight subsidiary. This EDI clearinghouse serves as the managed gateway for all incoming claims to UnitedHealthcare.

49. Until 2020, United marketed its EDI clearinghouse to healthcare providers and health insurers. Today, however, United claims that it no longer markets its EDI clearinghouse services to non-United providers, and only provides services to a handful of legacy health

insurers in addition to UnitedHealthcare itself. Instead, United's EDI clearinghouse routes most non-UnitedHealthcare claims to the second-largest EDI clearinghouse after Change.

C. Overview of Claims Editing Solutions

1. Claims Editing Technology

50. After a provider sends a claim to a health insurer, the insurer must review the claim for errors and determine whether and how much to pay the provider for the healthcare service rendered to the patient. Large health insurers receive millions of healthcare claims each day, so they must quickly determine whether the claim should be paid under the health plan's terms. Health insurers' overriding goal is to ensure that claims are paid accurately (according to the plan's policies) and promptly. By ensuring that claims are paid accurately, insurers protect their members from overpaying and reduce administrative costs for processing claims. Health insurers also seek to reduce overall medical costs, while avoiding erroneously rejecting claims or delaying payment so as to not frustrate providers and members.

51. In an effort to meet these goals, most health insurers purchase a claims editing solution from a third-party vendor. Claims editing solutions comb through each insurer's numerous rules, or "edits," to apply the relevant rules and automatically evaluate claims for errors. This software, for example, could apply edits to deny a claim for an individual lab test code when the test is part of a bundled lab panel on the same claim. Health insurers determine which edits to apply, including some edits that the insurer develops on its own and others developed in collaboration with a claims editing solution vendor, such as Change.

52. When healthcare claims are adjudicated, they first go through primary, or "first-pass," editing. Health insurers rely on first-pass claims editing solutions to review every claim received.

53. Claims are processed in real time during the first-pass claims editing phase, *i.e.*, the claim is immediately sent to the claims editing solution and is processed within milliseconds. This first-pass claims editing solution determines whether claims should be paid, rejected, or flagged for further review.

54. Once the first-pass claims editing solution reviews a claim, some claims go through a "second-pass" claims editing solution to find issues that may not have been identified. Unlike first-pass claims editing, second-pass claims editing does not typically occur in real time and is only applied to a subset of claims.

55. Health insurers prefer to edit claims as early as possible in the review process. Denying a claim that is not covered by the plan prior to payment is generally less costly than trying to recover money from a provider after the claim has already been paid. First-pass claims editing solutions are particularly important to large health insurers, which need high-speed claims editing solutions that can process millions of claims a day in real time. First-pass claims editing solutions save patients and health insurers billions of dollars each year by reducing costs and preventing overpayment, which makes healthcare more affordable for Americans than it would be otherwise.

56. First-pass claims editing solutions vendors often develop long-term relationships with health insurers, working together to create custom edits that are tailored to each health insurer's plans, policies, operating rules, and provider contracts. This extensive customization and strong collaboration create greater savings for the health insurer but also make switching claims editing solutions time consuming, costly, and disruptive to the insurer's business.

57. Health insurers must update their claims editing rules frequently to stay current with changing regulatory and compliance guidelines, evolving treatment protocols, and their own changing health plan policies.

58. Health insurers develop their own proprietary custom edits, and custom edits are a dimension of competition among insurers. Effective edits reduce medical and administrative costs to the health insurer and increase provider and member satisfaction by ensuring appropriate medical treatment while also processing claims quickly and accurately. Prior to implementing a particular edit in the claims adjudication process, an insurer must determine whether the benefits (*e.g.*, reduction of medical or administrative costs) will outweigh any risks (*e.g.*, making the health insurer less attractive to providers and members, both of which could switch to a competing insurer).

59. A health insurer's edits provide important insight into how the insurer adjudicates its claims. The information contained in claims edits—such as health plan policies and methodologies for calculating reimbursements—is very competitively sensitive. Claims edits are one means by which insurers differentiate themselves from their competitors.

2. Change and United Are the Top Two Vendors of First-Pass Claims Editing Solutions

60. Change is the top vendor of first-pass claims editing solutions, with a market share of over 50 percent. Change is viewed as the "gold standard, market-leading solution" for claims editing, and its ClaimsXten product is used by nine of the top ten health insurers—all but UnitedHealthcare. In 2020, Change reported that its first-pass claims editing solution saved its health insurer customers $10–$15 billion per year.

61. United's CES product is Change's most significant competitor in first-pass claims editing, with a market share of over 25 percent.

62. Change's and United's first-pass claims editing solutions collectively serve 38 of the top 40 health insurers in the country. If allowed to merge, they would have a combined market share of at least 75 percent.

63. Change's independence stands in contrast to United. United's largest health insurer rivals do not purchase claims editing solutions from United because they do not want to share their edits, which embody their proprietary plan and payment rules, with a competitor. Internally, United refers to its health insurer rivals' desire to avoid buying products from United as the "U-Factor." Before the Proposed Transaction, health insurers could avoid United by buying Change's first-pass claims editing solution. If this transaction is allowed to proceed, this alternative will vanish, and United's health insurance rivals would have no choice but to use a United-owned first-pass claims editing solution.

IV. RELEVANT MARKETS

A. The Sale of First-Pass Claims Editing Solutions in the United States Is a Relevant Market

64. United and Change compete for the sale of first-pass claims editing solutions in the United States.

1. The Sale of First-Pass Claims Editing Solutions is a Relevant Product Market

65. The sale of first-pass claims editing solutions is a relevant product market under Section 7 of the Clayton Act.

66. First-pass claims editing solutions, which include the first-pass claims editing software as well as the associated services, apply real time edits (*i.e.*, rules) early in the claims review process. There are no reasonable alternatives to first-pass claims editing solutions.

67. First-pass claims editing solutions are distinct products from second-pass claims editing solutions. First-pass claims editing solutions quickly process a high volume of claims in

real time using each health insurer's full library of edits, whereas second-pass claims editing solutions typically involve a narrower set of edits applied to a subset of claims and cannot process in real time.

68. Vendors, such as United and Change, and their health insurer-customers distinguish between first- and second-pass claims editing solutions in the ordinary course of business.

69. The sale of first-pass claims editing solutions satisfies the well-accepted "hypothetical monopolist" test set forth in the Department of Justice and Federal Trade Commission's *Horizontal Merger Guidelines* ("Horizontal Guidelines"). A hypothetical monopolist selling first-pass claims editing solutions would likely impose a small but significant and non-transitory price increase without losing sufficient sales to render that price increase unprofitable.

2. The United States Is the Relevant Geographic Market for the Sale of First-Pass Claims Editing Solutions

70. The United States is the relevant geographic market for the sale of first-pass claims editing solutions under Section 7 of the Clayton Act. A hypothetical monopolist of first-pass claims edit solutions in the United States could profitably impose a small but significant and non-transitory increase in price. Such a price increase would not be defeated by substitution away from first-pass claims editing solutions in the United States or by arbitrage, for example, by purchasing first-pass claims editing solutions outside of the United States. Thus, this geographic market satisfies the hypothetical monopolist test.

B. The Sale of Commercial Health Insurance to National Accounts in the United States Is a Relevant Market

71. UnitedHealthcare competes in the sale of commercial health insurance to national accounts throughout the United States.

1. The Sale of Commercial Health Insurance to National Accounts Is a Relevant Product Market

72. The sale of commercial health insurance to national accounts is a relevant product market under Section 7 of the Clayton Act.

73. National accounts are distinct customers with unique characteristics. They typically require a provider network covering multiple states, undertake a lengthy procurement process that involves requests for proposals to select health insurance plans, hire large consulting firms to aid in evaluating and selecting an insurer or insurers, and want flexible and customized benefit designs. UnitedHealthcare and other insurers have dedicated business units focused on selling and marketing to national accounts. UnitedHealthcare also maintains separate profit and loss statements for national accounts. UnitedHealthcare charges different prices and offers different plan benefits for national accounts than it does for other types of commercial health insurance customers.

74. The sale of commercial health insurance to national accounts satisfies the well-accepted "hypothetical monopolist" test. Under the Horizontal Guidelines, relevant markets may be defined around a group of customers that could be profitably targeted for price increases. Because health insurance is a significant employment benefit, a hypothetical monopolist of commercial health insurance sold to national accounts would likely impose a small but significant and non-transitory price increase without losing sufficient sales to render that price increase unprofitable. In response to the price increase, few national accounts would stop buying commercial health insurance for their employees. Similarly, few national accounts would self-supply insurance and build their own provider networks by contracting directly with doctors and hospitals and processing all of their employees' healthcare claims themselves. Because arbitrage

(the reselling of a product from one customer to another) is impossible, national accounts could not avoid a price increase by buying health insurance from other employers.

2. The United States Is a Relevant Geographic Market for the Sale of Commercial Health Insurance to National Accounts

75. The United States is a relevant geographic market under Section 7 of the Clayton Act for the sale of commercial health insurance to national accounts. National accounts headquartered in the United States seek health insurers with nationwide provider networks and have similar nationwide insurer options.

76. This geographic market satisfies the hypothetical monopolist test, as national accounts headquartered in the United States do not have reasonable substitutes to purchasing commercial health insurance from insurers doing business in this country. National accounts would not close their offices and move their companies to different countries in response to a small but significant and non-transitory increase in the price of commercial health insurance.

C. The Sale of Commercial Health Insurance to Large Group Employers in Various Local Markets Is a Relevant Market

77. UnitedHealthcare competes in the sale of commercial health insurance to large group employers in local markets throughout the United States.

1. The Sale of Commercial Health Insurance to Large Group Employers Is a Relevant Product Market

78. The sale of commercial health insurance to large group employers is a relevant product market under Section 7 of the Clayton Act.

79. Large group employers are a distinct set of customers. As set by state law, large group consists of employers with more than 50 employees (or, in four states, more than 100 employees). Health insurers that sell to them do not need to follow various regulatory requirements applicable to small groups, including limitations on factors that can be used in

determining rates and other licensing and rate-filing requirements. UnitedHealthcare and other health insurers have dedicated business units focused on selling and marketing to large group employers. UnitedHealthcare regularly distinguishes large group employers in its business reviews and strategic plans. UnitedHealthcare charges large group employers different prices and offers different plan benefits than it does for other types of commercial health insurance customers.

80. The sale of commercial health insurance to large group employers satisfies the well-accepted "hypothetical monopolist" test set forth in the Horizontal Guidelines. Because large group employers offer health insurance to attract and retain employees, a hypothetical monopolist of commercial health insurance sold to large group employers would likely impose a small but significant and non-transitory price increase without losing sufficient sales to render that price increase unprofitable. In response to the price increase, few large group employers would stop buying commercial health insurance for their employees. Similarly, large group employers are unlikely to build their own provider networks and administer their health plans themselves. Large group employers cannot avoid a price increase by purchasing commercial health insurance from other employers.

2. The Relevant Geographic Markets for the Sale of Commercial Health Insurance to Large Group Employers

81. The relevant geographic markets for the sale of commercial health insurance to large group employers are the core-based statistical areas (CBSAs) that are metropolitan statistical areas (MSAs) in the United States. These areas include more than 285 million people—over 85 percent of all Americans. Each CBSA that is an MSA is a relevant geographic market for the sale of commercial health insurance to large group employers under Section 7 of the Clayton Act.

82. When purchasing commercial health insurance, large group employers want health insurers to offer healthcare provider networks in the areas where their employees live and work. In each of these CBSAs, large group employers do not view insurance companies that lack a meaningful provider network in that area as reasonable substitutes for those that offer such a network.

83. Each of these markets satisfies the "hypothetical monopolist test" for the sale of commercial health insurance to large group employers. In each of these CBSAs, large group employers are unlikely to move their offices to a different area in response to a small but significant and non-transitory increase in the price of commercial health insurance.

V. ANTICOMPETITIVE EFFECTS

84. The Proposed Transaction would likely substantially lessen competition and harm consumers in the aforementioned relevant markets in three ways.

- *First*, by giving United broad access to its health insurer rivals' competitively sensitive information through Change's first-pass claims editing solution and EDI clearinghouse, the Proposed Transaction is likely to substantially lessen competition in the markets for the sale of commercial health insurance to national accounts and large group employers.
- *Second*, United's acquisition of Change's first-pass claims editing solution and EDI clearinghouse would enable United to raise the costs of its health insurance rivals, reducing their ability to compete with UnitedHealthcare. This would likely substantially lessen competition in the markets for the sale of commercial health insurance to national accounts and large group employers. Post-transaction, United could raise its health insurance rivals' costs through means such as denying or

delaying their access to innovations that would provide greater efficiency in claims processing.

- *Third*, United and Change are the two most significant competitors in the first-pass claims editing solutions market, with a combined market share of at least 75 percent. The Proposed Transaction would eliminate head-to-head competition between United and Change and tend to create a monopoly in that market. The Proposed Transaction is presumptively unlawful under longstanding Supreme Court precedent and the Horizontal Guidelines.

As a result, the Proposed Transaction would likely harm millions of Americans by leading to lower-quality, less innovative, and more costly commercial health insurance.

A. The Proposed Transaction Would Likely Substantially Reduce Competition in the Relevant Health Insurance Markets by Giving United Access to Its Rivals' Competitively Sensitive Information

85. Through its first-pass claims editing solution and EDI clearinghouse, Change has access to vast quantities of competitively sensitive information from United's health insurance rivals. By acquiring Change, United would obtain that competitively sensitive information and could use it to lessen the competition it would otherwise face absent the Proposed Transaction.

1. United Gaining Access to Its Health Insurance Rivals' Competitively Sensitive Information Through Change's First-Pass Claims Editing Solution Is Likely to Substantially Lessen Competition in the Sale of Commercial Health Insurance to National Accounts and Large Group Employers

86. As the first-pass claims editing vendor of choice for United's largest health insurance rivals, Change works with its health insurer-customers to incorporate the insurers' proprietary edits into the customer's claims editing solutions. Change's first-pass claims editing solution is known to drive the highest savings for health insurers—a figure between three and eight percent of annual total claim costs. These savings yield cost savings for national accounts

and large group employers, which often subsidize their employees' healthcare costs. These savings also translate into cost savings for employees and their families, who in turn pay lower health insurance premiums. Thus, the custom edits applied by Change's ClaimsXten product affect a plan's cost structure. An insurer's custom edits also provide a roadmap to its health plan and reimbursement policies and its risk allocation methodologies. For these reasons, insurers view their custom edits as competitively sensitive.

87. Custom edits affect competition in the national accounts and large group markets. National accounts and large group employers evaluate and choose health insurers on their cost-containment strategies. These strategies are embodied, in part, in the health insurer's customized edits. Health insurers can differentiate themselves from rivals by implementing innovative edits that help their employer-customers combat unnecessary costs and make healthcare more affordable for employees and their families.

88. United currently does not have access to its most significant rivals' customized claims edits because these health insurer rivals use Change's first-pass claims editing solution rather than United's offering. Post-transaction, United would have access to its health insurer rivals' proprietary edits through ClaimsXten. With this data, UnitedHealthcare would have the ability to disadvantage its rivals, including by mimicking their innovative policies to make their rivals' healthcare plans less attractive to customers (relative to UnitedHealthcare). This would reduce the rivals' incentives to innovate in claims edits, which would also reduce innovation in commercial health insurance plan and provider network design. As a result, United would no longer independently pursue commercial health insurance innovation as it would have absent this inside information of its rivals.

89. Innovation competition among health insurers would likely decline, because rival insurers would know that United could identify and appropriate the innovation through its access to the innovator's competitively sensitive edits. This harm to innovation would reduce competition in the sale of commercial health insurance to national accounts and large group employers, resulting in less affordable or lower quality plans.

90. Because there is no viable alternative to a first-pass claims editing solution, and with the merged firm having over 75 percent of that market, health insurer rivals would have little choice but to use the merged firm's first-pass claims editing solutions and expose their competitively sensitive information to United. Moreover, switching first-pass claims editing solutions is a significant undertaking and it would be difficult and risky for United's insurer rivals to switch away from ClaimsXten, even if a comparable solution were available.

2. United Gaining Access to Rivals' Competitively Sensitive Information Through Change's EDI Clearinghouse Is Likely to Substantially Lessen Competition in the Sale of Commercial Health Insurance to National Accounts and Large Group Employers

91. The Proposed Transaction would allow United to use much of the data flowing through Change's market-leading EDI clearinghouse. United would gain the ability to use its health insurance rivals' competitively sensitive information to advantage itself and diminish competition in the sale of commercial health insurance to national accounts and large group employers.

92. Switching EDI clearinghouses is a significant undertaking for health insurers and would be difficult and resource intensive.

93. Even health insurers that decide not to contract directly with Change could not escape the consequences of United's ownership of Change by "going around" Change's EDI clearinghouse. This is because health insurers cannot avoid routing many EDI transactions

through Change's EDI clearinghouse. Change has over one million connections with providers, and those providers' claims will "hop" from Change to the insurer's EDI clearinghouse even if the health insurers seek to avoid doing business with Change and its EDI. A health insurer is unlikely to be able to respond to the Proposed Transaction by inducing all of its in-network providers to directly connect with the insurer or shift volume away from Change's EDI clearinghouse. Finally, even if health insurer rivals could avoid Change going forward, they could do nothing about the decade's worth of historic data, representing billions of claims, that Change has collected as an independent company.

94. Today, United has limited access to the competitively sensitive information of its health insurer rivals that is obtained through EDI clearinghouses. Through ownership of Change's EDI pipes, however, United would have access and the right to use the claims data of health insurer rivals. United could use this competitively sensitive information when making decisions related to UnitedHealthcare's plan designs, benefits, provider network designs, and coverage terms. United already applies artificial intelligence and machine learning capabilities to its own claims data to, among other things, optimize its claims processing capabilities and generate administrative and medical cost savings. Post-transaction, United would be able to apply these artificial intelligence and machine learning capabilities to the claims data of its insurer rivals, giving itself exclusive competitive intelligence about its rivals, learning both from the historic and new claims data. At the same time, United would likely deny its health insurer rivals access to this pool of data, as well as to United's claims data and any insights gained from it. It would be difficult and improbable for those rivals to replicate the decade of historical data or the immense volume of data collected each day from competing insurers.

95. Using the claims data from Change's EDI clearinghouse, United could also reverse engineer its insurer rivals' claims edits, even if it did not also own ClaimsXten. This access would reveal key insights about health insurer rivals' health plan policies, including plan design and reimbursement methodologies. These information asymmetries would distort competition, leaving health insurer rivals less able to compete for large group and national accounts customers.

96. United would likely also use this EDI information advantage to identify which national accounts and large group employers are better insurance risks (and thus most profitable). United could then bid on the most profitable accounts and groups with the benefit of its one-sided inside look at its competitors' claims data. United's asymmetric use of this competitively sensitive information to selectively bid on the most profitable national accounts and large employer groups, while avoiding bids on riskier accounts and groups, would create a less-competitive market for commercial health insurance.

97. United's rival health insurers would perceive United as having the strong motivation to use the rival insurers' data obtained through Change, and United would indeed have that motivation because the profits in the relevant health insurance markets are significantly larger than the profits for Change's EDI clearinghouse.

98. United's newfound ability to access rivals' competitively sensitive information obtained from Change's EDI clearinghouse would harm innovation in the national accounts and large group markets. United would be in a position to identify and poach profitable innovations in plan design, benefits, provider network design, reimbursement design, and coverage terms from its competitors without bearing the cost and development risks. Faced with this prospect,

health insurer rivals would forgo innovation rather than subsidize United in competition against them.

B. The Proposed Transaction Is Likely to Substantially Reduce Competition in the Relevant Health Insurance Markets by Giving United the Ability and Incentive to Raise Its Rivals' Costs

99. Acquiring Change would give United the ability and incentive to raise its health insurance rivals' costs. Change's first-pass claims editing solution and EDI clearinghouse, which many of United's rivals use to compete against United, are critical inputs in the provision of health insurance. Given the great financial reward of obtaining national accounts and large group customers from its rivals, United would be incentivized to use its control over Change to weaken its rivals and thereby reduce competition in the relevant health insurance markets.

1. Acquiring Change's Claims Editing Solution Would Give United the Ability and Incentive to Raise Its Rivals' Costs

100. United's largest health insurer rivals rely on Change's ClaimsXten claims editing solution as a critical input that delivers billions of dollars in medical cost savings. Currently, Change has the incentive to make its claims editing innovations available to all its insurer-customers, and without the Proposed Transaction that incentive would continue; ClaimsXten itself was originally an innovation created by working with one of Change's insurer-customers. National accounts and large group employers—and their employee-members—benefit from these savings through lower premiums, medical expenditures, and copayments. After the transaction, United could raise its health insurer rivals' costs by charging higher prices for first-pass claims editing solutions or by delaying or withholding service, updates, or innovations that its rivals would have had absent the transaction.

101. These concerns are especially acute because United recognizes that insurers have few options other than Change for first-pass claims editing solutions. Even where an insurer has

other options, switching to a new vendor is costly, time-consuming, and disruptive. It would take competitors years to recreate the breadth of Change's library of edits and develop the necessary capability to shift a large health insurer to a new platform.

102. Because the profits in the relevant health insurance markets are significantly larger than the profits in the first-pass claims editing market, United would have the incentive to raise its rivals' costs to lessen the competition it would otherwise face in the relevant health insurance markets, even if it meant it lost some first-pass claims editing customers.

103. Because United will have the ability and incentive to increase its health insurer rivals' costs, the Proposed Transaction is likely to substantially lessen competition in the sale of commercial health insurance to national accounts and large group employers.

2. Acquiring Change's EDI Clearinghouse Would Give United the Ability and Incentive to Raise Its Rivals' Costs

104. As an independent company, Change is incentivized to pursue EDI clearinghouse innovations that benefit all health insurers using its product. As Change noted, "being neutral allows us to work on use cases that benefit the entire healthcare system." Absent the transaction, an independent Change would be well positioned, including through Change's existing provider relationships, to pursue certain innovations. Post-transaction, however, United would have the incentive to weaken its health insurer rivals by withholding or delaying their access to such innovations. This would render the insurer rivals less-effective competitors, thereby harming competition in the relevant health insurance markets.

105. United could use its control of Change's EDI clearinghouse as additional leverage in dealing with UnitedHealthcare's rivals by threatening to suspend service to those rivals—by "dropping them to paper" and sending those claims via paper rather than through the EDI clearinghouse—unless they concede to United's demands. "Dropping to paper" would have dire

consequence for insurers' competitiveness given the costs, time, and loss of accuracy associated with processing claims without an EDI clearinghouse. This also would lead to provider and member frustration with the insurers, resulting in reputational harm to the insurers. Post-transaction, United would have the incentive and ability to exploit its rivals' fear of this threat to soften the competition UnitedHealthcare faces in its national accounts and large group businesses. The threat of being dropped to paper would give United significant leverage when negotiating contractual provisions, including provisions for claims data rights.

106. The merged firm would have substantial incentive to use Change's EDI clearinghouse to raise health insurer rivals' costs. The profits obtained by UnitedHealthcare from gaining national accounts and large group employers from its rivals would be greater than the loss of profits from withholding EDI innovations or from losing customers that decline to purchase EDI clearinghouse services from the merged firm.

107. The Proposed Transaction would degrade the health insurance choices available to employers. National accounts and large group customers would have to either: (1) choose a UnitedHealthcare rival and suffer reduced levels of service due to lower-quality EDI clearinghouse service, or (2) choose UnitedHealthcare as their insurer and likely pay higher prices for poorer quality than would have been the case in a market with a competitive, independent Change. Either way, national accounts and large group employers—and their enrollees—would be worse off without an independent Change; innovation would be reduced and competition among health insurers would be lessened.

C. The Proposed Transaction Would Likely Substantially Lessen Competition and Tend to Create a Monopoly in First-Pass Claims Editing Solutions

108. United's acquisition of Change would eliminate important competition between them for the sale of first-pass claims editing solutions, resulting in health insurer-customers facing higher prices, lower quality, and reduced access to claims-editing innovations.

1. The Proposed Transaction Is a Presumptively Illegal Combination of the Two Leading First-Pass Claims Editing Solutions

109. The Supreme Court has held that mergers that significantly increase concentration in already concentrated markets are presumptively anticompetitive and, therefore, presumptively unlawful. Courts often use the Herfindahl-Hirschman Index (HHI), as described in the Horizontal Guidelines, to measure market concentration. HHIs range from 0, in markets with no concentration, to 10,000, in markets where one firm has 100 percent market share. According to the Horizontal Guidelines, mergers that both increase the HHI for a given market by more than 200 and result in an HHI above 2,500 are presumed to be anticompetitive.

110. Change and United are the largest and second largest vendors of first-pass claims editing solutions, with a combined market share of at least 75 percent. The Proposed Transaction would increase the HHI by at least 2,000 points and result in a post-merger HHI of at least 6,400, making the transaction presumptively anticompetitive.

2. The Proposed Transaction Would Eliminate Head-to-Head Competition Between United and Change in the Sale of First-Pass Claims Editing Solutions

111. United and Change compete vigorously against each other in the market for first-pass claims editing solutions. Three months before the transaction was announced, United executives described Change as the "#1 competitor for first pass" claims editing, and noted that United was "[s]econd behind Change for primary editing."

112. United and Change often compete head-to-head to win customers' contracts. This competition has resulted in lower prices to insurers for first-pass claims editing solutions. For example, United regularly approves 20-25 percent discounts for customers when competing with Change. In a 2019 bid, United gave an insurer a "sweetheart deal to win them away" from Change. Similarly, Change executives and sales representatives have recommended and approved discounts as high as 30 percent in response to price pressure from United. Due to the "U-Factor," United's customers generally consist of small and mid-size insurers, but even United's largest health insurance competitors will get quotes from OptumInsight in an attempt to gain a competitive discount from Change.

113. Health insurers rely on the competition between United and Change to secure reduced pricing, better contract terms, and higher-quality and innovative products. If allowed to proceed, the Proposed Transaction would eliminate this intense competition for first-pass claims editing solutions, leading to higher prices and reduced quality and innovation.

VI. THE MERGER SHOULD BE ENJOINED

114. In each of the relevant markets, the Proposed Transaction is likely to substantially lessen competition, resulting in lower quality, less innovation, or higher prices.

115. A substantial lessening of competition in any relevant market is a violation of Section 7 of the Clayton Act and is sufficient for the Court to enjoin the Proposed Transaction in its entirety.

VII. ABSENCE OF COUNTERVAILING FACTORS

116. The Proposed Transaction is unlikely to generate verifiable, merger-specific efficiencies in the relevant markets sufficient to prevent or outweigh the significant anticompetitive effects that are likely to occur.

117. New entry or expansion by existing first-pass claims editing solutions is unlikely to prevent or remedy the transaction's likely anticompetitive effects in the relevant markets. There are high barriers to entry, such as technical capabilities, the resources needed to develop and maintain edit libraries, and experience with sophisticated health insurers. Customers also face high switching costs when choosing a new first-pass claims editing solution.

118. New entry or expansion by existing EDI clearinghouses is also unlikely to prevent or remedy the transaction's likely anticompetitive effects in the relevant markets. There are high barriers to entry, such as technical capabilities and the resources needed to establish relationships with providers and insurers and develop a deep repository of claims data. Moreover, because United's rivals cannot disintermediate Change's EDI clearinghouse, entry or expansion would not ameliorate the competitive harm.

119. Restoring competition is the key to any effective antitrust remedy. The only acceptable remedy for an anticompetitive merger is one that completely resolves all of the competitive problems created by the merger. Defendants bear the burden of showing that any remedy they propose meets these standards. United has proposed divesting Change's ClaimsXten business in an attempt to remedy the anticompetitive effects of this merger. Change has had some discussions with potential buyers, but has not entered into a purchase agreement. Defendants have not proposed any remedy that would preserve competition and prevent the anticompetitive effects of this merger.

120. Efforts to cordon off a health insurance rival's competitively sensitive information obtained from Change's EDI clearinghouse and first-pass claims editing solutions through information firewalls would be insufficient to protect against the risk of United accessing and using this information. This is especially true given (1) United's longstanding interest in

acquiring this competitively sensitive data; (2) the frequent movement of employees, including senior executives, between Optum and United subsidiaries who would be in a position to gain insights into United's health insurance rivals while working for Optum and bring those insights to any future work for UnitedHealthcare; and (3) the regular enterprise-wide planning that United conducts, which involves its business unit executives from United, Optum, and UnitedHealthcare.

VIII. JURISDICTION, VENUE, AND COMMERCE

121. Plaintiff United States brings this action pursuant to Section 15 of the Clayton Act, 15 U.S.C. § 25, to prevent and restrain Defendants from violating Section 7 of the Clayton Act, 15 U.S.C. § 18.

122. Plaintiffs Minnesota and New York, by and through their respective Attorneys General, bring this action in their respective sovereign capacities and as *parens patriae* on behalf of the citizens, general welfare, and economy of their respective States under their statutory, equitable, or common law powers, and pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, to prevent and restrain Defendants from violating Section 7 of the Clayton Act, 15 U.S.C. § 18.

123. Defendants are both engaged in, and their activities substantially affect, interstate commerce. United sells health insurance and healthcare technology to customers across the United States and owns healthcare practices in many states. Change sells critical healthcare technology to health insurers, healthcare providers, and other customers across the United States. Defendants' sales have a substantial effect on interstate commerce. The Court therefore has subject-matter jurisdiction over this action under Section 15 of the Clayton Act, 15 U.S.C. § 25, and 28 U.S.C. §§ 1331, 1337(a), and 1345.

124. The Court has personal jurisdiction over each Defendant. Defendants transact business within this District and have agreed not to contest personal jurisdiction in this District.

125. Venue is proper in this district under Section 12 of the Clayton Act, 15 U.S.C. § 22, and under 28 U.S.C. § 1391.

IX. VIOLATIONS ALLEGED

126. Plaintiffs incorporate the allegations of paragraphs 1 through 125 above.

127. Unless enjoined, United's proposed acquisition of Change is likely to substantially lessen competition, and tend to create a monopoly, in interstate trade and commerce in the relevant markets in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18.

128. The acquisition would likely have the following anticompetitive effects, among others, in the relevant markets:

i. United would gain the ability and incentive to obtain and use its rivals' competitively sensitive information, harming the competitive process in the sale of commercial health insurance to national accounts and large group employers;

ii. United would gain the ability and incentive to raise its rivals' costs, harming the competitive process in the sale of commercial health insurance to national accounts and large group employers;

iii. competition between United and Change in the sale of first-pass claims editing solutions would be eliminated prices of first-pass claims editing solutions would likely increase to levels above what would prevail absent the transaction, and the quality of first-pass claims editing solutions would

likely be reduced compared to what would prevail absent the transaction; and

iv. competition and innovation in the relevant markets would be reduced generally.

X. REQUEST FOR RELIEF

129. The Plaintiffs request that the Court:

a. adjudge and decree United's acquisition of Change to violate Section 7 of the Clayton Act, 15 U.S.C. § 18;

b. permanently enjoin Defendants from consummating United's proposed acquisition of Change or from entering into or carrying out any other agreement, understanding, or plan by which Change would be acquired by, acquire, or merge with United;

c. award each Plaintiff an amount equal to its costs incurred in bringing this action on behalf of its citizens; and

d. grant Plaintiffs such other relief as the Court deems just and proper.

Dated: February 24, 2022

Respectfully Submitted,

FOR PLAINTIFF UNITED STATES OF AMERICA:

/s/ Doha G. Mekki
DOHA G. MEKKI
Principal Deputy Assistant Attorney General
Antitrust Division

/s/ Carol L. Sipperly
CAROL L. SIPPERLY
Acting Deputy Assistant Attorney General
Antitrust Division

/s/ Craig W. Conrath
CRAIG W. CONRATH
Director of Civil Litigation

/s/ Eric D. Welsh
ERIC D. WELSH (DC Bar ##998618)
Chief
Healthcare and Consumer Products Section

/s/ Jill C. Maguire
JILL C. MAGUIRE (DC Bar #979595)
Assistant Chief
Healthcare and Consumer Products Section

/s/ Bindi R. Bhagat
BINDI R. BHAGAT
BENJAMIN ABLE
JOSEPH ADAMSON
JARED T. BOND
MARKUS BRAZILL
JANET J. BRODY
JESSICA N. BUTLER-ARKOW (DC Bar# 430022)
TRAVIS R. CHAPMAN
VITTORIO E. COTTAFAVI
JEREMY C. KEENEY (DC Bar #1029015)
A. MAYA KHAN
GRACE LEE (DC Bar # 198304)
JOHN D. LINDERMUTH
GARRETT M. LISKEY (DC Bar #1000937)
RICHARD MOSIER (DC Bar #492489)
MARK ROHAN (DC Bar# 177193)
SPENCER SMITH (DC Bar # is 1720226)
DAVID M. STOLTZFUS
EMMA WAITZMAN (DC Bar #1738427)
JENNIFER A. WAMSLEY (DC Bar# 486540)
Trial Attorneys

U.S. Department of Justice
Antitrust Division
450 Fifth Street, NW, Suite 4100
Washington, DC 20530
Telephone: (202) 598-8681
Fax: (202) 307-5802
Email: Eric.Welsh@usdoj.gov

FOR PLAINTIFF STATE OF MINNESOTA:

KEITH ELLISON
Attorney General
State of Minnesota

/s/ Elizabeth Odette

ELIZABETH ODETTE (MN Bar #0340698)
Assistant Attorney General
James W. Canaday (MN Bar #030234X)
Deputy Attorney General
Jason Pleggenkuhle (MN Bar #0391772)
Assistant Attorney General
Katherine Moerke (MN Bar #0312277)
Assistant Attorney General

445 Minnesota Street, Suite 1400
St. Paul, Minnesota 55101-2131
elizabeth.odette@ag.state.mn.us
Telephone: (651) 757-1028
james.canaday@ag.state.mn.us
Telephone: (651) 757-1421
jason.pleggenkuhle@ag.state.mn.us
Telephone: (651) 757-1147
katherine.moerke@ag.state.mn.us
Telephone: (651) 757-1288

Attorneys for Plaintiff State of Minnesota

FOR PLAINTIFF STATE OF NEW YORK:

LETITIA JAMES
Attorney General

/s/ Christopher D'Angelo
Christopher D'Angelo (D.C. Bar No. 502220)
Chief Deputy Attorney General, Economic Justice Division
Christopher.D'Angelo@ag.ny.gov
Elinor R. Hoffmann, Chief, Antitrust Bureau
Elinor.Hoffmann@ag.ny.gov
Amy McFarlane, Deputy Chief, Antitrust Bureau
Amy.Mcfarlane@ag.ny.gov
Olga Kogan, Assistant Attorney General
Olga.Kogan@ag.ny.gov
Benjamin Cole, Assistant Attorney General
Benjamin.Cole@ag.ny.gov
New York State Office of the Attorney General
28 Liberty Street
New York, NY 10005
(212) 416-8262

Attorneys for Plaintiff State of New York

Change Healthcare and Optum Extend Merger Agreement

Published April 05, 2022

- **Combination will benefit patients, payers and providers by lowering costs and improving experiences**

EDEN PRAIRIE, Minn. and NASHVILLE, Tenn.: Optum, a diversified health services company, and Change Healthcare (NASDAQ: CHNG), a health care technology leader, have agreed to extend their merger agreement to December 31, 2022.

In a joint statement, the companies said: "The extended agreement reflects our firm belief in the potential of our combination to improve health care, and in our commitment to contesting the meritless legal challenge to this merger."

Change Healthcare and Optum share a vision for achieving a simpler, more intelligent and adaptive health system for patients, payers and providers. The combination of Optum and Change Healthcare will connect and simplify the core clinical, administrative and payment processes health care providers and payers depend on to serve patients. Increasing efficiency and reducing friction will benefit the entire health system, resulting in lower costs and a better experience for all stakeholders.

Change Healthcare and Optum will detail the benefits of this combination at a two-week trial scheduled to begin on August 1. The U.S. Department of Justice's attempt to block the combination is without merit and serves only to delay improving the experience and outcomes for all participants in the health system.

As part of the extension, Optum will pay a $650 million fee to Change Healthcare in the event the merger is unable to be completed because of the court's decision. Change Healthcare will pay a special cash dividend of $2.00 per share to its shareholders at or about the time of the closing.

About Optum

Optum is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone. With more than 190,000 people worldwide, Optum delivers intelligent, integrated solutions that help to modernize the health system and improve overall population health. Optum is part of UnitedHealth Group (NYSE: UNH). For more information, visit www.Optum.com .

About Change Healthcare

Change Healthcare (NASDAQ: CHNG) is a leading healthcare technology company focused on insights, innovation, and accelerating the transformation of the U.S. healthcare system through the power of the Change Healthcare Platform. We provide data and analytics-driven solutions to improve clinical, financial, administrative, and patient-engagement outcomes in the U.S. healthcare system.

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 8-K

CURRENT REPORT
Pursuant to Section 13 or 15(d)
of the Securities Exchange Act of 1934

Date of Report (Date of Earliest Event Reported): April 22, 2022

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware	001-38961	82-2152098
(State or Other Jurisdiction of Incorporation)	(Commission File Number)	(IRS Employer Identification No.)

424 Church Street, Suite 1400
Nashville, Tennessee 37219
(Address of Principal Executive Offices) (Zip Code)

(615) 932-3000
(Registrant's Telephone Number, Including Area Code)

Not Applicable
(Former Name or Former Address, if Changed Since Last Report)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

☐ Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

☐ Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

☐ Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

☐ Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.001 per share	**CHNG**	**The Nasdaq Stock Market LLC**
6.00% Tangible Equity Units	**CHNGU**	**The Nasdaq Stock Market LLC**

Indicate by check mark whether the registrant is an emerging growth company as defined in Rule 405 of the Securities Act of 1933 (§230.405 of this chapter) or Rule 12b-2 of the Securities Exchange Act of 1934 (§240.12b-2 of this chapter).

Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Item 8.01 Other Events.

On April 22, 2022, UnitedHealth Group Incorporated ("UnitedHealth Group"), as seller, entered into an equity purchase agreement and related agreements relating to the sale of the claims editing business ("ClaimsXten") of Change Healthcare Inc. (the "Company") to an affiliate of investment funds of TPG Capital for a base purchase price in cash equal to $2.2 billion (subject to customary adjustments). Consummation of the transaction is contingent on a number of conditions, including the consummation of the previously announced merger transaction pursuant to which UnitedHealth Group will acquire the Company. The Company believes that its merger with UnitedHealth Group will advance its ability to create products and services that improve the delivery of health care and reduce the high costs and inefficiencies of the health system, which the Company will share broadly with patients, providers, and payers.

Forward-Looking Statements

This current report on Form 8-K contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 with respect to the proposed merger with UnitedHealth Group. Some of these statements can be identified by terms and phrases such as "anticipate," "believe," "intend," "estimate," "expect," "continue," "could," "should," "may," "plan," "project," "predict" and similar expressions. The Company cautions readers of this report that such "forward looking statements," including without limitation, those relating to the proposed merger, wherever they occur in this report or in other statements attributable to the Company, are necessarily estimates reflecting the judgment of the Company's senior management and involve a number of risks and uncertainties that could cause actual results to differ materially from those suggested by the "forward looking statements." For a discussion of these risks and uncertainties, see the information under the captions "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Company's most recent Annual Report on Form 10-K filed with the Securities and Exchange Commission ("SEC") on May 27, 2021 as such factors may be updated from time to time in the Company's periodic filings with the SEC. The Company's forward-looking statements speak only as of the date of this report or as of the date they are made. The Company disclaims any intent or obligation to update any "forward looking statement" made in this report to reflect changed assumptions, the occurrence of unanticipated events or changes to future operating results over time.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, the Registrant has duly caused this report to be signed on its behalf by the undersigned hereunto duly authorized.

CHANGE HEALTHCARE INC.

By: /s/ Loretta A. Cecil
Name: Loretta A. Cecil
Title: Executive Vice President, General Counsel

Date: April 25, 2022

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, *et al.*, *Plaintiffs*, v. UNITEDHEALTH GROUP INCORPORATED, *et al.*, *Defendants*.	Civil Action No. 1:22-cv-0481 (CJN) **[REDACTED VERSION]**

POST-TRIAL BRIEF OF DEFENDANTS UNITEDHEALTH GROUP INCORPORATED AND CHANGE HEALTHCARE INC.

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INTRODUCTION

After fourteen months of pre-suit investigation, four months of intense discovery, tens of millions of pages of document productions, dozens of depositions, and a two-week trial, the record lays bare what UnitedHealth Group Incorporated ("UHG") and Change Healthcare Inc. ("Change") have contended all along: there is no legal basis for blocking this merger. Rather than grapple with economic realities, Plaintiffs' case instead caricatures the proposed transaction, challenging a horizontal merger that will never happen and conjuring up complex, multi-step vertical theories of harm that, on this record, would require repudiation of settled law. Antitrust enforcers cannot obtain a Clayton Act injunction simply by theorizing a possible state of the post-merger world in which competition is supposedly lessened. "[A]ntitrust theory and speculation cannot trump facts," and it was Plaintiffs' burden to make a "'fact-specific' showing that the effect of the proposed merger 'is likely to be anticompetitive,'" based on a "'comprehensive inquiry'" into the market's "'structure, history[,] and probable future.'" *United States v. AT&T Inc.*, 310 F. Supp. 3d 161, 190–92 (D.D.C. 2018) (citations omitted), *aff'd*, 916 F.3d 1029 (D.C. Cir. 2019). Plaintiffs have failed to do so.

In fact, Plaintiffs have not come close to carrying their burden. In place of the "comprehensive inquiry" mandated by the Clayton Act, Plaintiffs improperly cordon off a laundry list of inconvenient market facts as "irrelevant" to the case, among them: the strength of UHG's firewalls; the extensive vertical integration across the healthcare industry (supported by firewalls similar to UHG's); the Department of Justice's approval of similar mergers based on firewalls; and the lack of any evidence that Optum has ever shared competitive intelligence with UnitedHealthcare ("UHC") about UHC's rivals, despite having the theoretical ability to do so today. *See* 8/1/22 AM Trial Tr. 13:22–14:14 (Pls.' Opening). Although the inquiry under Section 7 of the Clayton Act is necessarily forward looking, this historical evidence reveals that

competition can thrive under the exact conditions that Plaintiffs claim will exist post-merger and speaks directly to the incentives and constraints that inform UHG's conduct in the marketplace. Plaintiffs therefore have no choice but to dismiss these historical factors—not because they say too little about the likely future state of competition, but because they say too much. It is hard to believe that Plaintiffs would deem all of this key evidence irrelevant in a case where history favored (rather than refuted) their theories, *see* United States' Proposed Conclusions of Law ¶ 69, *United States v. AT&T Inc.*, Case No. 1:17-cv-02511-RJL (D.D.C. May 8, 2018), ECF No. 127 ("Courts can also evaluate historical events in the market to assess whether a merger is reasonably likely to lead to coordinated effects."), and Plaintiffs' decision to ignore that evidence here only underscores how incompatible their theories are with market realities.

Plaintiffs' case seeks to stitch together out-of-context snippets of documents and testimony to paint a picture of the post-merger world that was disclaimed by every single fact witness in the case and refuted by the record as a whole. For all Plaintiffs' and their experts' predictions of competitive catastrophe, none of the supposed "victims" here—no rival payer, national-account or large-group customer, or insurance broker or consultant—sent a representative to trial to support Plaintiffs' theories of harm. That silence from the market speaks volumes, and is the lens through which the Court should view the record evidence in this case.

Plaintiffs' lone horizontal theory, premised on the combination of Optum's and Change's first-pass claims editing solutions, attacks a strawman. Because UHG has agreed to divest Change's claims editing business, ClaimsXten, to TPG Capital, L.P. ("TPG"), there is no horizontal overlap in the actual post-merger world for Plaintiffs to challenge. Even assuming that UHG and Change have the burden of proving that the divestiture will maintain competition in the post-merger world, however, that burden has been more than satisfied. ClaimsXten operated as

an independent product for over a decade, becoming the market leader in first-pass claims editing long before it was sold alongside Change's other offerings. Post-divestiture, ClaimsXten will be run by a management team with decades of experience with the product and the industry, and Plaintiffs presented no testimony from any ClaimsXten customers expressing concerns about the divestiture itself or about TPG as a buyer. That is hardly surprising. TPG is a preeminent private-equity firm with extensive experience in carve-out transactions and healthcare technology. TPG's investment history, its financial incentives, and its specific plans to grow and innovate ClaimsXten through research-and-development ("R&D") investments qualify TPG as precisely the kind of buyer that will ensure ClaimsXten remains a market-leading solution, thereby preserving and enhancing competition.

Plaintiffs' case thus centers on the kinds of vertical-merger theories that have not been successfully pressed in a federal district court in half a century. ***First***, Plaintiffs allege that UHG will misuse the claims data passing through Change's Electronic Data Interchange ("EDI") clearinghouse to give UHC a leg up on other payers, resulting in harm to competition in the markets for commercial health insurance sold to national accounts and large-group employers. One version of this data-misuse theory predicts that, after the merger: (i) one of UHG's subsidiaries, OptumInsight, will have access to claims data passing through Change's EDI clearinghouse; (ii) OptumInsight will conduct competitive surveillance on Change's EDI data and provide that data, or insights derived from it, to UHG's health-insurance arm, UHC; (iii) UHC will use the data or insights to reverse engineer and copy innovations that rival payers use to distinguish themselves in the relevant insurance markets; (iv) UHC's copying will chill further innovation by those rival payers; and (v) this reduced innovation will cause antitrust harm in the form of lower quality or higher cost health plans in the relevant insurance markets. The second version of Plaintiffs' data-

misuse theory contends that OptumInsight will use Change's EDI data to improve an underwriting tool known as Group Risk Analytics ("GRA"), which will be offered only to UHC, resulting in UHC competing less vigorously for certain employer customers (those with high risk pools). ***Second***, Plaintiffs claim that Optum will use Change's EDI clearinghouse to develop products that will be deployed for UHC's sole benefit, either because they will be withheld from the market altogether or because Optum will offer degraded versions to UHC's rivals. ***Third***, Plaintiffs allege that Optum will use Change's EDI clearinghouse itself to raise rival payers' quality-adjusted costs either by throttling rival payers' EDI transactions in real time or by "dropping them to paper."

All of Plaintiffs' vertical theories fail for a simple reason: they have been created out of whole cloth and completely lack supporting evidence. Plaintiffs' theories assume that, post-merger, UHG's entire business strategy and corporate culture would change; it would intentionally violate or repeal its existing firewall policies; it would violate Change's existing contracts and the additional contractual commitments that UHG has offered in connection with the merger; and it would sacrifice billions of dollars in revenue from Optum's growing external payer business in order to preference UHC in the marketplace. These assumptions reflect a profound misunderstanding of how businesses operate in the real world and, in particular, how UHG has achieved its success in the market—by earning and maintaining the trust of its customers. Indeed, UHG today does not engage in any of the conduct that Plaintiffs claim it will post-merger, whether misusing data, withholding products, or otherwise raising rivals' costs.

Plaintiffs therefore needed to show that the merger will change UHG's incentives, such that UHG would change its conduct going forward. Plaintiffs wholly failed to do so and, worse, they put on virtually no evidence that any of the post-merger conduct they hypothesize would substantially lessen competition in the markets for commercial health insurance sold to national

accounts and large-group employers. Although Plaintiffs theorized that UHG might have new incentives to engage in certain conduct post-merger, they have not set forth any coherent theory for how that conduct would translate into a substantial lessening of competition in their alleged markets. It was Plaintiffs' burden to make this showing without the benefit of any presumption, yet their theories ask the Court to take it on faith that the relevant markets will be substantially less competitive after the merger, without any meaningful explanation of why that would be so.

UHG and Change respectfully submit that the Court should deny Plaintiffs' request for a permanent injunction, enter judgment in favor of UHG and Change, and order that ClaimsXten be divested to TPG.

LEGAL STANDARD

Section 7 of the Clayton Act prohibits a merger if, "in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition." 15 U.S.C. § 18; UHG and Change's Conclusions of Law ("COL") ¶ 1.[1] Although Plaintiffs try to downplay their evidentiary burden, the language of Section 7 has long been interpreted to prohibit transactions only where harm is probable or likely: the "mere possibility" of harm to competition is not enough to establish a claim. *See United States v. AT&T, Inc.*, 916 F.3d 1029, 1032 (D.C. Cir. 2019) (quoting *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 n.39 (1962)); *see also Brown Shoe*, 370 U.S. at 323 ("[N]o statute was sought for dealing with ephemeral possibilities. Mergers with a probable anticompetitive effect were to be proscribed by this Act."); *United States v. Baker Hughes Inc.*, 908 F.2d 981, 984 (D.C. Cir.

[1] UHG and Change's Proposed Findings of Fact and Conclusions of Law are being filed concurrently with this memorandum.

1990) (Thomas, J.) ("Section 7 involves *probabilities*, not certainties or possibilities."); COL ¶¶ 2–6.

In a horizontal merger case, plaintiffs can establish a presumption of competitive harm by showing "that a transaction will lead to undue concentration in the market for a particular product in a particular geographic area." *See Baker Hughes*, 908 F.2d at 982 (footnote omitted); COL ¶ 19. Plaintiffs do not get that "short cut," or any resulting presumption of competitive harm, in a vertical-merger case. *AT&T*, 916 F.3d at 1032; COL ¶ 42. Plaintiffs instead "must make a 'fact-specific' showing that the proposed merger is 'likely to be anticompetitive,'" *AT&T*, 916 F.3d at 1032 (citation omitted); COL ¶ 43, "on the basis of record evidence relating to the market and its probable future," *AT&T*, 310 F. Supp. 3d at 190 (quoting *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116–17 (D.D.C. 2004)); COL ¶ 10. Plaintiffs cannot rely on "antitrust theory and speculation" to "trump facts," *AT&T*, 310 F. Supp. 3d at 190 (quoting *Arch Coal*, 329 F. Supp. 2d at 116–17); COL ¶¶ 10, 45, and evidence that "it could be *possible* to act in accordance with [plaintiffs'] theories of harm is a far cry from evidence that the merged company is *likely to do so* (much less succeed in generating anticompetitive harms as a result)," *AT&T*, 310 F. Supp. 3d at 210 (emphases added); COL ¶ 60. Any testimony and documentary evidence, or snippets thereof, must be viewed in context against all "other evidence related to the motivation for the challenged merger . . . that came out at trial." *AT&T*, 310 F. Supp. 3d at 210; COL ¶ 60.

ARGUMENT

I. PLAINTIFFS FAILED TO PROVE A LIKELY AND SUBSTANTIAL LESSENING OF COMPETITION UNDER THEIR HORIZONTAL THEORY.

Plaintiffs' horizontal theory—that the transaction would result in a merger to monopoly in the market for first-pass claims editing solutions—finds no support in the evidence. In the pre-merger world, the two leading products in the market, Change's ClaimsXten and Optum's Claims

Edit System ("CES"), are sold by competitor firms. The same will be true in the post-merger world: as a consequence of the divestiture, TPG will own the ClaimsXten business and Change's current management team will continue to operate it as the market-leading competitor to CES.

Plaintiffs virtually ignored the divestiture during their case in chief, declining to ask a single one of the few payer or provider witnesses who testified whether they were concerned about ClaimsXten's future (or claims-editing competition more generally) in light of the divestiture. When Plaintiffs did address the divestiture, they largely focused on "process" points, insinuating wrongly that the divestiture process was rushed and its outcome certain, reflecting a "cozy" relationship between UHG and TPG. Contrary to Plaintiffs' allegations, the undisputed evidence shows that UHG and Change used a well-known investment banker (Barclays) to run a robust and competitive M&A process, all by the book. TPG fully diligenced ClaimsXten, and TPG and UHG acted, as they always have, as arm's length market participants. Critically, the record shows that TPG will only increase competition for first-pass claims editing because TPG has the ability and financial incentives to grow ClaimsXten and intends to make substantial investments to achieve that growth. *See, e.g.*, 8/11/22 PM Trial Tr. 90:19–22 (Raj) ("[THE COURT:] Is there any world in which you, personally, TPG, as an entity, and the investors do better if ClaimsXten performs poorly? A. Absolutely not.); *id.* at 91:15–23 ("[THE COURT:] [N]et-net, the better ClaimsXten does between now and whatever might happen in 2026, whether it's a sale, a continued ownership, et cetera, the -- if, at that time, when you assess the value of the business in 2026, the better that ClaimsXten has performed in the interim, the more valuable it will be to you as an asset. Correct? A. That's 100 percent right."); UHG and Change's Findings of Fact ("FOF") ¶ 483. For those reasons, Plaintiffs' horizontal claim should be rejected.

Rather than affirmatively grapple with the competitive implications of the divestiture, Plaintiffs contend that UHG and Change bear the "burden" "to prove the divestiture w[ill] be sufficient" and will "replace the competition that's lost by the merger." 8/1/22 AM Trial Tr. 29:7–21 (Pls.' Opening). Plaintiffs' framing reflects cascading legal error, both in its allocation of the burden and in its articulation of the relevant statutory standard. To obtain a presumption of harm to competition, Plaintiffs needed to introduce evidence showing that the "transaction will lead to undue concentration in the [relevant] market." *Baker Hughes*, 908 F.2d at 982; COL ¶ 19. But the relevant "transaction" for purposes of their Section 7 claim "is in reality . . . the merger agreement including the . . . divestiture." *See, e.g.*, Mem. Op. at 5, *FTC v. Arch Coal, Inc.*, No. 1:04-cv-00534-JDB (D.D.C. July 7, 2004), ECF No. 67; COL ¶ 24. The "transaction" thus will not cause any increased concentration in the market for first-pass claims editing because, in the post-transaction world, ClaimsXten and CES will not be owned by the same entity due to the divestiture of ClaimsXten to TPG. Plaintiffs therefore do not get the benefit of a presumption of harm to competition on their horizontal theory that would shift the burden to UHG and Change. COL ¶¶ 33–34.

Regardless, Plaintiffs are wrong to suggest that UHG and Change would need "*to prove* the divestiture w[ill] be sufficient." 8/1/22 AM Trial Tr. 29:7–21 (Pls.' Opening) (emphasis added). "[T]he ultimate burden of persuasion" in a Section 7 case "remains with [plaintiffs] at all times." *Baker Hughes*, 908 F.2d at 983; COL ¶¶ 16–18, 35. A presumption of harm to competition only shifts the "burden of *production*" to UHG and Change, and that burden can be satisfied through evidence "that the prima facie case inaccurately predicts the relevant transaction's probable effect on future competition." *Baker Hughes*, 908 F.2d at 991 (emphasis added); COL ¶¶ 13, 35. The record conclusively shows that Plaintiffs' prima facie case—which alleges a merger

involving the two leading players in the market for first-pass claims editing—inaccurately predicts the state of the post-merger market, where TPG will own ClaimsXten.

Burden shifting aside, Plaintiffs are wrong that Section 7 requires a showing that a proposed divestiture perfectly maintains the existing level of competition in a relevant market. The plain text of Section 7 makes clear that the only relevant question is whether, in light of the divestiture, the transaction considered as a whole would be likely to "***substantially*** . . . lessen competition." 15 U.S.C. § 18 (emphasis added); COL ¶¶ 1, 30–32. Plaintiffs' approach to divestiture-related issues therefore stands antitrust law on its head, imposing a heightened burden of proof on UHG and Change (who do not bear the ultimate burden of persuasion) to show maintenance of competition at precisely the same level as the pre-merger world (a standard lacking support in the text of the Clayton Act).

Even so, the Court need not decide these threshold legal questions because whoever bears the burden of production or persuasion, and whatever the statutory standard, a TPG-owned ClaimsXten will not only maintain, but will likely increase, the level of competition for first-pass claims editing. A federal court tasked with evaluating the effect of a divestiture on competition considers a variety of factors, including "the likelihood of the divestiture; the experience of the divestiture buyer; the scope of the divestiture[;] the independence of the divestiture buyer from the merging seller[;] and the purchase price." *FTC v. RAG-Stiftung*, 436 F. Supp. 3d 278, 304 (D.D.C. 2020); COL ¶ 36. On each of these metrics, the trial evidence conclusively established that the divestiture will maintain and enhance future competition for first-pass claims editing.

Likelihood. Plaintiffs have not contested the likelihood of the divestiture, and for good reason: it is a virtual certainty. UHG and TPG have entered into a definitive purchase agreement, all conditions of which have been satisfied, except for those that will be satisfied either at closing

or by resolution of this case. 8/11/22 AM Trial Tr. 163:24–164:2 (Raj) ("Q. Mr. Raj, is this agreement from April 22 binding on TPG and UHG, as you understand it? A. It is. The only real contingency that I'm aware of is the outcome of this proceeding, but, otherwise, it's binding on us."); FOF ¶ 428.

Scope. The scope of the divestiture, which includes all assets necessary to operate ClaimsXten as a standalone business, also supports the divestiture. A "core aspect" of TPG's due-diligence process was determining whether the asset package it would acquire was "sufficient to operate ClaimsXten on a standalone basis." 8/11/22 AM Trial Tr. 160:11–14 (Raj); FOF ¶ 459. TPG concluded that there was not "any asset -- physical, human capital, intellectual property -- that TPG . . . need[ed] to stand up ClaimsXten[] [that was] not included in the asset package." 8/11/22 AM Trial Tr. 161:10–13 (Raj); FOF ¶ 460. The trial evidence supports TPG's conclusion. Carolyn Wukitch, Change's senior leader who currently manages ClaimsXten for Change, will be the CEO of ClaimsXten post-divestiture. 8/2/22 AM Trial Tr. 105:14–25 (de Crescenzo); FOF ¶ 436. Ms. Wukitch is bringing approximately 375 Change employees with her, including the entire ClaimsXten leadership team, 8/11/22 AM Trial Tr. 47:12–18 (Wukitch); 8/2/22 AM Trial Tr. 106:15–24 (de Crescenzo); FOF ¶¶ 434, 437, and all the technology "architecture around ClaimsXten" is included in the divestiture package, 8/11/22 AM Trial Tr. 40:11–41:1 (Wukitch); FOF ¶ 429.

Plaintiffs' main response is that ClaimsXten may be less successful if it is not sold alongside Change's other payment-accuracy offerings. But Plaintiffs do not contend that end-to-end payment accuracy comprises a relevant market, nor did they present any evidence on this illusory market segment, such as the products offered or the competitive landscape. More to the point, before ClaimsXten became part of Change in 2017, it was sold as a standalone product by

McKesson Corporation ("McKesson") for a decade, during which time it became the market leader in first-pass claims editing. *See* 8/11/22 AM Trial Tr. 17:1–12 (Wukitch); FOF ¶ 491. "Probably 90 percent" of ClaimsXten's current customers—including Aetna, Anthem, and Cigna—began buying ClaimsXten from McKesson as a standalone product, *see* 8/11/22 AM Trial Tr. 130:21–132:10, 141:20–25 (Wukitch); FOF ¶ 491, and multiple witnesses testified that they are unaware of a single customer who has since decided to buy ClaimsXten because it was included in a suite of products. 8/2/22 PM Trial Tr. 95:22–25 (Turner); 8/11/22 AM Trial Tr. 38:15–18 (Wukitch); FOF ¶ 490. In fact, Plaintiffs elicited no testimony showing that customers have any desire to buy other payment-accuracy solutions alongside ClaimsXten. ClaimsXten has been, is now, and will continue to be bought and sold as a standalone product, and it is inconceivable that a sophisticated buyer like TPG would agree to pay $2.2 billion if it thought anything different.

Experience. Plaintiffs also lack any meaningful response to TPG's relevant experience in healthcare and IT. TPG has significant experience with both carve-out transactions and healthcare assets, and historically has helped grow its healthcare businesses by increasing their R&D budgets by 156% as described in a retrospective assessment. *See, e.g.*, 8/11/22 PM Trial Tr. 8:16–9:14 (Raj); DX-0617A at .0009; FOF ¶¶ 445–50. TPG plans to follow this same playbook with ClaimsXten. Under Change, ClaimsXten's R&D budget was $14 million in FY2022. 8/11/22 PM Trial Tr. 34:20–35:4 (Raj); FOF ¶ 478. Under TPG, ClaimsXten's target R&D budget will increase to $17 million in FY2023, $26 million in FY2024, $28 million in FY2025, and $30 million in FY2026—that is, as compared to Change's R&D spending, TPG will more than double R&D spending within 4 years. 8/11/22 PM Trial Tr. 36:20–37:22 (Raj); FOF ¶ 478.

Plaintiffs' answer to TPG's concrete plans for growing ClaimsXten and its history of success in the healthcare space is to point out the obvious: TPG is a private-equity firm. According

to Plaintiffs, this fact somehow counts against TPG as a divestiture buyer because private-equity firms "have incentives that run different" to those of strategic buyers. *See, e.g.*, 8/1/22 AM Trial Tr. 30:7–17 (Pls.' Opening). Not so. The Clayton Act does not put a thumb on the scale against private-equity firms as divestiture buyers, and nothing in the law presumes, as Plaintiffs do, that such firms are somehow incapable of replicating competition in the markets in which they participate. Plaintiffs' position is belied by the Department of Justice's own Merger Remedies Manual, which recognizes that "in some cases a private equity purchaser may be preferred" to a strategic buyer because the private-equity firm has more "flexibility in investment strategy, [i]s committed to the divestiture, and [i]s willing to invest more when necessary." Antitrust Div., U.S. Dep't of Justice, *Merger Remedies Manual* 24–25 (Sept. 2020) (DX-0777 at .0027–28); FOF ¶ 468. The record evidence also conclusively refuted Plaintiffs' position. When the Court asked the co-managing partner of TPG whether "TPG, you personally, and your investors, benefit through this acquisition more the better ClaimsXten performs," he responded, "[a]bsolutely" and went on to explain that "the better [a] company does between the time we buy it and the time we're ready to sell it, the more money someone will pay us for that asset." 8/11/22 PM Trial Tr. 90:15–18, 91:8–14 (Raj); FOF ¶ 483. This alignment of incentives is precisely why TPG plans to make substantial R&D investments to help ClaimsXten grow and why ClaimsXten will compete just as fiercely post-merger as it does today, if not more.

Independence. TPG is an entirely independent buyer. Despite Plaintiffs alleging a "cozy" relationship between UHG and TPG, 8/1/22 AM Trial Tr. 30:3–6 (Pls.' Opening), the evidence showed that the two have done only a handful of deals together, each of which was conducted "at arm's length" and was "heavily and hotly negotiated." 8/11/22 PM Trial Tr. 5:3–9 (Raj); FOF ¶ 469. The existence of a standard transition services agreement ("TSA") between TPG and UHG

does not remotely suggest otherwise. The Department of Justice routinely signs off on divestitures that employ TSAs. FOF ¶ 470. And this particular TSA is both limited in scope and in fact necessary for the success of the divestiture, providing a routine 9–12 months of support for the "back-office parts of the business"—things like "finance systems, IT systems, [and] HR systems"—with no support offered for parts of the business that are "customer facing or product oriented." 8/11/22 AM Trial Tr. 164:25–166:25 (Raj); FOF ¶¶ 471–72. The duration and scope of the services provided under the TSA are "very typical" for carve-out transactions, and in no way render TPG—one of the leading private-equity firms in the country—beholden to UHG. 8/11/22 AM Trial Tr. 165:7–9, 166:9–25 (Raj); FOF ¶ 472.

Purchase Price. There can be no serious dispute over whether the $2.2 billion price tag for ClaimsXten is adequate and reflects ClaimsXten's standalone value. *See* 8/11/22 PM Trial Tr. 55:12–14 (Raj); FOF ¶ 428. Indeed, [redacted]. *See* DX-0616A at .0006; PX195 at 1; FOF ¶ 428.

In short, if ClaimsXten is divested to TPG, first-pass claims editing will remain just as competitive as it is today, if not more so, and that is dispositive under Section 7 of the Clayton Act. Plaintiffs have not presented any third-party testimony attacking the adequacy of the divestiture, and in fact the only payer witness [redacted] to address the issue confirmed that [redacted]; FOF ¶ 488. Plaintiffs' horizontal claim fails, and the Court should order the divesture. *See* Final Judgment at 9–15, *United States v. Gray Television, Inc.*, 1:21-cv-02041-CJN (D.D.C. Oct. 25, 2021), ECF No. 11 (ordering a divestiture); 16 C.F.R. § 802.70.

II. PLAINTIFFS FAILED TO PROVE A LIKELY AND SUBSTANTIAL LESSENING OF COMPETITION UNDER ANY OF THEIR VERTICAL THEORIES.

Unable to make a horizontal case, Plaintiffs resorted to vertical theories of competitive harm, all of which are speculative and unsupported by the record.

A. Plaintiffs failed to prove a likely and substantial lessening of competition under their data-misuse theory.

Plaintiffs' first vertical theory is that UHG would use the claims data that passes through Change's EDI clearinghouse to benefit UHC. One version of that theory claims that UHG would use Change's EDI data to reverse engineer rival payers' innovations, which would enable UHC to copy those innovations and chill rival payers from innovating further, thereby harming competition in the relevant markets for the sale of commercial health insurance. A second version of Plaintiffs' theory claims that UHG would use Change's EDI data to improve the GRA underwriting tool, which would enable UHC (and UHC alone) to bid less competitively (or not bid at all) on certain high-risk employer customers.

Both versions of Plaintiffs' data-misuse theory suffer from the same fundamental defects. ***First***, Plaintiffs assert that UHG would act in ways that contradict more than a decade of experience as a vertically integrated company, despite having no meaningful evidence that the merger will materially change UHG's incentives. Although Plaintiffs predict a tectonic shift in UHG's corporate culture and strategy, there are no internal UHG documents or testimony that show UHG even considering such a shift, much less making one, and Plaintiffs' economic expert offered neither an accepted methodology for assessing UHG's post-merger incentives, nor any quantification of those incentives. ***Second***, rival payers—large, sophisticated firms with powerful incentives to keep UHC from gaining a leg up—offered no testimony in support of Plaintiffs' theory. Indeed, rival payers squarely contradicted the "copying innovations" version of the theory, stating that the merger will not cause them to innovate any less with respect to health plans offered

to national accounts and large-group employers. ***Third***, no evidence whatsoever establishes that any of the actions Plaintiffs predict UHG would take after the merger would result in higher prices, lower quality, or any other harm to competition in the relevant commercial insurance markets.

1. The record does not support the "copying innovations" version of Plaintiffs' data-misuse theory.

The "copying innovations" version of Plaintiffs' data-misuse theory predicts that UHG will make radical changes to the way it has always done business despite a total absence of proof that the merger will change UHG's incentives. UHG's Optum subsidiary is—and always has been—"fiercely multi-payer in [its] orientation." 8/4/22 PM Trial Tr. 23:5–25 (Wichmann); 8/10/22 PM Trial Tr. 21:7–22:9 (Witty) ("I strongly, strongly believe that being multi-payer is a key feature of Optum, a key feature really, therefore, of UnitedHealth Group."); FOF ¶ 45. That means that Optum tries to sell each of its products to external payers. DX-0850; 8/5/22 AM Trial Tr. 62:23–63:3 (Yurjevich); FOF ¶¶ 46, 48, 73–74. Optum has been successful at doing so: of the approximately 230 payers in the United States, Optum has contracts with about 220 of them. 8/5/22 AM Trial Tr. 19:6–12 (Yurjevich); FOF ¶ 78. The list includes Aetna, Anthem, Cigna, many of the largest BlueCross BlueShield plans, and nearly all of UHC's other most significant rivals. *See* 8/5/22 AM Trial Tr. 12:8–18, 19:13–18 (Yurjevich); FOF ¶¶ 78, 87. Because Optum does business with so many external payers, it already has access to huge volumes of external payers' data. DX-0862 at .0014–15; FOF ¶¶ 83–87. Indeed, Optum currently has access to huge volumes of external payers' *claims data*—the exact form of data that passes through Change's EDI clearinghouse—in addition to other competitively sensitive pieces of information, such as payer-

provider reimbursement terms, payer-provider contracts, and payer-specific adjudication rules. DX-0862 at .0014–15; FOF ¶¶ 83–99.

UHG has every incentive to take the protection of such data "very seriously." 8/10/22 PM Trial Tr. 119:22–120:11 (Gehlbach); FOF ¶ 104. For as long as Optum has existed, UHG has maintained an enterprise-wide firewall policy that prohibits employees of one business unit from "participat[ing] in or facilitat[ing] communications that may reduce or eliminate competition between another Business Unit and its competitor(s)." DX-0529A at .0002; FOF ¶¶ 121–23. UHG has also operationalized its firewall policy through "robust" technological systems that prevent employees of one UHG business unit from accessing data housed within another UHG business unit. 8/5/22 PM Trial Tr. 31:12–32:4 (Dumont); FOF ¶¶ 124–26. UHG's firewall policy—and the technology behind it—have worked. Plaintiffs spent 18 months probing the effectiveness of UHG's firewalls through depositions, document productions, and written discovery. Yet Plaintiffs have not identified ***a single instance*** of Optum sharing external payers' data with UHC or UHC accessing external payers' data housed within Optum. FOF ¶¶ 127–29. That is no surprise: Optum's customers audit UHG's firewalls frequently, and none of those audits have turned up a breach. DX-0755; FOF ¶¶ 116–19. It is telling that after 18 months of scrutiny, and in-depth discovery into UHG's firewalls, Plaintiffs now deem UHG's track record regarding its firewall policies "irrelevant." *See* 8/1/22 AM Trial Tr. 13:22–14:4 (Pls.' Opening). But the Clayton Act does not permit Plaintiffs to ignore historical evidence simply because it hurts their case; it demands a "'fact-specific' showing that the effect of the proposed merger 'is likely to be anticompetitive,'" based on the "'structure, ***history***[,] and probable future'" of the markets at issue. *See AT&T*, 310 F. Supp. 3d at 192, 221 (emphasis added) (citations omitted); COL ¶¶ 44, 46–47.

As belt and suspenders, UHG also attempted to assuage Plaintiffs' unfounded concerns about its firewalls by adopting an additional, merger-specific firewall policy that reaffirms the company's existing policies and practices. UHG's merger-specific policy expressly prohibits the "disclosure of External Customer CSI to UHG business units that are competitors of such External Customers" as well as the "use of External Customer CSI to benefit UHG business units that are competitors of such External Customers." DX-0654 at .0002; FOF ¶¶ 130–33. After the merger, then, external payers would have the benefit of not one but two layers of firewall protection.

Plaintiffs seem to believe that neither layer of protection would prevent rogue employees from using data to reverse engineer other payers' innovations and then passing those innovations to UHC "remotely and over the phone." *See* 8/1/22 AM Trial Tr. 15:1–7 (Pls.' Opening). This "telephone" theory reflects an astonishingly naive view of how vertically integrated businesses operate, but more importantly it misunderstands the complicated nature of the data and insights at the heart of Plaintiffs' theory. As Plaintiffs' own claims-data expert, Dr. Handel, testified, reverse engineering rival payers' innovations "would take a team of analytics professionals some months or some meaningful amount of time." 8/8/22 PM Trial Tr. 38:16–39:3 (Handel); FOF ¶ 375. This is the stuff of machine learning models, regressions, and complex statistics—not whisper down the lane—and it severely undermines Plaintiffs' suggestion that any data misuse would be undetectable. In any event, if Plaintiffs' theory of data misuse were correct, Section 7 would prohibit the extensive vertical integration that exists in the healthcare space today because of the inherent risk of data misuse in every telephone conversation between employees of different business units. To state the obvious, that is not the law. *See United States v. CVS Health Corp.*, 2019 WL 4793060 (D.D.C. Sept. 4, 2019) (final judgment authorizing the merger of CVS and Aetna).

UHG's maintenance and enforcement of strong firewall policies is entirely consistent with its economic incentives and business model. Last year alone, non-UHG customers accounted for approximately $63 billion in Optum revenue, with OptumInsight accounting for $4.1 billion of that share. PX830 at USDOJ-008-000001519; 8/10/22 AM Trial Tr. 71:9–22 (Schumacher); FOF ¶ 384. If external payers stopped trusting Optum to keep their data away from UHC, then that "entire book of external business" would be "immediately at risk." 8/5/22 AM Trial Tr. 31:13–32:11, 71:6–14 (Yurjevich); FOF ¶ 385. If an external payer cannot trust one Optum business unit with its data, then it cannot trust any Optum business unit with its data, meaning that Optum risks losing the payer's business entirely, not just the $4.1 billion share from OptumInsight. 8/5/22 AM Trial Tr. 31:24–32:11 (Yurjevich); PX830 at USDOJ-008-000001519; 8/10/22 AM Trial Tr. 71:9–22 (Schumacher); FOF ¶¶ 384–85.

Although Plaintiffs cannot seem to grasp that UHG's firewalls align with its financial incentives in the pre- and post-merger world, the market gets it. One [redacted] plan, for example, was "highly confident and convinced" that Optum would not "share their Plan's information with United Healthcare" because doing so would "risk [Optum's] credibility or brand reputation." DX-0472 at .0004; FOF ¶¶ 95, 139, 383. That is exactly right—and credibility and reputation are all that stand between Optum and a $63 billion loss from misuse of data in the post-transaction world.

Plaintiffs discount all of the above—UHG's firewalls, their track record, and what they reveal about UHG's incentives—as "not relevant." 8/1/22 AM Trial Tr. 13:22–14:4 (Pls.' Opening). The transaction will change UHG's incentives, Plaintiffs say, and UHG's firewalls will change accordingly. *Id.* at 50:6–13. But Plaintiffs cannot meet their burden simply by intoning "changed incentives" like a mantra, and "things might change" is not a viable theory of vertical antitrust harm. To carry their burden, Plaintiffs needed to make a "'fact-specific' showing" that

the merger would change UHG's incentives, *AT&T*, 916 F.3d at 1032 (citation omitted); COL ¶ 43, and they have fallen well short of doing so.

The record reveals that, post-merger, Optum would have an equal or greater incentive to prohibit UHC from using rival payers' data to copy their innovations. Post-merger, Optum would still stand to lose at least $63 billion by sharing external payers' data (or innovations derived from that data) with UHC, including the $4.1 billion in external payer revenue generated by OptumInsight. *See* 8/5/22 AM Trial Tr. 31:24–32:11 (Yurjevich) ("Q. Why do you say that? Because Change is just going to be part of OptumInsight, but why are OptumRx and OptumHealth also affected? A. OptumRx and OptumHealth serve the same customers that we serve within OptumInisght. So our customers don't think of us as OptumInsight, OptumHealth or OptumRx. Our customers think of us as Optum."); FOF ¶¶ 384–85. Change likewise has billions in revenue from non-UHC payers that would be put at risk, even excluding the revenue ([redacted]) that comes from ClaimsXten. 8/10/22 AM Trial Tr. 134:19–24 (Schumacher); 8/15/22 AM Trial Tr. 39:24–41:17 (Murphy) ("But the other side of the equation is the cost of misusing data goes up, too, because you're not now just putting the existing Optum business at risk by misusing data, you're putting the Change business at risk by misusing data."); FOF ¶ 386. Setting the Change revenue aside, UHG expects that Optum's external-payer business will "continue to grow," 8/9/22 PM Trial Tr. 87:20–25 (McMahon); FOF ¶ 387, so Optum likely will have more than $63 billion to lose in future years, as compared to the approximately [redacted] in revenue that UHC generates from national-account and large-group customers, [redacted]; FOF ¶ 35.

The consequences of data misuse do not end with the risk of lost business. When questioned by the Court, Change's Senior Vice President and General Manager of Data Solutions unequivocally testified that Change's standard EDI contract prohibits the use of one payer's data for another payer's benefit. 8/3/22 AM Trial Tr. 47:12–24 (Suther) ("And if we felt that a [sic] interested health insurer were trying to, you know, reverse engineer the business practices of one of their competitors, that, in our mind, would be a violation of our confidentiality obligations under our agreement and wouldn't permit it."); FOF ¶¶ 232, 388. This testimony is corroborated by Change's longstanding business practice: Change has never sold one payer's data to a rival payer. 8/2/22 PM Trial Tr. 119:25–120:1 (Suther); FOF ¶ 233. Plaintiffs' theory of harm thus requires an inference that UHG would adopt a different interpretation of Change's contracts post-merger, thereby exposing itself to significant legal liability. Further, UHG offered amendments to Change's customer contracts to guarantee that "UHG will maintain commercially reasonable firewall and information security policies to protect Customer's Confidential Information from being disclosed" to UHC. DX-0766 at .0004; FOF ¶¶ 403–08, 410–11. Nearly 2,900 of Change's customers took UHG up on that offer. DX-0214S; FOF ¶ 409. UHG has therefore voluntarily assumed additional contract liability that constrains its ability to act in the manner Plaintiffs hypothesize. That is not the conduct of a company that intends to turn around and misuse rival payers' data to copy their innovations, and Plaintiffs have no evidence suggesting otherwise.

Rather than address the substantial costs that data misuse would impose on UHG, Plaintiffs and their economist take the position that any such costs would be "negligible" because "rivals aren't going to know whether United uses this information." 8/9/22 PM Trial Tr. 54:5–55:19 (Gowrisankaran); FOF ¶ 392. This is pure speculation: Dr. Gowrisankaran conducted no investigation whatsoever into whether external payers would be able to detect UHG's misuse of

their data. FOF ¶ 393. Nor did he provide any methodology to the Court that comes close to satisfying Rule 702 of the Federal Rules of Evidence. FOF ¶ 393. Equally problematic, Dr. Gowrisankaran simply zeroed out the potential costs to UHG by assuming away the "legal ramifications" that would flow from data "sharing," even though the sharing he hypothesizes is contrary to UHG's policies, contractual commitments, and—under Plaintiffs' theory—qualifies as a violation of antitrust law. *See* 8/15/22 PM Trial Tr. 28:8–29:11 (Gowrisankaran) ("I made no contention that, as a result of this merger, UnitedHealth Group was going to misuse its rivals' data that it's going to use it in a way that violates legal standards or its contracts."); FOF ¶ 394. The risk of legal liability is real and significant—and it cannot be ignored simply because it is inconsistent with Plaintiffs' theory.

On the other side of the scale, Plaintiffs have vanishingly little proof that UHG stands to gain anything by misusing external payers' data. Today, UHG does not use external payers' data to reverse engineer those payers' innovations. *See, e.g.*, 8/4/22 PM Trial Tr. 31:4–7 (Wichmann); 8/5/22 AM Trial Tr. 13:23–14:16 (Yurjevich); 8/8/22 AM Trial Tr. 89:25–90:10 (Higday); 8/10/22 AM Trial Tr. 73:14–74:16 (Schumacher); 8/10/22 PM Trial Tr. 119:22–120:11 (Gehlbach); FOF ¶ 104. By Plaintiffs' own logic, that means UHG does not currently have sufficient incentive to engage in reverse engineering. Plaintiffs therefore needed to prove that Change's EDI data would give UHG *additional* incentive to engage in reverse engineering, and such incentive would exist only if Change's EDI data made reverse engineering more valuable than it is today.

Plaintiffs have not come close to showing that reverse engineering would be more valuable post-merger. Optum currently has huge volumes of external payers' claims data. DX-0862 at .0014–15; FOF ¶¶ 83–87, 90–96. Plaintiffs have not shown how much of that data Optum has; what innovations could be reverse engineered from that data; or how valuable those innovations

would be—*i.e.*, how much new national-account or large-group business UHC could win as a result of the innovations. Optum also has significant volumes of other types of external payers' data (*e.g.*, provider guides, contracts, and payer-specific adjudication rules that Optum receives in connection with its payment-integrity products). DX-0862 at .0015; FOF ¶¶ 83–84, 88–93, 95–99. Plaintiffs have not shown how much of that other data Optum has; what innovations could be reverse engineered from that data; or how valuable those innovations would be. In short, Plaintiffs have not established a baseline of how valuable reverse engineering would be today, and without that baseline, Plaintiffs cannot prove that reverse engineering would be ***more*** valuable post-merger.

Plaintiffs' inability to estimate and compare the value of innovations that Optum could reverse engineer before and after the merger is not just a failure of proof, it highlights the implausibility of their theory more broadly. What is difficult for Plaintiffs to estimate is equally difficult for UHG, and no evidence establishes that UHG would be able to confirm that the innovations it could reverse engineer from Change's EDI data would give a greater benefit to UHC than the $63 billion in lost sales that they would cost Optum, to say nothing of the additional legal liabilities. In fact, Optum was never able to quantify the incremental data that it would receive through the merger, nor was Optum ever able to determine the incremental percentage of claims for which it would obtain secondary-use rights. *See* 8/5/22 AM Trial Tr. 123:4–11 (Musslewhite); 8/10/22 AM Trial Tr. 96:21–97:1 (Schumacher); PX027 at UHG-2R-0006509717 ("Due to potential data overlaps between Optum primary data sets (NHI/dNHI and Optum Labs Data Warehouse (OLDW), which leverages NHI data plus external sources) and Cambridge data, estimating how much additional data will be added to Optum's pool is very difficult."); FOF ¶¶ 335–36.

In any event, a reverse-engineering strategy would be self-defeating in the long run. The few major payers that use Change's EDI clearinghouse could stop doing so and could apply pressure to providers to do the same. Empirical evidence shows that switching is not prohibitively expensive for many providers. As Plaintiffs' own economist opined, between 2018 and 2020, 30.2% of all Change's provider customers reduced the volume of claims that they transmitted through Change's EDI clearinghouse by 50% or more. 8/9/22 PM Trial Tr. 4:6–16 (Gowrisankaran); FOF ¶ 205. Against these statistics, Plaintiffs offered only anecdotal evidence from two provider witnesses who testified that switching clearinghouses would be costly or disruptive for them. But combined, those providers add up to "less than one-tenth of 1 percent" of Change's total volume of claims transmitted, 8/3/22 AM Trial Tr. 147:8–12 (Peresie); FOF ¶ 213, and they both purchase Change's EDI services as a component of Change's revenue-cycle-management ("RCM") software, not on a standalone basis, PX1008 at 143:15–20 (Mincher); 8/8/22 AM Trial Tr. 26:3–15 (Spady); FOF ¶ 215. Nothing in the record establishes that the experience of those two provider witnesses is "representative of the entire universe of [providers]," *see United States v. SunGard Data Sys., Inc.*, 172 F. Supp. 2d 172, 192 (D.D.C. 2001), and the empirical evidence suggests that their experience is not representative. As such, the testimony of the two provider witnesses should carry little weight.

Lacking evidence of changed incentives, Plaintiffs instead try to dress up portions of internal UHG documents as evidence that UHG intends to change its behavior post-merger. *See* PX027; PX054; PX944. But those documents—which discuss potential use cases for Change's data—do not state that the data could be valuable because it could benefit ***UHC exclusively***. Unbroken and unrebutted testimony from UHG's witnesses confirms that any potential uses of Change's EDI data would benefit ***all payers equally***, consistent with Optum's multi-payer business

model. 8/5/22 PM Trial Tr. 47:4–50:14 (Dumont); 8/8/22 AM Trial Tr. 49:13–69:7 (Higday); 8/4/22 PM Trial Tr. 81:1–86:9 (Hasslinger); FOF ¶ 337–41. None of those use cases require Optum to share competitively sensitive information with UHC. If anything, then, UHG's internal documents reveal that UHG wanted Change's data for procompetitive purposes.

To see just how fundamentally Plaintiffs misunderstand UHG's enterprise incentives, the Court need only review the testimony of Plaintiffs' economist. In his report and testimony, Dr. Gowrisankaran cites UHG's CEO, Andrew Witty, as saying "that UnitedHealth Group needs to think about United at an enterprise level," 8/9/22 AM Trial Tr. 90:4–18 (Gowrisankaran); PX947 ¶ 25 & n.43; FOF ¶ 395, to create the impression that UHG invariably favors its most profitable business unit, UHC in whole, without regard for the incentives of its other business units or any external constraints. The trial presentation, however, exposed this reading as at best incomplete, and at worst misleading. The full picture of Mr. Witty's testimony makes clear that maximizing enterprise value "sometimes . . . would involve [separate business units'] assets being worked together," and "sometimes individually," all subject to "the important caveat of all of the rule sets" that limit UHG's conduct. *See* DX-0852 at 296:1–297:17 (Witty); FOF ¶ 395. All of UHG's efforts, then—whether "meeting the needs of the marketplace" or "meeting the needs of physicians and patients"—seek to "mak[e] the best of" the organization's assets, subject to meaningful "constraints," including market incentives, contractual limitations, firewall policies, and business ethics. *See* DX-0852 at 296:1–297:17 (Witty); FOF ¶ 395.

Plaintiffs' case also fails for the basic reason that they have not marshalled any evidence of harm to competition in the relevant markets. Under Plaintiffs' theory, what harms competition is not the copying of innovations itself, but the chilling of innovation by other payers and the resulting effect on health plans sold to national accounts and large-group employers. *See Brown*

Shoe Co. v. United States, 370 U.S. 294, 320 (1962) (stating that Section 7 is "concern[ed] with the protection of competition, not competitors"); COL ¶ 44. Plaintiffs offered next to no evidence about the dynamics of the markets for commercial health insurance sold to national accounts or large-group employers, leaving a host of questions unanswered: Where would UHC deploy innovations it copied from rivals? Would these innovations enable UHC to win bids for national-account and large-group customers? At what threshold would UHC's copying chill rival payers from innovating? Would the absence of rival payers' would-be innovations have any effect on national-account and large-group customers? If so, would the effect be a substantial lessening of competition? And what particular innovations, separately or together, would accomplish this substantial lessening? Each of these questions is an essential link in Plaintiffs' case, and they have answered none of them, providing yet more reasons to reject Plaintiffs' theory.

Plaintiffs' "copying innovation" theory does not just suffer from a failure of proof, it is squarely contradicted by the scant payer testimony that did make it into the record. An Aetna employee testified that he was "not forecasting" Aetna innovating any less as a result of the merger. 8/1/22 PM Trial Tr. 94:23–95:2 (Lautzenhiser); FOF ¶ 399. [redacted]

[redacted]; FOF ¶ 399. A Cigna employee testified that Cigna would not "ever compete less for any reason." PX1005 at 169:14–16, 169:19–170:6 (Dill); FOF ¶ 399. Finally, a former Cigna employee with no authority to testify on Cigna's behalf, Lynn Garbee, stated that Cigna "would still innovate" post-merger, but that "they would be more careful where they put their edits." 8/1/22 PM Trial Tr. 14:17–22 (Garbee); FOF ¶ 399. But Ms. Garbee then explained that she was referring to moving those edits out of ClaimsXten—a concern solved by the divestiture. 8/1/22 PM Trial Tr. 15:22–16:12 (Garbee); FOF ¶ 399. Ms. Garbee's statement is the

closest Plaintiffs came to marshalling third-party support for their theory, and it is still light years away from testimony that any payer will innovate less. In sum, Plaintiffs presented no testimony from any national account or large-group employer about the likely effects of the transaction on competition, and the payer testimony in the record affirmatively refutes Plaintiffs' central, data-misuse theory.

2. The record does not support the "improving GRA" version of Plaintiffs' data-misuse theory.

The "improving GRA" version of Plaintiffs' data-misuse theory fares no better. This version of Plaintiffs' theory hinges on the notion that Optum would refuse to sell an improved version of its GRA tool to external payers. 8/9/22 PM Trial Tr. 13:1–6 (Gowrisankaran) ("Q. Doctor, I need you to answer the question yes or no. If Optum did market GRA to all payers, then you don't know what would happen, true? A. I didn't look at what would happen to competition if it were offered on an equal footing to all payers for that particular [product], yes."); FOF ¶ 55. But Optum has never offered a product only to UHC. DX-0850; 8/5/22 AM Trial Tr. 62:23–63:3 (Yurjevich); FOF ¶¶ 53, 73–74. Here too, Plaintiffs have failed to prove that UHG would be incentivized to change its behavior post-merger. Dr. Gowrisankaran did not even attempt to calculate what UHC would purportedly gain by being the only payer with access to an improved version of GRA. Nor did he attempt to calculate what Optum would lose by foregoing sales of an improved version of GRA to external payers. Thus, Dr. Gowrisankaran's prediction that Optum would withhold an improved version of GRA is little more than a guess.

Worse, that guess is predicated on a blatant factual error. At his deposition, Dr. Gowrisankaran testified that Optum sells the current version of GRA only to UHC. 8/9/22 PM Trial Tr. 6:5–8 (Gowrisankaran); FOF ¶ 54. But at trial, he admitted he was wrong about that; GRA is sold to both UHC and external payers. 8/9/22 PM Trial Tr. 6:9–7:6 (Gowrisankaran);

8/5/22 AM Trial Tr. 55:9–57:13 (Yurjevich); DX-0850; FOF ¶ 54. Dr. Gowrisankaran made the same mistake with respect to a second Optum product, first testifying that a tool known as Portfolio Optimization was offered exclusively to UHC, but later conceding that the product was in fact marketed to all payers. 8/9/22 PM Trial Tr. 13:17–14:10 (Gowrisankaran); 8/5/22 AM Trial Tr. 60:22–61:10 (Yurjevich); DX-0850; FOF ¶¶ 60–61. Given those errors, Dr. Gowrisankaran's analysis should get zero weight.

Plaintiffs' fallback theory—that Optum would offer an improved version of GRA to UHC while offering only a degraded version to the market—also finds no support in the trial record. Optum has never sold one version of a product to UHC and a lesser version to external payers because that would be antithetical to its business model. 8/5/22 AM Trial Tr. 61:11–22 (Yurjevich) ("[I]t would be ridiculous for us to offer a different product in the commercial market than we do for United."); FOF ¶ 62. Plaintiffs made no serious effort to prove that Optum would have new incentive to do so post-merger: Dr. Gowrisankaran did not calculate the benefit UHC would get from using an improved version of GRA or what sales Optum would lose if it marketed a degraded version of GRA to non-UHC payers.

Beyond an absence of evidence of UHG's supposedly changed incentives, direct evidence contradicts Plaintiffs' theory. OptumInsight's Chief Operating Officer testified that Optum has no plans to use Change's EDI data to improve GRA; that Optum does not even know whether Change's data could be used to improve GRA; and that, post-merger, Optum intends to continue selling identical versions of GRA to both UHC and rival payers. 8/5/22 AM Trial Tr. 55:9–60:14 (Yurjevich); FOF ¶ 56. This credible, unrebutted testimony makes it impossible for Plaintiffs to meet their burden on the "improving GRA" version of their theory.

But again, Plaintiffs failed to show that the post-merger conduct they predict would result in any harm to competition, much less substantial harm. Plaintiffs claim that an improved version of GRA would allow UHC (and only UHC) to more accurately gauge the medical risk associated with particular employer customers and bid (or not bid) accordingly. To begin with, UHC does not conduct risk analysis when bidding on administrative-services-only ("ASO") customers because the customers are the ones taking on the risk. 8/10/22 PM Trial Tr. 106:11–22 (Gehlbach); FOF ¶ 57. Almost all national accounts are ASO customers, and UHC has also "seen an increased interest in ASO across the large group segment." 8/10/22 PM Trial Tr. 101:1–9, 102:5–14 (Gehlbach); FOF ¶ 57. Any improved version of GRA thus would have little effect in the market for national accounts, and a diminishing effect in the market for large-group employers.

Even within the market for fully insured large-group accounts, UHC currently uses GRA only in the underwriting process for employers with between 51 and 300 eligible employees. 8/10/22 PM Trial Tr. 115:22–24 (Gehlbach); FOF ¶ 58. Plaintiffs have no evidence that any improved version of GRA could or would be used for any additional employers. So the record does not support the suggestion that any improved version of GRA could substantially affect competition for (the very few) fully insured national accounts or (the shrinking number) of fully insured large-group employers with more than 300 employees.

There is also reason to doubt whether Change's EDI data would enable UHC to more accurately gauge medical risk for *any* employer customers. Under the Health Insurance Portability and Accountability Act ("HIPAA"), only de-identified data can be used to improve a product like GRA. At both Optum and Change, information about a patient's employer is removed during the de-identification process, 8/3/22 AM Trial Tr. 13:16–15:4 (Suther); 8/5/22 PM Trial Tr. 30:3–10 (Dumont); FOF ¶ 342, which according to UHG and Change's data expert, Professor Catherine

Tucker, would prevent UHG from learning anything "about a particular employer's risk profile"—a "glaring" problem for Plaintiffs' theory, 8/12/22 AM Trial Tr. 28:17–29:10 (Tucker); FOF ¶ 343.

Finally, to the extent Plaintiffs contend that UHC would harm competition by improving its assessment of customer risk pools through some unspecified means other than GRA, that theory also fails. No evidence establishes how exactly UHC would improve its risk analysis; Change's de-identified data cannot be used for such purposes because it is missing employer information; and UHC does not perform risk analysis for ASO customers, which include nearly all national accounts and many large-group employers.

In sum, with respect to both versions of Plaintiffs' data-misuse theory, Plaintiffs have failed to make the "'fact-specific' showing" of likely and substantial harm to competition that the law demands of them. *AT&T*, 916 F.3d at 1032 (citation omitted); COL ¶ 43.

B. Plaintiffs failed to prove a likely and substantial lessening of competition under their other vertical theories.

Plaintiffs advance two additional vertical theories, neither of which is supported by the record. Plaintiffs contend that UHG will use Change's assets to develop and withhold from the market (in whole or in part) innovations like Change's Real-Time Settlement project or Optum's Transparent Network offering. Plaintiffs also contend that UHG will use Change's EDI clearinghouse to raise external payers' quality-adjusted costs. For reasons discussed below, these theories also fail.

As an initial matter, an actual product must exist in order for Optum to have the ability or incentive to raise rivals' costs by withholding or degrading that product, and neither Real-Time Settlement nor the Transparent Network are marketable products today. "Real-Time Settlement is a concept[,] . . . not a product," and it "is not close to being a product." 8/3/22 PM Trial Tr. 57:1–10 (Joshi); FOF ¶ 251. Optum's Transparent Network is further along in the development

process, and Optum is "really hopeful" that it will be a success. 8/5/22 PM Trial Tr. 120:25–122:11 (Schmuker); FOF ¶ 295. But Optum cannot yet "say definitively" whether it will ever be a marketable product. 8/5/22 PM Trial Tr. 120:25–122:11 (Schmuker); FOF ¶ 295. That uncertainty is a serious strike against Plaintiffs, who bear the burden to prove that Optum will ***likely*** withhold these innovations from rivals, resulting in a substantial lessening of competition in the downstream markets for the sale of commercial insurance to national accounts and large-group employers.

Moreover, Optum has never withheld a product from external payers, nor sold different versions of a product internally and externally. 8/5/22 AM Trial Tr. 61:11–22, 62:23–63:3 (Yurjevich); FOF ¶¶ 62, 73–74. Plaintiffs' supposed proof of Optum's changed incentives—in the form of Dr. Gowrisankaran's "vertical math"—is deeply flawed. To put it mildly, Dr. Gowrisankaran was equivocal about the specific product that Optum supposedly will withhold post-transaction—Optum's nascent Transparent Network offering or Change's Real-Time Settlement project. *Compare* PX820 ¶ 250 (opining on the number of members that rival payers would need to lose "in order for foreclosure of the Transparent Network to be profitable" for UHG), *with* PX947 ¶ 30 ("The concern of foreclosure is whether United would have an incentive to raise rivals' costs using Change's Real-Time Settlement").

Dr. Gowrisankaran's "vertical math" also assumes that the Transparent Network would provide value to UHC even if UHC were the only payer using it. That assumption is faulty, as the record amply shows. The Transparent Network "wouldn't work if it were one payer and one provider." 8/5/22 AM Trial Tr. 83:18–84:6 (Yurjevich); 8/5/22 PM Trial Tr. 114:5–16 (Schmuker) (explaining that "with one payer you wouldn't drive enough provider participation" and thus "wouldn't have a viable business opportunity"); FOF ¶ 297. Indeed, every document discussing

the Transparent Network refutes Plaintiffs' theory, making clear that Optum intends for the Transparent Network to be multi-payer because that is the only way the product will work. *See* DX-0748 at .0014 ("Platform will be multi-payer, multi-provider[.]"); 8/5/22 AM Trial Tr. 82:6–25 (Yurjevich); DX-0557 at .0009, .0014, .0016 (including in UHG's synergy model significant revenues from sales of the Transparent Network to non-UHC payers); FOF ¶¶ 296–303.

Perhaps most importantly, Dr. Gowrisankaran's "vertical math" hinges upon a foundational—but unsubstantiated—assumption that Optum would have market power in the market for EDI-related innovations. 8/9/22 PM Trial Tr. 52:11–53:7 (Gowrisankaran) (acknowledging that Plaintiffs' innovation theory "depend[s] on there being market power in these innovations that result from EDI clearinghouse in these integrated platforms"); FOF ¶ 325. The Court asked Dr. Gowrisankaran whether he had defined the market for such innovations, and he conceded: "I have not defined that market." 8/9/22 PM Trial Tr. 52:11–53:7 (Gowrisankaran); FOF ¶ 325. Dr. Gowrisankaran went on to opine that "there's likely not going to be substitutes" to the Transparent Network. 8/9/22 PM Trial Tr. 52:11–53:7 (Gowrisankaran). But the record refutes his prediction. A Change witness testified that at least six other firms are currently developing integrated platforms, including a partnership between Google and Blue Shield of California. 8/3/22 PM Trial Tr. 67:9–17 (Joshi); DX-0212 at .0002; FOF ¶¶ 261–62. A UHG witness identified additional competitors, including Waystar, one of the largest EDI clearinghouses. 8/5/22 PM Trial Tr. 121:6–24 (Schmuker); PX947 ¶ 81 & n.177; FOF ¶ 322. And UHG and Change's economic expert Dr. Murphy testified that Availity, one of the largest EDI clearinghouses, may also be innovating in the space. DX-0862 at .0059; 8/15/22 AM Trial Tr. 85:22–86:7 (Murphy); PX947 ¶ 81 & n.177; FOF ¶ 323.

Plaintiffs' final vertical claim—that UHG will use Change's EDI clearinghouse to raise rivals' costs—was all but abandoned at trial. Dr. Gowrisankaran expressly disclaimed offering an opinion on the theory. 8/9/22 PM Trial Tr. 24:23–25 (Gowrisankaran) ("Q. You don't offer an opinion about whether Optum would raise pricing on Change's current EDI clearinghouse network, correct? A. That's correct."); FOF ¶ 220. In any event, for the theory to work, Change would need to have market power in the payer market for EDI clearinghouse services, which it does not. DX-0813 ¶ 30 ("Change does not have substantial market power over payers[.]"); FOF ¶¶ 191, 196–97. Thus, Plaintiffs' final theory fails on the merits even if Plaintiffs have not abandoned it.

* * *

For the foregoing reasons, Plaintiffs have failed to prove that the transaction would likely cause substantial harm to competition in the relevant markets. UHG and Change respectfully submit that the Court should deny Plaintiffs' request for a permanent injunction, enter judgment in favor of UHG and Change, and order that ClaimsXten be divested to TPG.

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Respectfully submitted,

By: */s/ Craig S. Primis*
Craig S. Primis

Matthew J. Reilly, P.C. (D.C. Bar No. 457884)
Craig S. Primis, P.C. (D.C. Bar No. 454796)
K. Winn Allen, P.C. (D.C. Bar No. 1000590)
Richard Cunningham (D.C. Bar. No. 1644119)
T.J. McCarrick (D.C. Bar. No. 219283)
KIRKLAND & ELLIS LLP
1301 Pennsylvania Avenue, N.W.
Washington, DC 20004
Telephone: (202) 389-5000
Facsimile: (202) 389-5200
matt.reilly@kirkland.com
craig.primis@kirkland.com
winn.allen@kirkland.com
tj.mccarrick@kirkland.com

Alexia R. Brancato (NY0467)
KIRKLAND & ELLIS LLP
600 Lexington Avenue
New York, NY 10022
Telephone: (212) 446-4800
Facsimile: (212) 446-4900
alexia.brancato@kirkland.com

Charles Loughlin (D.C. Bar. No. 448219)
Justin W. Bernick (D.C. Bar. No. 988245)
HOGAN LOVELLS US LLP
555 Thirteenth Street, NW
Washington, D.C. 20004
Telephone: (202) 637-5600
Facsimile: (202) 637-5910
chuck.loughlin@hoganlovells.com
justin.bernick@hoganlovells.com

Counsel for Defendant UnitedHealth Group Incorporated

Sara Y. Razi (D.C. Bar No. 473647)
Abram J. Ellis (D.C. Bar No. 497634)
Nathaniel Preston Miller (D.C. Bar No. 1021557)
SIMPSON, THACHER & BARTLETT LLP
900 G Street, NW
Washington, DC 20001
Telephone: (202) 636-5500
Facsimile: (202) 636-5502
sara.razi@stblaw.com
aellis@stblaw.com
preston.miller@stblaw.com

David I. Gelfand (D.C. Bar No. 416596)
Daniel P. Culley (D.C. Bar No. 988557)
CLEARY GOTTLIEB STEEN & HAMILTON LLP
2112 Pennsylvania Ave, N.W.
Washington, DC 20037
Telephone: (202) 974-1500
Facsimile: (202) 974-1999
dgelfand@cgsh.com

Counsel for Defendant Change Healthcare Inc.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the 31st day of August 2022, a copy of the foregoing Post-Trial Brief of Defendants UnitedHealth Group Incorporated and Change Healthcare Inc. was electronically transmitted to the Clerk of Court using the CM/ECF system, which will transmit notification of such filing to all registered participants.

/s/ *Craig S. Primis*
Craig S. Primis, P.C. (D.C. Bar No. 454796)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, *et al.*, *Plaintiffs*, v. UNITEDHEALTH GROUP INCORPORATED and CHANGE HEALTHCARE, INC., *Defendants*.	Civil Action No. 1:22-cv-0481 (CJN)

MEMORANDUM OPINION

The United States, joined by New York and Minnesota (collectively, "the Government"), seeks to enjoin UnitedHealth Group's proposed acquisition of Change Healthcare. In its Complaint and pretrial filings, the Government made several allegations that, if proven, would raise serious questions about whether the proposed merger violates Section 7 of the Clayton Act. But after a thorough trial on the merits—which lasted over two weeks, included testimony from over two dozen witnesses, and introduced more than 1,000 exhibits—the Court concludes that the Government has not met its burden of proving that the transaction is likely to substantially lessen competition in the relevant markets. The Court therefore enters judgment for Defendants. This Memorandum Opinion constitutes the Court's findings of fact and conclusions of law. *See* Fed. R. Civ. P. 52(a).

I. Background

A. Healthcare Claims Processing

At a high level, payments for services in the American healthcare system proceed through a simple process: Health insurers, also known as "payers," pay medical claims submitted by

caregivers, also known as "providers."[1] The process begins with a provider treating a patient. The provider then submits a claim to a payer so that she can be reimbursed for her services. Before payment is made, the payer evaluates the claim and determines how much, if anything, it should pay. If appropriate, the payer then reimburses the provider for that amount. The patient, of course, may be responsible for some (or perhaps even all) of the provider's bill.

This payment process, although simple in theory, is complex in practice. Historically, payers and providers used paper and phone to communicate between and among each other and to process claims. But this approach was costly in terms of time and money—large health insurers, after all, receive millions of claims per day. Plaintiffs' Exhibit ("PX") 821 ¶ 24. The process was also prone to fraud and error—problems that payers would try to remedy after-the-fact through a practice known as "pay and chase." PX-820 ¶ 33. Naturally, this approach to processing claims yielded substantial administrative waste, the cost of which flowed from payers to providers, and ultimately, to patients. *Id.* at ¶ 34.

Over the years, technological innovations have revolutionized claims processing, resulting in less waste and lower costs. Two of those innovations are center stage in this case: claims editing and Electronic Data Interchanges (EDI). The Government claims that the proposed acquisition will harm competition by consolidating control over these critical inputs to commercial health insurance.

1. Claims Editing

Most health insurers use a payment integrity product called claims editing to adjudicate medical claims. 8/1/22 AM Trial Tr. 117:21–118:11 (Garbee). The software implements a payer's coverage policies by using a set of rules, or "edits," to determine whether a particular claim

[1] Providers include physicians, hospitals, clinics, and other caregivers.

received from a provider should be paid or rejected. *See* PX-820 ¶ 40. Some of these rules are "standard" edits common to the industry—such as edits to weed out fraudulent or duplicate claims—while others are "custom" edits tailored to a particular payer's health plans and reimbursement policies. PX-1005 at 62:1–64:6 (Dill). A payer's custom edits are considered proprietary, as these edits reflect payer-specific strategies to reduce healthcare costs. 8/9/22 PM Trial Tr. 73:19–75:8 (McMahon).

The industry generally distinguishes between two types of claims editing: "first-pass" and "second-pass." PX-820 ¶ 41. First-pass claims editing automatically processes every claim that a health insurer receives—which, for certain insurers, may be millions of claims per day. *Id.* First-pass claims editing occurs early in the lifecycle of a claim—during the adjudication—and the software generates a response within milliseconds. *Id.*; 8/2/22 PM Trial Tr. 43:23–44:4 (Turner). Second-pass claims editing, by contrast, typically occurs post-adjudication and may involve significant manual review. PX-820 ¶ 42.

By helping payers avoid reimbursement for improper claims, claims editing obviates the need for the costly post-payment review typified by the "pay and chase" model. *See id.* at ¶ 33. Without claims editing, an insurer would be more vulnerable to overpayment, making it less competitive with rivals. *See* 8/9/22 PM Trial Tr. 73:6–18 (McMahon). Claims editing is therefore considered a key input for health insurers. *See id.*

2. EDI Clearinghouses

EDI clearinghouses are another critical input in commercial health insurance markets. Often called "pipes," EDI clearinghouses enable the electronic transmission of claims, remittances, and other information between and among payers and providers. 8/2/22 AM Trial Tr. 15:7–21, 26:4–12 (de Crescenzo). Compared to the days in which claims were transmitted by paper or by

phone, EDI clearinghouses facilitate much faster processing and result in much less administrative waste. PX-820 ¶ 37. Some estimates suggest that manual claim submissions can cost health insurers over ten times as much as electronic submissions. *Id.* In 2021, 97 percent of medical claims were submitted electronically, and 95 percent of providers and 99 percent of insurers used EDI clearinghouses. *Id.* at ¶ 38. Overall, the EDI clearinghouse market is "extremely competitive." 8/3/22 AM Trial Tr. 128:23–129:9 (Peresie).

To send and receive a particular EDI transaction, a payer and provider must be connected to the same EDI clearinghouse. *Id.* at 54:7–55:20. But because no EDI clearinghouse has a direct connection with every payer and provider, *id.* at 60:10–16, an indirect connection is sometimes necessary to complete a transaction, *id.* at 54:16–20. On the provider side, such a connection can be established through channel partners, which are third-party vendors that submit claims on behalf of providers. *Id.* at 58:2–59:25. Channel partners are typically connected to multiple EDI clearinghouses, enabling them to redirect claims across clearinghouses with ease. *Id.* at 121:3–20. Providers can also establish an indirect connection through trading partners, which are EDI clearinghouses that route transactions between and among each other. *Id.* at 60:10–61:7. On the payer side, an indirect connection can be established through an "EDI gateway." *Id.* at 118:21–119:11. EDI gateway vendors consolidate claims from multiple clearinghouses into a single stream that flows to the payer. *Id.* at 56:7–11. Put another way, an EDI gateway can serve as an entry point for all of a particular payer's EDI transactions. *Id.*

As one might imagine, a substantial amount of data flows through EDI clearinghouses. *See* PX-820 ¶ 36. And these data cover the entire lifecycle of a claim—both pre- and post-adjudication. Pre-adjudicated claims data include details about the provider, the patient, the employer group, the location of care, the diagnosis, the services and procedures rendered, and the billed amounts.

8/1/22 AM Trial Tr. 132:13–133:7 (Garbee). Post-adjudicated claims data can include even more information, such as details about the provider-payer contract, the payer's claims edits, the medical policy and benefit design, the final paid amount, and adjudication decisions. *Id.* at 134:17–135:23.

B. The Commercial Health Insurance Market

On to more familiar terrain—the commercial health insurance market. Most Americans obtain their health insurance through employer-sponsored plans. 8/10/22 AM Trial Tr. 105:16–19 (Schumacher). These plans are typically divided into two groups—small group and large group—based on the number of employees. PX-820 ¶ 89. In most states, small group employers have between two and fifty employees, while large group employers have more than fifty employees.[2] *Id.* Within the large group category, the industry refers to the largest employers as "national accounts." *Id.* at ¶ 90. National accounts are generally employers with over 5,000 employees spread out across multiple states. *Id.* The industry refers to the remaining employers—generally, those with between fifty and 5,000 employees and with a smaller geographic footprint—as large group employers. *Id.* ¶¶ 89–90.

Employers typically choose either a self-funded "administrative services only" ("ASO") plan or a fully insured plan. *Id.* ¶ 91. For ASO plans, the employer covers its members' medical costs and pays the insurer a fee to administer the plan and to access the insurer's provider network. PX-1013 at 55:25–56:24 (Golden). For fully insured plans, the employer pays a premium to the insurer, which in turn administers the plan *and* covers members' medical costs itself. *Id.* Large group employers, especially national accounts, tend to purchase ASO plans. *See id.* at 131:17–132:21 ("[N]ational accounts works almost exclusively in self-funding."); 8/10/22 PM Trial Tr. 102:8–14 (Gelbach) (noting the increased popularity of ASO plans among large group employers).

[2] Four states set the cutoff at 100 employees. *See* PX-820 ¶ 89.

The markets for national accounts and other large group customers are highly competitive. *See* 8/9/22 PM Trial Tr. 85:21–86:3 (McMahon); 8/10/22 PM Trial Tr. 101:18–20 (Gelbach). To gain a competitive edge over rivals, insurers innovate across multiple dimensions, including premiums and fees, provider networks, cost-control strategies, utilization management, benefit design, claims processing, and underwriting methods. *See* Proposed Findings of Fact and Conclusions of Law of the United States ("Gov't Proposed Findings"), ECF No. 119 at ¶¶ 71–74.

II. The Parties and the Proposed Acquisition

A. UnitedHealth Group

UnitedHealth Group ("UHG") is a vertically integrated healthcare enterprise with two main subsidiaries. The first is UnitedHealthcare ("UHC"), which is the nation's largest commercial health insurer and UHG's benefits business. UHC offers health insurance plans for individuals, employers, and small businesses. *See* 8/4/22 AM Trial Tr. 95:14–97:2 (Wichmann). The company also provides Medicare and Medicaid services. *Id.* All told, UHC's insurance business covers approximately 50 million people. PX-820 ¶ 59.

UHG's second main subsidiary is Optum. Optum includes three companies—OptumHealth, OptumRx, and OptumInsight—that provide a broad range of healthcare-related services. OptumHealth offers care delivery and management, OptumRx offers a wide array of pharmacy services, and OptumInsight offers software solutions and services for healthcare business needs, including payment integrity services for payers and providers. *See* 8/4/22 AM Trial Tr. 96:13–97:5 (Wichmann). OptumInsight is also one of the two dominant players in the market for first-pass claims editing. PX-103 at 1.

Although UHC is Optum's largest customer, Optum also sells its services to non-UHC payers in all three lines of its business. *See* 8/4/22 PM Trial Tr. 23:5–25 (Wichmann) (Optum is

"fiercely multi-payer in orientation."); *id.* at 3:11–21 ("[F]iercely multipayer . . . mean[s] that [Optum's] business is organized to serve all payers."). Andrew Witty, the current CEO of UHG, testified that maintaining multi-payer relationships is key to preserving a competitive edge. 8/10/22 PM Trial Tr. 21:11–20 (Witty). Witty testified that Optum maintains a "strictly arm's length relationship[]" with UHC, *id.* at 22:12–15, while OptumInsight's Chief Operating Officer testified that Optum treats UHC as a customer "very similar to the way" it treats its other commercial customers, 8/5/22 AM Trial Tr. 22:9–16 (Yurjevich).

B. Change Healthcare

Change Healthcare is a healthcare technology company that provides data solutions aimed at improving clinical decision-making and simplifying payment processes across the healthcare system. PX-195 at 31. In 2017, Change entered into a joint venture with McKesson Corp.'s Technology Solutions division to create the healthcare technology company that exists today. 8/2/22 AM Trial Tr. 92:20–94:7 (de Crescenzo).

Change has three main business units. First, its Software and Analytics business offers payers solutions aimed at improving, among other things, financial performance and payment accuracy. PX-195 at 33. One of these solutions is ClaimsXten—Change's first-pass claims editing product. *Id.*; 8/11/22 AM Trial Tr. 13:7–17 (Wukitch). Second, Change's Network Solutions business facilitates "financial, administrative and clinical transactions, electronic business-to-business and consumer-to-business payments," and aggregation and analytical data services. PX-195 at 34. Change provides these Network Solutions services, in part, through its EDI clearinghouse. *Id.* Finally, Change's Technology Enabled Services business provides services such as revenue cycle management, value-based care, pharmacy benefits administration, and healthcare consulting. *Id.*

Change's ClaimsXten is the market-leading product in first-pass claims editing. 8/11/22 AM Trial Tr. 15:1–14 (Wukitch). ClaimsXten "deploys automated rulesets to improve payment accuracy, reduce appeals and drive administrative savings." PX-195 at 33. McKesson released ClaimsXten in 2006, 8/11/22 AM Trial Tr. 8:1–5 (Wukitch), and the product became the "market leader" in first-pass claims editing before McKesson's joint venture with Change, *id.* at 17:8–18. That success continued after the joint venture, as reflected in ClaimsXten's near-70 percent market share for first-pass claims editing, as well as its 99 percent customer retention rate. 8/2/22 PM Trial Tr. 85:14–18 (Turner); 8/11/22 AM Trial Tr. 21:22–23 (Wukitch).

Change also operates the largest EDI clearinghouse in the United States. 8/4/22 PM Trial Tr. 55:1–25 (Hasslinger); 8/10/22 PM Trial Tr. 69:23–70:1 (Witty). Like other EDI clearinghouses, a substantial amount of claims data flows through Change's clearinghouse. PX-820 ¶ 183. Change's customers sometimes grant Change "secondary-use rights" to these data. 8/2/22 PM Trial Tr. 101:12–22 (Suther). This means that Change has the right to use the data for purposes beyond providing clearinghouse services, subject to certain legal and contractual restraints. *Id.*; 8/3/22 AM Trial Tr. 17:23–18:5 (Suther). Change may obtain secondary-use rights directly through a contract with the payer. 8/2/22 PM Trial Tr. 104:2–17 (Suther). Alternatively, Change can acquire secondary-use rights indirectly through channel and trading partners, so long as the payer has granted secondary-use rights to those intermediaries. *Id.* at 104:18–106:22.

Today, Change uses the data for which it has secondary-use rights in its Data Solutions business. *Id.* at 101:5–15. That business licenses de-identified data to third parties, including data aggregators and life sciences companies. *Id.* at 119:19–119:24. Change does not sell or share the data with other payers. *Id.* at 119:25–120:1.

C. The Proposed Acquisition

In January 2021, UHG announced its agreement to acquire Change for approximately $13 billion. *See* Compl., ECF No. 1 at ¶ 26. Following the proposed merger, OptumInsight will combine with Change for the stated purpose of "minimiz[ing] the amount of friction between payers and providers." 8/9/22 PM Trial Tr. 92:11–93:25 (McMahon). UHG claims that by combining the service-oriented skill set of OptumInsight with the product-oriented skill set of Change, the proposed merger will generate significant benefits for the healthcare system through clinical alignment, claims accuracy, and payment simplification. *See* 8/10/22 PM Trial Tr. 28:25–30:9 (Witty); PX-195 at 1; Defendants' Exhibit ("DX") 0748 at .0005.

UHG asserts that, on the claims accuracy front, the proposed acquisition can help to shore up holes in the claims payment process, which is still plagued by substantial administrative waste. *See* DX-0748 at .0004. UHG also asserts that Change's broad connectivity to payers and providers is complementary to Optum's payer integrity services and expertise. *See* PX-195 at 1 ("[Change] brings a scaled transaction network built on extensive payer and provider connections, which complements Optum's advanced payment integrity analytics and content, as well as Optum's revenue cycle management solutions.").

UHG claims that the beneficiaries of the proposed acquisition will be "all constituents"—payers, providers, and patients. 8/4/22 PM Trial Tr. 11:10–12:2 (Wichmann). "[B]y pursuing edits not previously deployed," UHG claims, the merged companies can improve payment accuracy and leave payers with lower administrative costs. PX-004 at UHG-2R-0003249659. UHG claims that providers would benefit from fewer denied claims and "accelerated cash flow from avoided denials." *Id.* And, it says, "improved claims accuracy will enhance the patient experience through clear communication of benefits, deductible status[,] and payer network

economics at point of referral." PX-195 at 1; *see also* 8/9/22 PM Trial Tr. 92:11–93:25 (McMahon) (combining the abilities of Change and Optum will "enable the patient at the point of service to be able to know what their obligation is right at the doctor's office").

III. Procedural History

A. The Complaint

In February 2022, after investigating the proposed acquisition for over a year, the United States, joined by the states of New York and Minnesota, sued to block the transaction. In its request for relief, the Government asks that the Court "adjudge and decree United's acquisition of Change to violate Section 7 of the Clayton Act, 15 U.S.C. § 18," and "permanently enjoin Defendants from consummating United's proposed acquisition of Change." Compl., ECF No. 1 at ¶ 129(a)–(b).

B. Divestiture, Firewall Policy, and Customer Commitments

In January 2022, UHG announced its intention to divest Change's ClaimsXten upon consummation of the proposed acquisition. 8/11/22 AM Trial Tr. 61:1–62:10 (Wukitch); DX-0616 at .0001. And in April 2022, UHG entered a $2.2 billion purchase agreement with private-equity firm TPG Capital ("TPG") to carry out the divestiture. DX-0579 at .0001. All conditions of that agreement have been satisfied, except for those to be satisfied at closing or upon the resolution of this lawsuit. *See* 8/11/22 AM Trial Tr. 163:24–164:2 (Raj). The divestiture package includes all four of Change's current claims editing products. *Id.* at 13:8–20 (Wukitch).

In May 2022, UHG issued its "UnitedHealth Group Firewall Policy for Optum Insight and Change Healthcare," which addresses the sharing of customers' competitively sensitive information (CSI) following the transaction. PX-599 at -682. According to UHG, this firewall policy was issued to address the specific context of the Change transaction and does not represent

any shift in longstanding company policy on data sharing. *See* Proposed Findings of Fact of Defendants ("Defs.' Proposed Findings"), ECF No. 121 at ¶ 130.

Between May and June 2022, UHG sent letters to Change's EDI customers including certain statements regarding how those customers' CSI would be treated if the transaction closes. 8/2/22 AM Trial Tr. 130:24–135:6 (de Crescenzo).

C. The Trial

Following substantial discovery, *see* Scheduling and Case Management Order, ECF No. 42, the trial began on August 1, 2022, and the Government completed its rebuttal case on August 15, 2022. Over two dozen witnesses testified. The Government called two expert witnesses in its case-in-chief—Dr. Benjamin Handel and Dr. Gautam Gowrisankaran. Defendants likewise called two expert witnesses—Dr. Catherine Tucker and Dr. Kevin Murphy. Dr. Gowrisankaran was the Government's sole rebuttal witness. On August 31, 2022, the parties filed post-trial briefs along with proposed findings of fact and conclusions of law. The Court heard closing arguments on September 8, 2022.

IV. Legal Standard

A. The Clayton Act

Section 7 of the Clayton Act prohibits mergers and acquisitions "where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. As the statutory text makes clear, Section 7 does not require the Government to prove that a merger is *certain* to cause competitive harm. *See Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962) ("Congress used the words 'may be substantially to lessen competition' . . . to indicate that its concern was with probabilities, not certainties."). After all, Section 7 is a prophylactic

measure that "seeks to arrest restraints of trade in their incipiency[,] before they develop into full-fledged restraints violative of the Sherman Act." *Id.* at 323 n.39.

But just as Section 7 allows for less than absolute certainty of competitive harm, it also requires more than a "mere possibility" of such harm. *Id.*; *United States v. Baker Hughes Inc.*, 908 F.2d 981, 984 (D.C. Cir. 1990) ("Section 7 involves *probabilities*, not certainties or possibilities."). To prove a Section 7 violation, "the government must show," by a preponderance of the evidence, "that the proposed merger is likely to *substantially* lessen competition, which encompasses a concept of reasonable probability." *United States v. AT&T, Inc.*, 916 F.3d 1029, 1032 (D.C. Cir. 2019) (cleaned up); *United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 49 (D.D.C. 2011).

Under this standard, "antitrust theory and speculation cannot trump facts," and "the Government must make its case on the basis of the record evidence relating to the market and its probable future." *United States v. AT&T, Inc.*, 310 F. Supp. 3d 161, 190 (D.D.C. 2018) (cleaned up), *aff'd*, 916 F.3d 1029 (D.C. Cir. 2019). "Only examination of the particular market—its structure, history and probable future—can provide the appropriate setting for judging the probable anticompetitive effect of the merger." *Id.* (quoting *United States v. General Dynamics Corp.*, 415 U.S. 486, 498 (1974)) (cleaned up). In the end, the Court must make a "predictive judgment, necessarily probabilistic and judgmental rather than demonstrable," *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 719 (D.C. Cir. 2001) (quoting *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1389 (7th Cir. 1986)), but that judgment must be informed by real-world evidence that the specific merger under review is likely to substantially lessen competition, *see generally AT&T*, 310 F. Supp. 3d 161.

B. *Baker Hughes* Burden-Shifting Framework

Because Section 7 assigns courts the "uncertain task of assessing probabilities," the Court of Appeals has developed a burden-shifting framework to guide the inquiry. *Baker Hughes*, 908 F.2d at 991. Under that framework, "the government must first establish a *prima facie* case that the merger is likely to substantially lessen competition in the relevant market." *AT&T*, 916 F.3d at 1032. If the government establishes its *prima facie* case, "the burden shifts to the defendant to present evidence that the *prima facie* case inaccurately predicts the relevant transaction's probable effect on future competition, or to sufficiently discredit the evidence underlying the *prima facie* case." *Id.* (cleaned up).

Although a more compelling *prima facie* case calls for a more compelling rebuttal, the defendant need not "produce evidence 'clearly' disproving future anticompetitive effects," as such a requirement would force the defendant "to rebut a probability with a certainty" and free the government from its ultimate burden of persuasion. *Baker Hughes*, 908 F.2d at 991–92. Instead, if the defendant rebuts the *prima facie* case, "the burden of producing additional evidence of anticompetitive effects shifts to the government, and merges with the ultimate burden of persuasion, which remains with the government at all times." *AT&T*, 916 F.3d at 1032 (quoting *Baker Hughes*, 908 F.2d at 983). The Government's "failure of proof in any respect will mean the transaction should not be enjoined." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116 (D.D.C. 2004).

The Court of Appeals has not expressly held that the *Baker Hughes* framework applies to vertical mergers challenged under Section 7, but the Parties agree that the framework applies to all of the Government's theories here—with one caveat. In challenging a horizontal merger—that is, a merger between direct competitors—the government can establish its *prima facie* case simply

by showing that the "merger would produce a firm controlling an undue percentage share of the relevant market, and would result in a significant increase in the concentration of firms in that market." *Heinz*, 246 F.3d at 715 (cleaned up). Such a showing, which is typically made by presenting market-share statistics, triggers "a presumption that the merger will substantially lessen competition." *Id.* (quotations omitted). The burden then shifts to the defendant to rebut the presumption by showing "that the market-share statistics give an inaccurate account of the merger's probable effects on competition in the relevant market." *Id.* (cleaned up).

For a vertical merger—that is, a merger between companies that perform different supply chain functions for a common good or service—"there is no short-cut way to establish anticompetitive effects, as there is with horizontal mergers." *AT&T*, 310 F. Supp. 3d at 192 (quotations omitted). That is because "vertical mergers produce no immediate change in the relevant market share." *AT&T*, 916 F.3d at 1032. Accordingly, the government meets its *prima facie* burden in vertical merger cases by making a "fact-specific showing that the proposed merger is likely to be anticompetitive." *Id.* (quotations omitted).

V. Analysis

Before analyzing the Government's claims, the Court must define the relevant antitrust markets in which to conduct the analysis. *See FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 24 (D.D.C. 2015) ("Merger analysis starts with defining the relevant market."). A relevant market has two components: (1) a product and (2) geographic boundaries. *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 193 (D.D.C. 2017); *see also United States v. Marine Bancorp., Inc.*, 418 U.S. 602, 618 (1974) ("Determination of the relevant product and geographic markets is a necessary predicate to deciding whether a merger contravenes the Clayton Act." (quotations omitted)).

Here, the Government defines three relevant antitrust markets: (1) the sale of first-pass claims editing solutions in the United States; (2) the sale of commercial health insurance to national accounts in the United States; and (3) the sale of commercial health insurance to large group employers in core-based statistical areas that are also metropolitan statistical areas (*i.e.*, cities and suburbs). Gov't Proposed Findings, ECF No. 119 at ¶¶ 77–83, 332. Defendants (hereafter, "UHG," "United," or Defendants) lodge no objection to these definitions; they assume those are relevant antitrust markets and contend that the Government has failed to show that the merger is likely to substantially lessen competition in each. The Court therefore accepts the Government's proposed market definitions.

The Government offers three independent theories of competitive harm—one horizontal and two vertical—and thus three independent reasons for why the proposed merger is illegal under Section 7. First, the Government argues that the proposed acquisition is an illegal horizontal merger because it would tend to create a monopoly in the sale of first-pass claims editing solutions in the United States. *Id.* at ¶ 8. Second, the Government argues that the proposed acquisition is an illegal vertical merger because UHG's control over a key input—Change's EDI clearinghouse[3]—would give it the ability and incentive to use rivals' CSI for its own benefit, which in turn would lessen competition in the markets for national accounts and large group commercial health insurance. *Id.* And third, the Government argues that the proposed acquisition is an illegal vertical merger because United's control over Change's EDI clearinghouse would give it the

[3] In vertical merger cases, the government will identify "a product or service that is supplied or controlled by the merged firm and is positioned vertically or is complementary to the products and services in the relevant market." U.S. Dep't of Justice & Fed. Trade Comm'n, Vertical Merger Guidelines 3 (2020). This item is called a "related product," and it "could be an input, a means of distribution, access to a set of customers, or a complement." *Id.* Here, the related product is EDI clearinghouse services. *See* 8/9/22 AM Trial Tr. 45:1–15 (Gowrisankaran).

ability and incentive to withhold innovations and raise rivals' costs to compete in those same markets for national accounts and large group plans. *Id.*

After review of the parties' arguments, the evidence presented at trial, the entire record, and the applicable law, the Court holds that the Government has failed to carry its burden on each of its theories of competitive harm.

A. The Government Has Failed to Show That the Proposed Merger is Likely to Substantially Lessen Competition Under Its Horizontal Theory.

The Government's horizontal case is simple: The proposed acquisition would combine the first-pass claims editing solutions of the two largest competitors in the market—Change, which controls just under 70 percent of the market, and OptumInsight, which controls about a quarter of the market—and leave UHG with a market share above 90 percent. *Id.* at ¶ 35; 8/9/22 AM Trial Tr. 24:18–21 (Gowrisankaran). The acquisition would also result in a highly concentrated market, as measured by the Herfindahl-Hirschman Index ("HHI"). *See* 8/9/22 AM Trial Tr. 25:11–16, 26:9–18 (Gowrisankaran) (explaining that the proposed merger would produce a market with an HHI of 8,831, an increase in HHI of 3,577 over the pre-merger HHI). Defendants, for their part, do not dispute these market-share and concentration statistics. *See*, *e.g.*, 8/5/22 PM Trial Tr. 83:5–11 (Schmuker).

The Government also contends that the acquisition would eliminate head-to-head competition in the market for first-pass claims editing. Gov't Proposed Findings, ECF No. 119 at ¶¶ 344–50. The Government stresses that Change and OptumInsight engage in intense competition over the price and quality of their first-pass claims editing products, and the Government contends that this competition would end if the acquisition were to close, because no other player in the market can fill Change's shoes. *Id.* at ¶ 349. Indeed, OptumInsight views itself and Change as the "primary editors in the payer market," 8/5/22 PM Trial Tr. 86:12–20 (Schmuker), and Change

views OptumInsight's Claims Edit System as the only "major competitor" to ClaimsXten, 8/2/2022 PM Trial Tr. 79:7–24 (Turner).

UHG contends that the Government is at war with a post-merger world that will never come to be. That is because UHG has agreed to divest Change's claims editing business, ClaimsXten, to TPG upon consummation of the proposed acquisition. This divestiture, UHG says, rebuts the Government's market-share statistics. UHG also argues that TPG will preserve (if not enhance) the competitive environment that exists today. *See* Defs.' Proposed Findings, ECF No. 121 at ¶¶ 418–19, 440.

1. Legal Standard for Evaluating the Proposed Divestiture's Effect on Competition

Because UHG does not dispute the Government's pre-divestiture market-share statistics, the key question is whether the divestiture of ClaimsXten to TPG resolves the Government's horizontal claim. Before answering that question, however, the Court must consider a threshold matter: *Who* bears the burden of proving the competitive implications of the divestiture, *when* must that party satisfy its burden, and *what* exactly must that party prove?

The Government's briefs, and some of its arguments during trial, would require the acquisition and divestiture to be treated as separate transactions, *see* 9/8/22 PM Trial Tr. 26:18–27:2 (Gov't Closing), as a result of which the burden would fall on UHG to prove, as part of its rebuttal case under the *Baker Hughes* framework, that the divestiture will "replace the competitive intensity lost as a result of the merger," Gov't Proposed Findings, ECF No. 119 at ¶¶ 410–11 (quoting *United States v. Aetna, Inc.*, 240 F. Supp. 3d 1, 60 (D.D.C. 2017)) (cleaned up). This view has some support in District case law. *See Aetna*, 240 F. Supp. 3d at 60; *see also FTC v. RAG-Stiftung*, 436 F. Supp. 3d 278, 304 (D.D.C. 2020) ("Defendants have the burden to show that a proposed divestiture will replace the merging firm's competitive intensity."); *Sysco*, 113 F. Supp.

3d at 73 (holding that defendants bear the burden of proving in rebuttal that the divestiture will "maintain the premerger level of competition" (cleaned up)). At other times, however, the Government seemed to concede that it bears the ultimate burden of proving that, even after the divestiture, there will likely be a substantial lessening of competition. *See* 9/8/22 PM Trial Tr. 163:20–23 (Gov't Closing) ("We have to persuade Your Honor at the end of the day, after they've come in with their divestiture evidence, that Your Honor believes that there's a *substantial* lessening of competition." (emphasis added)).

UHG counters that the Government's standard (at least as articulated in its briefs) contradicts the text of Section 7 and the *Baker Hughes* burden-shifting framework. *See* Proposed Conclusions of Law of Defendants ("Defs.' Proposed Conclusions"), ECF No. 121 at ¶ 29. It argues that the burden should be on the Government to prove, as part of its *prima facie* case, that the combined effect of the merger and the divestiture will likely lessen competition substantially. *See id.* at ¶¶ 26, 29; *see also FTC v. Libbey, Inc.*, 211 F. Supp. 2d 34, 51 (D.D.C. 2002) (considering amended merger agreement as part of the government's *prima facie* case). UHG stresses that a transaction challenged under Section 7 can consist of multiple agreements, including a divestiture, and that the transaction being challenged here is really the proposed acquisition *together with* the divestiture. Defs.' Proposed Conclusions, ECF No. 121 at ¶¶ 22–24. On this view, the burden of proof regarding the acquisition—including the divestiture—remains on the Government at the *prima facie* stage. And whatever the *prima facie* standard, UHG argues, the Government still bears the ultimate burden of proving that the acquisition is likely to substantially lessen competition.

The Court agrees with UHG that the Government's proposed standard (at least the strongest version)—which admittedly finds support in this District's case law—contradicts the text of Section 7 and the *Baker Hughes* framework. As the Government would have it, UHG must prove

that the divestiture will maintain the *same* level of competition that existed in the pre-merger market. But the text of Section 7 is concerned only with mergers that "*substantially* . . . lessen competition." 15 U.S.C. § 18 (emphasis added). By requiring that UHG prove that the divestiture would preserve exactly the same level of competition that existed before the merger, the Government's proposed standard would effectively erase the word "substantially" from Section 7.[4]

The Government's standard (at least in its strongest form) is not only inconsistent with the text of Section 7 but would make a mess of the *Baker Hughes* framework and the ultimate burden of persuasion. In the Government's view, a divestiture must be *ignored* at the *prima facie* stage—at least if the divestiture was not part of the original transaction—as a result of which the government can meet its *prima facie* burden with market-share statistics that have no connection to the post-acquisition world. Then, in the Government's view, a defendant must prove that there is *no* lessening of competition. This would allow the Government to rely on statistics that bear no relationship to the post-acquisition world and would shift the burden of persuasion to the defendant to prove that there is *no* competitive harm—rather than to require the government to prove that there is *substantial* competitive harm. That approach cannot be squared with the text of Section 7 or with *Baker Hughes*. *See Baker Hughes*, 908 F.2d at 992 ("Imposing a heavy burden of production on a defendant would be particularly anomalous where, as here, it is easy to establish

[4] To illustrate, suppose before a merger a market is highly competitive—to use overly simplified math, call it 50-50. Further suppose that, following the merger and without the divestiture, the market would be highly anticompetitive—using the same simplified math, call it 95-5. But also imagine that the divestiture would result in a market that is highly competitive, but just a little less competitive than the market before the merger and divestiture—call it 51-49. Under the Government's proposed standard (or at least its most aggressive version), the merger would be enjoined because the companies would be unable to prove that the divestiture fully restored the pre-merger level competition. That would be true even though the merger (with the divestiture) would cause only the slightest lessening of competition, not a substantial lessening.

a prima facie case. The government, after all, can carry its initial burden of production simply by presenting market concentration statistics. To allow the government virtually to rest its case at that point, leaving the defendant to prove the core of the dispute, would grossly inflate the role of statistics in actions brought under Section 7."); *see also id.* at 991 ("A defendant required to produce evidence 'clearly' disproving future anticompetitive effects must essentially persuade the trier of fact on the ultimate issue in the case.").

In any event, UHG contends—and the Court agrees—that the evidence leads to the same result under either standard. This is because the evidence demonstrates that the divestiture will restore the competitive intensity lost because of the acquisition. For purposes of the remaining analysis, then, the Court proceeds under the Government's proposed standard.[5]

2. The Government Has Satisfied Its *Prima Facie* Burden.

Under the *Baker Hughes* framework, the Government must first make its *prima facie* case that the proposed acquisition is likely to substantially lessen competition in the sale of first-pass claims editing solutions in the United States. Under the Government's preferred standard discussed above, based on the evidence presented at trial, that burden is easily met. The evidence established that the merging entities (absent the divestiture) would control over 90 percent of the relevant market. 8/9/22 AM Trial Tr. 24:18–21 (Gowrisankaran). The evidence also established that the merger (again, absent the divestiture) would produce a market with an HHI of 8,831, an

[5] The Court agrees with UHG that the relevant transaction here is the proposed acquisition agreement *including* the proposed divestiture. As discussed above, treating the acquisition and the divestiture as separate transactions that must be analyzed in separate steps allows the government to meet its *prima facie* burden based on a fictional transaction and fictional market shares. And here, without the benefit of the market-share presumption, the Government cannot meet its *prima facie* burden of proving that the combined effect of the proposed merger and the divestiture is likely to substantially lessen competition.

increase in HHI of 3,577 over the pre-merger HHI. *Id.* at 25:11–16, 26:9–18. The Government has thus shown that, absent the divestiture, the "merger would produce a firm controlling an undue percentage share of the relevant market, and would result in a significant increase in the concentration of firms in that market." *Heinz*, 246 F.3d at 715 (cleaned up). This showing triggers a presumption that the merger violates Section 7. *Id.*; *see FTC v. Swedish Match*, 131 F. Supp. 2d 151, 166 (D.D.C. 2000) (presumption triggered because merging entities controlled 60 percent of the market); *H & R Block*, 833 F. Supp. 2d at 72 (presumption triggered because post-merger HHI totaled 4,691, an HHI increase of around 400).

The evidence also established that the merger (again, absent the divestiture) would "eliminate head-to-head competition" in the market for first-pass claims editing solutions. *Aetna*, 240 F. Supp. 3d at 91 ("Mergers that eliminate head-to-head competition between close competitors often result in a lessening of competition." (quotations omitted)). Change and OptumInsight view each other as principal competitors in first-pass claims editing, *see* 8/5/22 PM Trial Tr. 86:12–20 (Schmuker), and that competition would end as a result of the proposed merger (again, assuming no divestiture).

Applying the Government's proposed standard as discussed above, the Government has made a *prima facie* showing that the proposed merger is likely to substantially lessen competition, having relied on both a presumption of harm and evidence of lost head-to-head competition. UHG's rebuttal case should be proportional in strength. *See Aetna*, 240 F. Supp. 3d at 91. UHG does not dispute the Government's market-share and concentration statistics, nor does it dispute the claim that Change and OptumInsight are head-to-head competitors. Instead, UHG argues that the proposed divestiture resolves the Government's concerns.

3. The Proposed Divestiture Resolves the Anticompetitive Concerns.

Again, applying the Government's burden-shifting framework, UHG must prove in rebuttal that the proposed divestiture to TPG will "restore the competition lost by the merger." *Id.* at 60 (cleaned up). To assess whether a divestiture will restore competition, courts consider several factors, including "the likelihood of the divestiture; the experience of the divestiture buyer; the scope of the divestiture[;] the independence of the divestiture buyer from the merging seller[;] and the purchase price." *RAG-Stiftung*, 436 F. Supp. 3d at 304. On each of these metrics, the trial evidence and the record demonstrated that the divestiture will preserve competition in the market for first-pass claims editing.

a. Likelihood of the Divestiture

The evidence established, and the Court finds, that UHG's divestiture of ClaimsXten to TPG is a virtual certainty. UHG and TPG have already entered a definitive purchase agreement, and all conditions of that agreement have been satisfied, except for those to be satisfied at closing or by the resolution of this lawsuit. *See* DX-0579 at .0064–66; 8/11/22 AM Trial Tr. 163:24–164:2 (Raj) ("Q. Mr. Raj, is this agreement from April 22 binding on TPG and UHG, as you understand it? A. It is. The only real contingency that I'm aware of is the outcome of this proceeding, but, otherwise, it's binding on us."). The Government, for its part, does not contest the likelihood of the divestiture.

b. Experience of TPG

The evidence demonstrated, and the Court finds, that TPG has the experience necessary to compete effectively in the claims editing market. TPG is one of the world's leading private-equity firms, with over $100 billion in assets under management. DX-0617 at .0009. Nehal Raj, TPG's co-managing partner, testified at trial about the firm's investment strategy: "[W]e are

fundamentally growth-oriented investors. . . . [W]e make money from growing the businesses that we invest in, so we have a growth-oriented philosophy." 8/11/22 AM Trial Tr. 148:9–21 (Raj). He explained that TPG accelerates growth in the businesses it acquires by investing in research and development ("R&D") and by pursuing add-on acquisitions. *Id.* at 149:8–20. As for returns, Raj testified that TPG earns almost all its profits by growing its businesses and then selling them for more than it paid, which aligns TPG's incentives with the performance of its investments. *Id.* at 150:20–151:7.

The evidence also established, and the Court finds, that TPG has significant experience with "carve-out investments," that is, investments in which TPG buys a division of a larger company and then operates it as a standalone business. *Id.* at 151:8–151:22 ("[Carve-out investments is] one of our most successful areas. Historically, it's one of the deal types that we enjoy doing the most because it aligns very well with this growth transformation thesis that we have, or investment philosophy that we have. So, we've done a number of carve-outs over the years."). The evidence established that TPG has completed successful carve-outs of Dell, AT&T, Pfizer, and Intel, among other companies. *See* DX-0619 at .0004–5.

The evidence also demonstrated that TPG has significant experience in the healthcare industry. Since 2003, TPG has deployed over $24 billion of total equity in the healthcare space. DX-0617 at .0010. TPG has invested in healthcare providers, medical products, and healthcare services and IT. *Id.* And it has invested in payer services. *Id.*; 8/11/22 PM Trial Tr. 9:25–10:5 (Raj). TPG has increased R&D spending in its healthcare companies by 156%, and it has contributed around $8 billion to mergers-and-acquisitions activity on behalf of those companies. DX-0617 at .0009. On average, TPG holds its healthcare investments for eight years before

exiting, which tends to be longer than the holding period for its other investments. 8/11/22 AM Trial Tr. 149:24–150:5 (Raj).

The evidence at trial established, and the Court finds, that TPG intends to invest substantially in the ClaimsXten business. Under Change's ownership, ClaimsXten's R&D budget for fiscal year 2022 was $14 million. 8/11/22 PM Trial Tr. 34:20–35:4 (Raj); DX-0402 at .0020. The evidence establishes that TPG plans to increase that budget to $17 million in 2023, $26 million in 2024, $28 million in 2025, and $30 million in 2026. 8/11/22 PM Trial Tr. 35:20–37:18 (Raj); DX-0402 at .0020, .0031. By doubling ClaimsXten's R&D budget within the next four years, TPG expects that it will be able to improve the product "and accelerate revenues as a result." 8/11/22 PM Trial Tr. 40:22–41:16 (Raj).

The Government contends that TPG's lack of experience in claims editing, as well as its status as a private-equity firm, doom any claim that TPG will be able to restore the competitive pressure that Change would have exerted on OptumInsight absent the merger. Gov't Proposed Findings, ECF No. 119 at ¶ 36. But as discussed below, the evidence established (and the Court finds) that the scope of the divestiture package includes ClaimsXten's current senior leadership and management team—including some of the same people who elevated ClaimsXten to the top of the claims editing market. This approach is consistent with the Government's own Merger Remedies Manual, which recognizes that "[p]rivate equity purchasers often partner with individuals or entities with relevant experience, which may inform the Division's evaluation of whether the purchaser has sufficient experience to compete effectively in the market over the long term." U.S. Dep't of Justice, Merger Remedies Manual 25 (2020).

Also misplaced is the Government's argument that ClaimsXten will be less competitive because TPG is a private-equity firm. At trial, the Government stressed that "TPG . . . is a private

equity firm, and private equity firms can have incentives that run different to the strategic buyers here. Their incentives or commitments to innovation are not always aligned with those of the strategic buyers." 8/1/22 AM Trial Tr. 30:7–15 (Gov't Opening). But the evidence at trial established—and the Court finds—that TPG's incentives are geared toward preserving, and even improving, ClaimsXten's competitive edge. In response to a question from the Court, TPG's co-managing partner made clear that TPG's success turns on ClaimsXten's success: "[T]he better [a] company does between the time we buy it and the time we're ready to sell it, the more money someone will pay us for that asset." 8/11/22 PM Trial Tr. 90:15–18, 91:8–14 (Raj). Raj also testified why ownership of ClaimsXten by TPG may result in more ClaimsXten-related innovation than was achieved at Change: "[A] small division of a big company usually doesn't get the focus or the resource[s] that it may optimally need to be as successful as it can. . . . And so our belief is we'll be able to invest more in the product [than Change], make it better for customers, and accelerate revenues as a result." *Id.* at 40:22–41:16.

This testimony is borne out by the evidence at trial demonstrating TPG's concrete plans to more than double ClaimsXten's R&D budget. *Id.* at 35:20–37:18; DX-0402 at .0020, .0031. And it is consistent with the Government's Merger Remedies Manual, which recognizes that "in some cases a private equity purchaser may be preferred" to a strategic buyer because a private-equity firm has more "flexibility in investment strategy, [i]s committed to the divestiture, and [i]s willing to invest more when necessary." Merger Remedies Manual at 24–25.

To be sure, the question is whether TPG will preserve competition in the relevant market, not whether TPG has a general incentive to maximize its return on investment. *See Sysco*, 113 F. Supp. 3d at 73 (recognizing the buyer's "financial commitment" but still rejecting the proposed divestiture because the court was "not persuaded that" the buyer would "be able to step into [the

seller's] shoes to maintain . . . the pre-merger level of competition"). But based on the evidence discussed above and below, the Court finds that TPG is well-positioned to maintain, and perhaps even improve upon, ClaimsXten's performance in the claims editing market.

c. Scope of the Divestiture

The evidence at trial established that the scope of the divestiture is also sufficient to preserve competition. The evidence established, and the Court finds, that a "core aspect of [TPG's] due diligence" was determining whether the divestiture package was "sufficient to operate ClaimsXten on a standalone basis." 8/11/22 AM Trial Tr. 160:11–14 (Raj). And TPG concluded that it was. *Id.* at 160:15–25 ("We came to the conclusion that what we were receiving was more than sufficient to succeed. As you can imagine, we have every incentive to analyze that and run that to ground."); *see also id.* at 161:10–13 ("Q. Okay. Is there any asset -- physical, human capital, intellectual property -- that TPG believes it needs to stand up ClaimsXten, but is not included in the asset package? A. There's not."). The evidence also demonstrated that TPG's conclusion that ClaimsXten is "a highly separable asset" capable of succeeding on its own was based on extensive due diligence, including conversations with ClaimsXten customers who explained that the product "was sold very independently to the market." *Id.* at 158:1–8, 160:15–25.

The evidence also established, and the Court finds, that a large team of individuals with extensive experience managing ClaimsXten will continue to work with the business post-divestiture. A core member of that team is Carolyn Wukitch, whose testimony at trial revealed the breadth of her experience with and knowledge of claims editing. Wukitch has worked with claims editing products since 1990, and she has performed managerial responsibilities since 2000. *Id.* at 10:8–13 (Wukitch). She currently serves as Change's Senior Vice President and General Manager

for Network and Finance Management. *Id.* at 6:21–23. In that role, Wukitch manages the ClaimsXten business, which has a 99 percent customer retention rate under her leadership. 8/2/22 AM Trial Tr. 105:14–25 (de Crescenzo); 8/11/22 AM Trial Tr. 21:22–23 (Wukitch). Before arriving at Change, Wukitch held the same position at McKesson, the company that first developed ClaimsXten. Post-divestiture, Wukitch will serve as CEO of the ClaimsXten business. 8/11/22 AM Trial Tr. 10:18–21 (Wukitch).

The evidence established that, along with Wukitch, around 375 other individuals will continue working with ClaimsXten as part of the divestiture. *Id.* at 47:12–18. This includes ClaimsXten's 70-person clinical-content team—the "clinicians or medical coders who have responsibility for defining the clinical content, or the edits, the rule library within the solution." *Id.* at 53:13–54:2. And it includes the 60-person software-and-engineering team, as well as the 200-person customer-success team. *Id.* at 54:3–22. Other employees were evaluated on a person-by-person basis, accounting for "their experience [and] their success record with claims editing." *Id.* at 45:12–46:1. For example, out of the fifteen sales employees that support Change's payment-accuracy products, seven will continue to work with the divested business. *Id.* at 45:18–23. Those seven sales employees were chosen because they "have a proven track record selling ClaimsXten." *Id.*

The evidence established, and the Court finds, that TPG is "very clear" that the above management team will run the business day-to-day. *Id.* at 150:6–19 (Raj) ("[O]ur role is really to put the right people in those seats and have the management team run the companies."). Post-divestiture, then, ClaimsXten will be managed by much of the same team that turned it into the market leader in first-pass claims editing.

Against the evidence demonstrating that TPG has the resources and incentives to preserve (and indeed expand) ClaimsXten's competitive edge post-divestiture, the Government claims that ClaimsXten will be less successful because it will not be sold alongside Change's other payment-accuracy products. The argument: Change currently markets ClaimsXten together with at least six other payment-accuracy products; these products address payment accuracy at various stages, from pre-submission to audit and recovery; the divestiture covers only one of these products (claims editing); and thus TPG cannot replicate how Change currently competes to sell ClaimsXen. *See* Gov't Proposed Findings, ECF No. 119 at ¶¶ 368–70.

The Court disagrees. The evidence established, and the Court finds, that before Change acquired ClaimsXten in 2017, it was sold as a standalone product by McKesson for approximately a decade.[6] During that time, ClaimsXten became the market leader in first-pass claims editing. 8/11/22 AM Trial Tr. 17:1–12 (Wukitch). The evidence further established that, since 2017, Change has continued to sell ClaimsXten to customers on a standalone basis, and it has continued to be the market leader. And the record is devoid of evidence that customers have purchased ClaimsXten from Change as part of a broader suite of payment-accuracy products. *Id.* at 38:15–18 ("Q. Are you aware of any instance where a customer purchased ClaimsXten because ClaimsXten was sold alongside another payment accuracy solution? A. No."); 8/2/22 PM Trial Tr. 95:22–25 (Turner) ("Q. Are you aware of any instances where Change won primary claims editing business from a customer because ClaimsXten was a part of an end-to-end suite? A. No.").

[6] The evidence established, and the Court finds, that ClaimsXten was a standalone product at McKesson and has continued to be a standalone product at Change. 8/11/22 AM Trial Tr. 17:1–18:22 (Wukitch). As Wukitch put it, ClaimsXten is not "technically integrated with any other products," and "[i]t doesn't require anything from another part of Change Healthcare to be successful in the market." *Id.* at 18:13–17. The evidence established, and the Court finds, that the divestiture package comprised "the full suite . . . needed to have a successful claims editing business" post-divestiture. *Id.* at 40:17–22.

To the contrary, the evidence established, and the Court finds, that no customer has ever bought ClaimsXten in conjunction with another payment-accuracy product. 8/11/22 AM Trial Tr. 132:7–10 (Wukitch). Nor has any customer ever, through separate transactions, bought the full suite of payment-accuracy products that the Government now claims is essential to preserving competition. *Id.* at 105:25–106:6.

The Government stresses that Change has historically touted—and marketed—ClaimsXten as being just a part of its end-to-end "payment accuracy suite." Gov't Proposed Findings, ECF No. 119 at ¶ 371 (citing PX-415 at -575). The Government offered evidence at trial that Change has pursued a corporate strategy of "moving from selling point solutions to selling *comprehensive*, *integrated solutions* to address more complex customer needs." *Id.* at ¶ 372 (citing PX-530 at 964). That strategy is reflected in recent business plans, which describe Change as "uniquely positioned to be the first and only vendor to deliver on a fully-integrated suite of end-to-end Payment Accuracy solutions, securing a differentiated and defensible position in a growing $4B market." PX-413 at 70. And it is reflected in what Change recently told a customer—that its end-to-end suite "provides the opportunity for a more cohesive strategy that optimizes for maximum savings" and that "[i]ndividual solutions and other vendors do not provide this additional level of optimization." PX-414 at -361.

The Court agrees with the Government that the evidence established that Change has attempted to market ClaimsXten together with other products—and that, post-divestiture, such marketing efforts will be impossible. But the evidence also established, and the Court finds, that

the success of ClaimsXten does not turn on its being part of a broader suite of payment-accuracy products. *See supra* at 28–29.[7]

In sum, the Government's central point is that post-divestiture, TPG will be unable to offer a full suite of payment accuracy products, which was Change's core strategy and marketing point pre-divestiture. But the applicable standard does not require TPG to become Change's alter ego; it merely requires TPG to preserve the level of competition that existed in the relevant market before the merger. All the evidence points in the same direction: The scope of the divestiture is likely to achieve that goal.

d. Independence of TPG

The evidence demonstrated, and the Court finds, that TPG is an independent buyer and that it will be an independent competitor in the first-pass claims editing market. TPG's preexisting relationship with UHG consists of a few "heavily and hotly negotiated" deals that were each conducted "at arm's length." 8/11/22 PM Trial Tr. 5:3–9 (Raj). The evidence provided no serious reason to doubt that TPG will compete vigorously with UHG in the market for first-pass claims editing solutions. *See id.* at 5:16–22 (Raj) ("Q. Will the fact that TPG has done deals in the past with UnitedHealth Group in any way impact the vigor with which ClaimsXten will compete in the marketplace assuming the transaction goes forward? A. No, absolutely not. We're going to do the very best we can with this investment irrespective of any history.").

[7] TPG need not replicate exactly how Change goes about competing. The relevant antitrust market here is the market for *first-pass claims editing solutions*, not the market for *other* payment-accuracy products, and thus the analysis must focus on TPG's ability to replicate Change's competitive intensity in the market for first-pass claims editing. That TPG will be unable to replicate Change's broader "end-to-end" strategy is irrelevant; the Government has offered zero evidence that customers would be less likely to purchase ClaimsXten absent the option to purchase other payment accuracy products. Nor has it offered any other evidence that Change's bundled offering is what drives ClaimsXten's success.

e. Purchase Price

Although the Government suggests that speed and certainty of closing were the primary factors driving UHG's selection of TPG as the buyer, *see* Gov't Proposed Findings, ECF No. 119 at ¶¶ 365–66, nothing in the record provided any reason to doubt the adequacy of the purchase price—and the Court finds that the purchase price here was adequate.

* * *

"Ultimately, antitrust deals in probabilities, not certainties." *RAG-Stiftung*, 436 F. Supp. 3d at 308 (cleaned up). Even under the Government's proposed standard, then, UHG's "burden is only to show that the divestiture will likely replace" the competitive intensity lost because of the merger. *Id.* UHG has "far exceeded that threshold." *Id.* Indeed, the trial evidence shows—and the Court concludes—that competition in the post-divestiture market for first-pass claims editing will match, and perhaps even exceed, its current levels.

Under what the Court believes is the correct legal standard, that evidence prevents the Government from meeting its *prima facie* burden. Alternatively, under the Government's preferred standard, the evidence enables UHG to meet its burden at the rebuttal stage, and the Government provides no additional evidence to carry its burden of persuasion.

The Court therefore holds that the Government has failed to show that the proposed merger is likely to substantially lessen competition in the market for first-pass claims editing solutions in the United States. The Court will require UHG to divest ClaimsXten to TPG as proposed.[8]

[8] A divestiture ordered by a federal court "in an action brought by the Federal Trade Commission or the Department of Justice" is exempt from the filing requirements of the Hart-Scott-Rodino Antitrust Improvements Act. 16 C.F.R. § 802.70.

B. The Government Has Failed to Show That the Proposed Merger is Likely to Substantially Lessen Competition Under Its Vertical Theories.

Turning to the Government's claims regarding the vertical components of the proposed transaction, the Government advances two theories of competitive harm. First, the Government argues that United's control over Change's EDI clearinghouse would give United the ability and incentive to use rivals' CSI for its own benefit. Second, the Government argues that United's control over Change's EDI clearinghouse would give United the ability and incentive to foreclose rivals' access to key inputs on competitive terms by withholding innovations, thereby raising those rivals' costs. The effect of these actions, says the Government, would be to substantially lessen competition in the markets for national accounts and large group commercial health insurance.

1. The Government's Data-Misuse Theory Fails.

Consider, first, the Government's data-misuse argument.[9] The claim starts by contending that Optum, through its post-acquisition control of Change's EDI clearinghouse, will gain broad access and use rights to the claims data of UHC's rivals. The argument then posits that Optum will have an incentive to share the data—or at least the competitively sensitive insights that can be gleaned from the data—with UHC. Knowing this, UHC's rivals will innovate less, out of fear that UHC will free ride off their innovations, thereby resulting in harm to competition in the relevant insurance markets. In essence, then, this vertical theory can be distilled to four steps, each of which the Government must establish is likely: (1) Optum will gain incremental access and use rights to the claims data of UHC's rivals; (2) Optum will have an incentive to share these data—or the competitively sensitive insights derived from the data—with UHC; (3) rival payers' fear of

[9] By "misuse," the Court means the claim that United would use its competitors' data for anticompetitive purposes. The Court appreciates the Government's position that United need not violate applicable law or company policy to appropriate rival payers' claims data.

UHC using these data or insights will chill innovation; and (4) less innovation means less competition in the relevant markets.

The evidence at trial highlighted weaknesses in each of these steps. But the central problem with this vertical claim is that it rests on speculation rather than real-world evidence that events are likely to unfold as the Government predicts. Governing law requires the Court to "mak[e] a prediction about the future," and that prediction must be informed by "record evidence" and a "fact-specific showing" as to the proposed merger's likely effect on competition. *AT&T*, 310 F. Supp. 3d at 190–92 (quotations omitted). Under this standard, "antitrust theory and speculation cannot trump facts." *Id.* at 190 (quotations omitted).

The evidence adduced at trial established that, for it to be likely that the proposed acquisition would substantially lessen competition, United would have to uproot its entire business strategy and corporate culture; intentionally violate or repeal longstanding firewall policies; flout existing contractual commitments; and sacrifice significant financial and reputational interests. The Government has failed to show that United's post-merger incentives will lead it to take such extreme actions. Nor has the Government put forward real-world evidence that United's rivals are likely to innovate less out of fear that United will poach their data. No payer witness made that claim; in fact, all the payer witnesses testified to just the opposite. Although the Government's data-misuse argument has other shortcomings, these two defects stand out above the rest.

a. Data Access and Use Rights

The Government contends that, if the acquisition closes, United will gain access to the huge cache of competitively sensitive claims data that passes through Change's EDI clearinghouse, along with accompanying rights to use those data for its own economic advantage. Gov't Proposed

Findings, ECF No. 119 at ¶ 94. These data cover the entire lifecycle of a claim—both pre- and post-adjudication.

The evidence at trial established, and the Court finds, that claims data can have competitive value. Pre-adjudicated claims data, for example, may provide insight into which markets and providers generate claims, which employer groups contract with specific payers, and which employer groups are the most and least healthy. 8/1/22 AM Trial Tr. 133:11–23 (Garbee). This information in turn can help a payer identify which employers a rival may want to pursue as potential customers. *Id.* at 133:14–134:9.

Post-adjudicated claims data generally have more proprietary information. PX-1013 at 395:1–24 (Golden). Such data can include information about payers' discounts, provider network contracts, benefits, claims edits, adjudication decisions, and final paid amounts. 8/1/22 AM Trial Tr. 135:12–23 (Garbee); *see also id.* at 134:17–135:23. This information reflects a payer's "adjudication logic," and a rival who gains access to it could learn that payer's "whole adjudication process." 8/10/22 PM Trial Tr. 158:19–25 (Gelbach); 8/1/22 AM Trial Tr. 135:12–23 (Garbee).

The evidence established that Change has secondary-use rights for around 50 percent of the claims data passing through its EDI clearinghouse. *See* 8/9/22 AM Trial Tr. 87:22–88:7 (Gowrisankaran). Because just over half of all commercial medical claims touch Change's EDI clearinghouse, *see* PX-820 ¶ 185, Change thus has use rights for about a quarter of all commercial claims data transmitted between payers and providers. The percentage is lower for many of UHC's primary competitors—Change has use rights for 12 to 21 percent of claims data for these payers. DX-0862 at .0027; 8/15/22 PM Trial Tr. 89:9–90:1 (Gowrisankaran). Optum will inherit these use rights after the proposed merger.

The Government contends that United, after gaining these data (and accompanying use rights) through the acquisition, will have the ability and incentive to use its rivals' claims data to discern and co-opt its rivals' competitive strategies and practices. One of the Government's expert witnesses—Dr. Handel—identified five potential "use cases" for these claims data. In particular, Dr. Handel testified that these claims data would allow United to learn valuable information about its rivals' utilization management practices, pricing and reimbursement strategies, provider network designs, claims adjudication processes, and underwriting techniques. 8/8/22 AM Trial Tr. 124:1–11 (Handel).

As noted above, the evidence established that Optum will acquire claims data (and some secondary-use rights) as a result of the proposed acquisition. The evidence also established, however, that Optum currently has access to claims data and CSI relating to UHC's payer competitors. Today, Optum receives proprietary information—including payer-specific adjudication rules, payment policies, and contract information—in connection with the services it renders to its non-UHC customers. DX-0862 at .0015. The evidence thus established (and the Court finds) that Optum already receives much of the same kinds of information that is included in the claims data that passes through Change's EDI clearinghouse. *See* 8/5/22 AM Trial Tr. 48:5–8 (Yurjevich) ("Q. Do you receive, for contracts and duplicates, the data that would be included in an EDI remittance? A. Yes, we do."). The evidence also established that Optum's external customers include some of UHC's chief competitors.

As a result, there is overlap between the types of data to which Optum already has access and the types of data passing over Change's EDI clearinghouse. The Government therefore could have strengthened its case by quantifying the *amount* of incremental (*i.e.*, new) data that would be available to Optum post-merger, as well as the value of that incremental data to UHC. But Dr.

Handel made no attempt to do so. *See* 8/8/22 PM Trial Tr. 38:16–22 (Handel). Nor could he—Dr. Handel did not review the claims data that Optum receives today, so he had no baseline against which to measure incremental increases in the amount and value of the data. *See id.* at 6:25–7:5 ("Q. And as you prepared your opinion in this case, you did not have a detailed understanding of which non-UHC payers provide claims data or other competitively sensitive information to Optum today in the course of a contractual relationship between that payer and Optum; isn't that correct? A. Yes."); *id.* 7:6–18 ("Q. As part of your work in this case, you also did not specifically quantify, by which I mean number of claims received over a period of time, the claims data that Optum currently has provided to it by non-UHC payers; isn't that correct? A. Yes, that's correct.").[10]

The Government makes much of the (admittedly valuable) secondary-use rights associated with Change's claims data—rights that Optum largely, but not completely, lacks today. *See* 8/15/22 PM Trial Tr. 33:7–16 (Gowrisankaran) (distinguishing access to data from rights to use data); PX-820 Ex. 10 (demonstrating that Optum may have secondary-use rights for up to 4.2 percent of claims data that pass through its EDI clearinghouse). But the Government never fully addressed Optum's ability (or lack thereof) to extract competitively sensitive insights from the data it already receives from non-UHC payers. *See*, *e.g.*, 8/8/22 PM Trial Tr. 9:20–25 (Handel) ("Q. Dr. Handel, you don't know whether the information that this payer provides to Optum today under this contract is sufficient for Optum to analyze that information and derive the types of competitive insights that you identified in your report; isn't that correct? A. I believe so, yeah. I don't know."); *id.* at 17:24–18:4 (same); *id.* at 18:12–23 (same). Put another way, the Government

[10] Dr. Gowrisankaran did quantify the percentage of post-acquisition data for which Change has (and Optum will have if the acquisition goes through) secondary-use rights. *See* PX-820 Ex. 10. But he did not quantify how much of the data would be new to Optum—that is, he did not quantify how the data are different from what are already available to Optum.

never established that Optum cannot do now, at least in some degree, what the Government says it will do after the proposed acquisition.

This matters for two reasons. First, if United is already in possession of data from which competitively sensitive insights could be gleaned and shared with UHC, then there has to be something about the proposed acquisition that would change United's ability and incentive to do so with Change's data. And second, if the ability and incentive already exist, then present circumstances can serve as a natural experiment for what might occur in the post-acquisition world. Under Section 7 case law, courts must consult pre-merger conduct and history in making their predictive judgment about the state of post-merger competition. *See AT&T*, 916 F.3d at 1039 ("The district court had to determine whether the economic theory applied to the particular market by considering evidence about the structure, history, and probable future of the . . . industry." (quotations omitted)); *FTC v. Foster*, 2017 WL 1793441, at *38 (D.N.M. May 29, 2007) ("Natural experiments, *i.e.*, evidence that the posited harm has occurred under circumstances similar to the transaction, are relevant to the merger analysis." (cleaned up)). And as explained in more detail below, the record is devoid of any evidence that United has ever used its rivals' claims data to allow UHC to glean competitively sensitive insights from that data.

Nevertheless, it is clear from the record that Optum would acquire *some* incremental data (and some corresponding secondary-use rights) following the acquisition. And the evidence established that these data and rights could enable United to do *some* things that it cannot do today. The Court will therefore assume that the Government, for purposes of its *prima facie* case, has established the first step of its data-misuse theory.

b. Sharing Data and CSI

Turning to step two of its data-misuse theory, the Government argues that Optum will have a strong incentive to share rival payers' data and CSI with UHC. In fact, the Government claims that Change's data rights are what motivated the proposed merger. Gov't Proposed Findings, ECF No. 119 at ¶ 135. It relies on the deposition testimony of David Wichmann, the former CEO of UHG, who stated that Change's data rights were the "foundation by which the business case was made . . . to pursue the transaction." PX-1009 at 6 (274:21–275:14) (Wichmann). The Government also points to several ordinary course documents in which United executives expressed interest in Change's "data" and "data rights." *See* Gov't Proposed Findings, ECF No. 119 at ¶¶ 135–42. In its closing argument, the Government said that these documents are "the best evidence of how the parties viewed the real world." 9/8/22 PM Trial Tr. 13:13–15 (Gov't Closing).

But mere references to data and data rights cannot prove this step of the Government's claim. After all, both Optum and Change are companies in the business of dealing with data, so the fact that Optum was discussing Change's data and data rights during due diligence is hardly a surprise. Far more relevant would have been evidence that United executives wanted to acquire Change's data and data rights for the purpose of equipping UHC with competitive intelligence about its rivals. But the exhibits and deposition testimony on which the Government relies do not reveal such an intention, and the trial testimony uniformly rejected any suggestion that the purpose of, or rationale for, the acquisition was to allow the use of claims data in this way. *See*, *e.g.*, 8/5/22 AM Trial Tr. 124:1–10 (Musslewhite) ("Q. Mr. Musslewhite, I just have a few more questions. We've heard a lot in this case about the deal rationale for the Change transaction is to gain access to Change's data and their data rights and use that to benefit UHC. As the executive sponsor for this deal, what's your reaction to that? A. We would never do that. We never talked about that.

It would never be something that OptumInsight could do as a functioning business entity."); 8/4/22 PM Trial Tr. 79:9–16 (Hasslinger) ("Q. And when the executives asked you to look more into Change's data rights or data assets, did you understand that they were interested in acquiring Change's data or data rights so that they could share that with UHC? A. No. Q. And did you understand that those executives wanted to use Change's data for competitive intelligence for UHC? A. No."); *id.* at 32:8–17 (Wichmann) ("Q. I think your testimony is that when you were considering the transaction as a whole, that you did not put any value on the possibility that UHC would have access to Change payer data for the purpose of competing against its payer competitors[?] A. Absolutely not. Q. You did not personally? A. I did not personally, and nobody I interacted with did either.").

More fundamentally, the evidence established, and the Court finds, that United's incentives are not nearly as one-sided as the Government suggests. To be sure, the evidence did establish that United has an incentive to arm UHC with valuable insights about its health insurance rivals. But the evidence also established that United has incentives to protect its external customers' (including its rival payers') claims data and CSI—incentives that are embodied in United's firewall policies and customer contracts. The question, then, is which set of incentives is most likely to drive United's post-acquisition behavior.

The Court finds, based on all the evidence presented at trial, that United's incentives to protect external customers' data outweigh its incentives to "misuse" that data. For starters, the evidence established that Optum currently pursues a multi-payer business strategy, and the success of that strategy turns on payers and providers trusting that their data will be protected. At trial, Witty explained the importance of this multi-payer strategy: "I strongly, strongly believe that being multi-payer is a key feature of Optum, a key feature, really, therefore, of UnitedHealth

Group." 8/10/22 PM Trial Tr. 21:7–13 (Witty). He went on: "[I]f you didn't have multi-payer relationships or relationships with competitors of different parts of the organization, it would be very easy to lose your edge." *Id.* at 21:16–19. Non-UHC payer revenue makes up a substantial portion of OptumInsight's total payer revenue, DX-0813 Ex. 2, and three of its top five external customers are among UHC's largest competitors, DX-0656A at .0004. The evidence thus established (and the Court finds) that Optum has strong incentives to preserve these relationships, and that doing so requires maintaining customers' trust that their data and CSI will not fall into the hands of UHC. *See* 8/10/22 PM Trial Tr. 28:18–21 (Witty) (stressing that misusing rivals' data "would be hugely destructive, not just to our reputation but to our economic interest, because customers are not going to come back to an organization which abuses their data in that way").

The evidence also demonstrated, and the Court finds, that United has developed a corporate culture consistent with upholding that trust. Witness after witness testified under oath that United has built a culture of trust and integrity around protecting the CSI of its external customers, including rival payers. Witty, for example, testified that data sharing "would be against the tone, the culture, the rules, everything we stand for in the organization." *Id.* at 28:2–24. Steve Yurjevich, the Chief Operating Officer of OptumInsight, likewise testified that the company's "culture" is to "treat customers' data as they would treat their data themselves." 8/5/22 AM Trial Tr. 64:11–14 (Yurjevich). And when asked by the Court what would happen if employees were instructed to share data with UHC, Peter Dumont—UHG's Chief Privacy Officer—firmly and credibly responded: "I honestly think you would see a lot of people quitting." 8/5/22 PM Trial Tr. 75:7–16 (Dumont).

Consistent with this testimony, the record contains no evidence that Optum has used *its* access to external payers' data for the purpose of sharing that data with UHC. *See*, *e.g.*, 8/10/22

AM Trial Tr. 73:14–74:16 (Schumacher) ("Q. Mr. Schumacher, are you personally aware of any instance in which a rival payer -- in which rival payer claims data or other rivals' CSI was passed from Optum to UnitedHealthcare? A. I am not. Q. Are you personally aware of any instance in which Optum analyzed rival payer claims data and provided UnitedHealthcare with competitive insight about its rivals? A. I am not."); 8/10/22 PM Trial Tr. 119:22–120:11 (Gehlbach) ("Q. In that time [at UHC], are you aware of any instance in which you or anyone else associated with UnitedHealthcare received from Optum competitively sensitive information about a rival payer? A. No."); 8/5/22 AM Trial Tr. 38:23–25 (Yurjevich) ("Q. Have you ever lost a customer because they thought OptumInsight was misusing or stealing their data? A. Absolutely not.").[11]

Also relevant are certain structural guarantees that exist to prevent CSI from being shared between Optum and UHC. The Court will discuss two of those structural protections: firewalls and customer contracts.

Start with United's firewall policies. The evidence established, and the Court finds, that firewalls are an industry standard means of protecting CSI in the vertically integrated healthcare space. 8/15/22 AM Trial Tr. 38:14–24 (Murphy) ("Firewalls in this industry for protecting CSI have been deemed to be effective."). The evidence also established that, for over a decade—beginning well before the proposed acquisition here—United has maintained a corporate antitrust firewall that expressly prohibits the sharing of CSI between business units. That policy provides: "You must not participate in or facilitate communications that may reduce or eliminate competition

[11] When asked whether United planned to reverse course and use Change's payer data to benefit UHC, every single witness answered—credibly and without equivocation—that United would never do so. *See*, *e.g.*, 8/10/22 PM Trial Tr. 28:2–24 (Witty); 8/4/22 PM Trial Tr. 31:4–7 (Wichmann); 8/5/22 AM Trial Tr. 13:23–14:16 (Yurjevich); 8/8/22 AM Trial Tr. 89:25–90:10 (Higday); 8/9/22 PM Trial Tr. 101:11–17 (McMahon); 8/10/22 AM Trial Tr. 73:14–74:16 (Schumacher); 8/10/22 PM Trial Tr. 119:22–120:11 (Gehlbach).

between another Business Unit and its competitor(s)." DX-0529 at .0002. The policy also requires employees to "[e]xercise caution when communicating with a customer or supplier who is a competitor of another UHG Business Unit," and to "[a]void serving as a conduit of information or an intermediary between the 'competitor' and the other Business Unit." *Id.* at .0003. The evidence does not reflect a single instance in which these firewalls have been breached. *See*, *e.g.*, 8/5/22 PM Trial Tr. 42:24–43:2 (Dumont) ("Q. Have there been any violations of United's firewall policies where a UnitedHealthcare employee actually accessed Optum external customer data? A. Not that I'm aware of."); 8/4/22 AM Trial Tr. 101:6–10 (Wichmann) ("Q. Were you aware of any employees of United across the business segments using competitively-sensitive information learned from one business segment and applying it to another? A. No.").

In May 2022, United took a related step by issuing guidance to address the Change transaction specifically and the data sharing principles that will apply post-merger. 8/5/22 PM Trial Tr. 40:1–4 (Dumont). The evidence established, and the Court finds, that this transaction-specific policy was not designed to alter United's longstanding approach to information sharing, but rather was intended to memorialize existing practices and to address specific concerns raised in relation to the proposed acquisition. *Id.* at 40:11–24; *see also* DX-0654 at .0001 ("This Policy sets forth specific guidelines consistent with the UHG antitrust compliance policy with respect to the use and disclosure of competitively sensitive information obtained from customers of Optum Insight or Change."). Among other things, the May 2022 policy provides:

- "The disclosure of External Customer CSI to UHG business units that are competitors of such External Customers is strictly prohibited."
- "The use of External Customer CSI to benefit UHG business units that are competitors of such External Customers is strictly prohibited."
- "UHG employees may not access External Customer CSI unless such access is necessary to perform their job responsibilities."

- "External Customer CSI shall be logically separated from other UHG business unit data within Electronic Data Sites. No employees of other UHG business units that are competitors of an External Customer shall have access to the locations where External Customer CSI is stored within such Electronic Data Sites."

DX-0654 at .0002.

The Government disputes the effectiveness of these policies. The Government argues that the terms of the May 2022 firewall do not cover payers' claims data that come from providers, channel partners, and trading partners, because those parties are not competitors of UHC. Gov't Proposed Findings, ECF No. 119 at ¶ 203. But by its terms the May 2022 policy protects the CSI of "External Customers," which include all "Optum Insight or Change customers who are not a UHG business unit." DX-0654 at .0002. The evidence established that nearly all payers in the United States are customers of OptumInsight. *See* 8/5/22 AM Trial Tr. 19:6–12 (Yurjevich) (explaining that around 220 of the 230 payers in the United States are OptumInsight customers, including many of UHC's main rivals). The evidence thus established, and the Court finds, that those customers' data are protected by this policy, even if the data are acquired by Optum indirectly through a provider or an intermediary. *See*, *e.g.*, 8/5/22 PM Trial Tr. 42:12–18 (Dumont) ("Q. So, just to walk that through with an example, if Optum receives data about a UnitedHealthcare competitor from a healthcare provider, could Optum share that data with UnitedHealthcare since it's not coming from a competitor directly? A. It could not. That would be against a number of our policies; [the May 2022] policy in particular.").

The Government also contends that the policies can be amended—or even repealed—in the future. Gov't Proposed Findings, ECF No. 119 at ¶ 202. That's theoretically true. But the Government does not explain how it can meet its burden of proof simply by asserting that "things may change." And the evidence demonstrated that United is likely to preserve its firewall policies

moving forward. Its corporate antitrust policy, after all, has been in place since 2007, and the evidence demonstrated that United has strong incentives to maintain its May 2022 firewall as well. *See*, *e.g.*, DX-0813 ¶ 147 (OptumInsight's "multi-payer business is predicated on payers and providers trusting that its firewalls will protect their data."). The Government has failed to show that United's incentives would change so drastically post-merger that it would abandon these comprehensive, industry-standard firewall protections.

Indeed, in assessing United's post-merger incentives, the Court must consider the financial and reputational costs to United if it were to breach or water down its firewall policies. *See* 8/12/22 AM Trial Tr. 95:13–22 (Tucker) ("Q. [Y]ou also have to think about the other incentives that would be pushing in the other direction, to include the firewall policies, reputational risk, and the like. Correct? A. Yes, that's precisely correct. And the way I might characterize it is to understand the dynamics of the incentives in this situation and the extent to which United and Optum can anticipate the very negative consequences of a breach of firewalls, for example."). The evidence established, and the Court finds, that those costs would be high. Last year, non-UHG customers accounted for around $63 billion in Optum revenue across all three business units. 8/10/22 AM Trial Tr. 71:9–22 (Schumacher). The evidence demonstrated that if those same customers stopped trusting OptumInsight to protect their data, then that "entire book of external business" would be "at risk," 8/5/22 AM Trial Tr. 71:6–14 (Yurjevich), because customers think of Optum as a single unit, *id.* at 31:24–32:11.

The evidence also demonstrated, and the Court finds, that UHC's rivals recognize Optum's strong incentives to comply with the firewalls and protect customers' data. One competitor, for example, noted that it was "highly confident and convinced" that Optum would not "share their Plan's information with UnitedHealthcare" because doing so would "risk [Optum's] credibility

and brand reputation." DX-0472 at .0004. The Government offered no conflicting testimony at trial—indeed, the Government did not call a single rival payer witness to testify against United's firewalls or any other aspect of its data protection measures.

On top of its firewalls, the evidence established that Optum's contracts require the protection of customer data. These contracts generally require that Optum use all "reasonable commercial means" to protect its external customers' data and prevent sharing of those data with UHC. *See*, *e.g.*, DX-0314 at .0012 ("Optum and its Affiliates in the health services line of business shall prevent and maintain commercially reasonable safeguards to prevent the disclosure of Customer Data to, and access or use of Customer's Data by, United Healthcare and/or any of its Affiliates."); DX-0468 at .0016 ("During the Term of this Agreement, each Party shall protect the other Party's Confidential Information using the same degree of care as it uses to protect its own Confidential Information of like nature."). What is more, the contracts typically permit payer customers to audit Optum's data protection measures. 8/5/22 AM Trial Tr. 71:15–72:4 (Yurjevich).

The evidence also established that, even when Optum receives payer data from providers and intermediaries, rather than from payers themselves, it treats the data as if they came directly from the payer and thus provides the contractually required protection. *Id.* at 15:4–22 ("Q. [S]o if Optum receives . . . claims data of [a rival] relating to [that rival's] national accounts, but it doesn't get that claims data from [the rival], it gets it from some other source, does Optum view its commitments to [the rival] in its contracts as covering that data or those data? A. Yes, absolutely."). In short, using rival payers' data to benefit UHC would conflict with Optum's contractual obligations to its payer customers. 8/4/22 PM Trial Tr. 31:23–32:7 (Wichmann).

The evidence established that, like Optum's contracts, Change's contracts protect the data and CSI of its customers. For example, Change's Master Relationship Agreements (MRAs) provide: "Each party will protect and safeguard the other party's Confidential Information with at least the same care used for its own Confidential Information of a similar nature, but no less than reasonable care." DX-0843 at .0004; *see also* 8/3/22 AM Trial Tr. 47:12–24 (Suther) ("[I]f we felt that a[n] interested health insurer were trying to, you know, reverse engineer the business practices of one of their competitors, that, in our mind, would be a violation of our confidentiality obligations under our agreement.").

The Government contends that Change's MRAs are subordinate to its Business Associate Agreements (BAAs), which specify that they "modif[y]" the underlying agreements and "govern in the event of conflict or inconsistency." Gov't Proposed Findings, ECF No. 119 at ¶ 196; PX-460 at -613. And, the Government argues, the BAAs confer broad secondary-use rights: "Change Healthcare . . . may Use or Disclose such de-identified data unless prohibited by applicable law." PX-460 at -610. According to the Government, this language would allow Optum to share rival payers' CSI with UHC.

But the evidence demonstrated, and the Court finds, that Change has never operated under this interpretation. Tim Suther, the Senior Vice President and General Manager of Change's Data Solutions business, testified that if a "payer wanted specific information about one of its competitors" from Change, then Change "would view that as a violation of [its] confidentiality obligations and . . . would turn that down." 8/3/22 AM Trial Tr. 46:13–24 (Suther). Consistent with that understanding, Change does not sell payers' claims data to other payers. 8/2/22 PM Trial Tr. 119:25–120:1 (Suther); 8/3/22 AM Trial Tr. 10:15–11:5 (Suther). And even when Change licenses de-identified data to third parties, its customer agreements often include "substantial"

restrictions, along with "significant contractual remedies" and even audit rights to ensure that third parties comply with Change's contractual restrictions. *See* 8/3/22 AM Trial Tr. 33:21–34:4 (Suther); PX-174 at -06.

These practices cast doubt on the Government's interpretation, and at the very least, suggest that there would be high costs to exploiting potential gray areas. *See* 8/3/22 AM Trial Tr. 44:2–5 (Suther) ("[Confidentiality is] oxygen to our business. Honoring the commitments that we've made to our customers is essential. As we mentioned earlier, doing otherwise would be catastrophic to the business."). What is more, it is far from clear that the BAAs even conflict with the MRAs. The BAAs confer use rights, and the MRAs impose a standard of care for handling confidential information. The contracts can thus be read in harmony to allow Change to use the data—by licensing it to data aggregators, for example—while at the same time prohibiting Change from sharing the data with rival payers. And, in any event, contracts are not the only layer of protection for CSI—United's firewalls can still serve as a backstop.

For all the above reasons, the evidence at trial established, and the Court finds, that United will have strong legal, reputational, and financial incentives to protect rival payers' CSI after the proposed merger. Still, the Government's expert, Dr. Gowrisankaran, says that the costs of data misuse would be "negligible" for United, because even though United may lose "some business" as a result of the merger, other customers will just "assume the risk," and those customers are unlikely to later leave because they will never know if United misuses their data. 8/9/22 PM Trial Tr. 55:3–56:10 (Gowrisankaran). This contention, in the Court's view, rests on speculation and is unsupported by any real-world evidence.

The Government and Dr. Gowrisankaran are on firmer ground when they argue that United is a vertically integrated firm with an incentive to maximize its overall profits, not just the profits

of an individual subsidiary like Optum. After all, it has long been "a principle of antitrust law" that "a business with multiple divisions will seek to maximize its total profits." *AT&T*, 916 F.3d at 1043. For this reason, "the operations of a corporate enterprise organized into divisions must be judged as the conduct of a single actor," with each division pursuing the common interests of the whole. *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 770 (1984). Here, the Government contends that United's corporate-wide interests and incentives will be to share CSI with UHC, even if doing so hurts Optum, because that is the best way to maximize corporate-wide profits.

It is of course true that, in some cases, the optimal strategy for maximizing corporate-wide profits will be to leverage one division of the business to benefit another division. But it is also true that, in other cases, the best way to maximize corporate-wide profits will be for the first division to do business with as many customers as possible, including competitors of the sister division. *See AT&T*, 916 F.3d at 1043 (crediting the district court's conclusion that "Turner Broadcasting's interest in spreading its content among distributors . . . would redound to the merged firm's financial benefit"). It is consistent with the corporate-wide profit maximization principle to assess which strategy is "the best way to increase company wide profits . . . in a particular industry." *Id.* at 1044 (quotations omitted).

Witty, the CEO of UHG, explained all this in his deposition testimony. The Government seizes upon his statement "that UnitedHealth Group needs to think about United at an enterprise level," 8/9/22 AM Trial Tr. 90:4–18 (Gowrisankaran), while ignoring his observation that maximizing enterprise value "sometimes . . . would involve [separate business units'] assets being worked together," and "sometimes individually," subject to "the important caveat of all of the rule sets" that limit UHG's conduct, *see* DX-0852 at 296:1–297:17 (Witty).

And at trial, Witty testified that enterprise value would not be maximized—in fact, it would be harmed—if Optum shared competitively sensitive data with UHC. *See* 8/10/22 PM Trial Tr. 28:2–24 (Witty) ("Q. [The Government's] expert also testified that because of your enterprise approach, that that would cause people at OptumInsight to give data concerning UHC's rivals over to UHC so they could beat them in the marketplace. And what's your response to that? A. So again, first of all, that would be against the tone, the culture, the rules, everything that we stand for in the organization. . . . [And] it would be hugely destructive, not just to our reputation but to our economic interest."). The Government downplays the relative gains and losses between UHC and OptumInsight by focusing only on OptumInsight's revenue, rather than the revenue of Optum as a whole. But as the evidence demonstrated at trial, and as the Court finds, data misuse would place all of Optum's $63 billion in external revenue at risk, because customers think of Optum as a single unit. *See* 8/5/22 AM Trial Tr. 31:24–32:11 (Yurjevich). The trial evidence did not demonstrate that the potential gains to UHC would outweigh this potential loss.

In sum, the evidence established that the Government's claim fails to account for all of United's post-merger incentives, including its incentives to preserve its multi-payer business model, to maintain its internal culture, and, ultimately, to protect its financial and reputational interests. The Government, at most, presented evidence that United would have some incentive (and ability) to exploit competitors' competitively sensitive data for its own economic benefit following the acquisition. "But evidence . . . that it could be possible to act in accordance with the Government's theories of harm is a far cry from evidence that the merged company is likely to do so." *AT&T*, 310 F. Supp. 3d at 210. The Court must make a "predictive judgment" about the competitive effect of the proposed merger, *Heinz*, 246 F.3d at 719 (quotations omitted), and that prediction must be based on real-world evidence related to the "structure, history[,] and probable

future" of the relevant markets, *AT&T*, 310 F. Supp. 3d at 190. Here, that evidence—the widespread use of firewalls in the industry, United's history of compliance with its own firewalls, the customer contracts, and the convincing testimony from senior executives about United's practices and incentives—weighs strongly against the Government's position.

c. Future Innovation

Even if the Government had established that United's post-merger incentives would drive it to "misuse" Change's claims data, the Government also had to demonstrate a likely substantial lessening of competition. The Government based its theory of competitive harm here on reduced innovation by other payers.[12] *See* 8/9/22 AM Trial Tr. 75:5–17 (Gowrisankaran); *see also* Gov't Proposed Findings, ECF No. 119 at ¶¶ 188–89. This theory of harm does not necessarily depend on United's *actual* misuse of rivals' data for competitive insights—according to the Government, United's rivals will reduce innovation because "regardless of what United's going to do, United's rivals are going to *think* that United will act in its own interests." 8/9/22 AM Trial Tr. 91:13–92:25 (Gowrisankaran) (emphasis added); *see also* 9/8/22 PM Trial Tr. 45:4–16 (Gov't Closing Argument) ("[United's rivals] will *assume* that that data and those rights will be used. And, as a result, they will see that lessening [of innovation]." (emphasis added)).

Yet the Government provided zero real-world evidence that rival payers are likely to reduce innovation. The Government did not call a single rival payer to offer corporate testimony that it would innovate less or compete less aggressively if the proposed merger goes through. Nor did

[12] At trial, Dr. Gowrisankaran suggested that UHC may use its rivals' CSI to assist its underwriting practices, which may harm competition in ways other than reducing innovation. *See* 8/9/22 AM Trial Tr. 97:10–24 (Gowrisankaran). But for reasons discussed above, the Government has not proven that UHG is likely to misuse its rivals' CSI.

any of the rival payer employees who did testify support the Government's theory. To the contrary, all the payer witnesses rejected the notion that the proposed merger would harm innovation.

For example, a Cigna employee was asked, "You are not going to compete less aggressively after UnitedHealthcare acquires Change Healthcare?" Her answer: "So in my personal opinion, I don't think we ever compete less for any reason. We always go at it really hard. That's our job." PX-1005 at 169:14–16, 169:19–170:1 (Dill). An Aetna employee was likewise asked, "This transaction certainly won't cause your group at Aetna to innovate less, will it?" His answer: "It should not. . . . I'm not forecasting any [less innovation]." 8/1/22 PM Trial Tr. 94:23–95:2 (Lautzenhiser). An Anthem employee was also asked, "[A]ssuming that the transaction between Change and Optum moves forward and goes through, that's not going to stop Anthem from innovating its health plans, right?" His answer: "Yeah. Absolutely. We will continue to innovate." PX-1019 at 256:16–20, 256:24–25 (Chennuru). Finally, a former Cigna employee was asked, "After the United-Change transaction was announced, you don't recall Cigna competing less aggressively for employer business?" Her answer: "No. In innovating, though, they would be more careful where they put their edits. They would still innovate but be more careful about where they put it." 8/1/22 PM Trial Tr. 14:17–22 (Garbee). As Garbee later clarified, she was talking about keeping edits away from ClaimsXten—a concern solved by the divestiture. *See id.* at 15:22–16:12.

In short, the testimony from rival payers who were asked about innovation is inconsistent with the Government's theory of competitive harm, and the Government did not offer any other rival payer testimony on this score. The Government is thus left to rely solely on the testimony of one of its experts. *See* 8/9/22 AM Trial Tr. 75:5–17 (Gowrisankaran) ("Q. How would United gaining rights to its health insurer rivals' competitively-sensitive information affect those rivals'

incentives to invest in the competitive advantages you described a few minutes ago? A. Well, if United were able to appropriate or free-ride off of those innovations, then that's going to mean that these rivals are going to invest less in innovation."). But "antitrust theory and speculation cannot trump facts; the Government must make its case on the basis of the record evidence relating to the market and its probable future." *AT&T*, 310 F. Supp. 3d at 190 (quotations omitted). Based on the record here, including the evidence from actual market participants, the Court concludes that the Government failed to establish that the acquisition would result in less innovation by rival payers.

d. Harm to Competition

Imagine, however, that rival payers did testify that they would scale back innovation. Even then, the Government would still have to prove that that reduction in innovation would be likely to *substantially* lessen competition in the relevant markets.

The Government rests on the axiomatic truth that payers who are innovating less are also competing less. But it made no attempt to show that the lessening of innovation and competition would be *substantial*. In fact, the Government's own expert admitted that rival insurers would still innovate after the proposed merger. Dr. Gowrisankaran was asked, "Does your opinion that post-merger United would use its health insurance rivals' competitively-sensitive information to copy rivals' innovations depend on United's rivals' stopping all innovations?" 8/9/22 AM Trial Tr. 96:9–12 (Gowrisankaran). Dr. Gowrisankaran answered: "Oh, no, it really doesn't. . . . Of course insurers are going to keep innovating even if this merger were to go forward. They would just have less of an incentive to innovate and it would just lessen innovation. It wouldn't remove it entirely." *Id.* at 96:13–97:1. But establishing that the proposed merger would "lessen innovation" (and thus competition) and that insurers would have "less of an incentive to innovate" (and thus

compete) does not establish that the proposed merger would *substantially* lessen competition. The Government failed to offer evidence demonstrating that that standard is met here. But the Court need not rest its holding on this point, as the Government failed to establish other steps in its theory.

* * *

In sum, based on the Court's review of all the evidence in this matter, the Court concludes that the Government has failed to make a *prima facie* case of a likely substantial lessening of competition under its data-misuse theory. Each step of the Government's argument must be true for its theory to work, yet each step suffers from serious flaws. The most serious flaws, however, are the failures to prove (1) that United is likely to misuse the data in the ways the Government contends and (2) that rival payers will innovate less as a result.

2. The Government's Foreclosure Theory Fails.

The Government's second vertical theory posits that United will have the ability and incentive to raise rival payers' costs by withholding or delaying the sale of EDI-related innovations—specifically, integrated platforms.[13] The Government stresses that Optum and Change have long competed to develop their own integrated platforms—Optum, through an idea called the Transparent Network, and Change, through a concept called Real-Time Settlement—and that if United acquires Change, United would control the development of the only integrated platform that is also scaled. Gov't Proposed Findings, ECF No. 119 at ¶ 266. And if that happens, the Government contends, rival payers would likely be stuck with United, because no other firm is well-suited to build a competing platform. *Id.* United could then foreclose access to the integrated platform, such as by withholding or delaying sales. *Id.* And more than that, United

[13] Integrated platforms are intended to reduce administrative waste and speed up payment to providers by shifting claims edits "to the left," *i.e.*, by applying edits earlier in the payment process. PX-820 ¶¶ 48–53.

would have an incentive to do so, because the downstream commercial health insurance markets are more lucrative than the upstream healthcare IT markets. *Id.* at ¶ 286.

The Government's foreclosure theory has significant flaws. To begin, the evidence overwhelmingly established, and the Court finds, that both Real-Time Settlement and Transparent Network are "concepts," *not* actual products. *See* 8/11/22 AM Trial Tr. 34:2–5 (Wukitch) ("Q. First of all, does Change Healthcare have an existing offering called Real-Time Settlement? A. No. It is a concept that's in development."); 8/3/22 PM Trial Tr. 57:1–10 (Joshi) ("So, Real-Time Settlement is a concept. It is not a product today. It is not close to being a product."); 8/5/22 PM Trial Tr. 120:25–122:11 (Schmuker) (noting that Optum cannot "say definitively" whether Transparent Network will ever be a marketable product). This fact puts the Government in an awkward position: It must prove that United will likely withhold from its rivals products that don't even exist. That may be why the Government did not define the relevant EDI-related innovation market. *See* 8/9/22 PM Trial Tr. 52:18–53:7 (Gowrisankaran) ("I didn't define the market for integrated platforms because these are products that are just being developed now.").

Moreover, the evidence did not establish that Optum will likely withhold Transparent Network or Real-Time Settlement (if either becomes a product) from external payers. The evidence established, and the Court finds, that Optum has never withheld a product from external payers—in fact, it currently markets all of its payment integrity products to UHC's biggest rivals. *See* 8/5/22 AM Trial Tr. 41:12–42:20 (Yurjevich). When asked for his reaction to the Government's claim that Optum will withhold innovations from rival payers, former United CEO Wichmann testified that the allegation was "without foundation" because "[t]he business is fiercely multi-payer." 8/4/22 PM Trial Tr. 6:3–9 (Wichmann). He also testified that in his 23 years at

United, he could not "think of any instance where OptumInsight withheld products and services to rivals of UHC[.]" *Id.* at 6:13–16.

The evidence also established, and the Court finds, that Optum has never sold one version of a product to UHC while selling a degraded version to other customers. *See id.* at 3:22–24 ("Q. Does OptumInsight ever favor UHC by not selling products and services to rival payers or selling them a degraded product? A. No."); *see also* 8/5/22 AM Trial Tr. 61:15–22 (Yurjevich) ("[I]t would be ridiculous for us to offer a different product in the commercial market than we do for United. We have no incentive as OptumInsight to offer a different product.").

At trial, the Government's expert acknowledged that he mistakenly claimed in his deposition that Optum withholds two products—Group Risk Analytics and Portfolio Optimization—from external customers. *See* 8/9/22 PM Trial Tr. 7:3–6 (Gowrisankaran) ("Q. And then you saw my opening statement and you realized Optum does, in fact, sell Group Risk Analytics to external payers, correct? A. That's right."); *id.* at 14:5–10 ("Q. And you understand Portfolio Optimization is marketed to external payers? A. I understand it now is, yes."). Although no other payer uses Portfolio Optimization today, *see* 8/10/22 PM Trial Tr. 150:10–13 (Gehlbach), the version that Optum markets to other external customers is not a "degraded or lesser version" than the one used by UHC, 8/5/22 AM Trial Tr. 61:2–19 (Yurjevich).

To be sure, the evidence established that Optum has piloted some products with UHC before taking them to market, and there are plans to do the same with Transparent Network. *See* 8/10/22 PM Trial Tr. 47:4–48:2 (Witty). But there is no evidence in the record that the *purpose* of these pilot periods is to unfairly benefit UHC to the detriment of its rivals. To the contrary, the evidence established, and the Court finds, that such pilots benefit the broader market because they allow Optum to "validat[e] that the thing we've developed is market tested, that we are pricing it

fairly, competitively, and we can stand behind it." *Id.* at 24:11–25:8. The evidence established that this is standard market practice. *See* 8/15/22 AM Trial Tr. 66:15–67:7 (Murphy) ("[H]aving a period where you use it internally before you make it available externally . . . is very consistent with the economics of vertical integration" because "it provides you an opportunity to develop things in-house, get it working, make it work in the way you think is useful, and then mak[e] it more broadly available in the marketplace.").

All of the foregoing aligns with Optum's multi-payer business strategy, and the evidence demonstrated that Optum has strong incentives to maintain that strategy. *See* 8/10/22 PM Trial Tr. 27:19–28:1 (Witty) ("And I would presume that if [we withheld products from non-UHC payers], ultimately, somebody else is going to develop a competitive product that is multi-payer and put me out of business. It makes no sense. So from my point of view, we are resolutely committed . . . to multi-payer as a key dimension of the economic model of the company."); *see also* 8/5/22 AM Trial Tr. 61:16–22 (Yurjevich) ("[I]t would be ridiculous for us to offer a different product in the commercial market than we do for United. We have no incentive as OptumInsight to offer a different product. In fact, you've heard me talk about how important a multi-payer business is. And so we want to deliver the best value we can for our external customers."). By making its innovations available exclusively to UHC, Optum would risk sales to over 80 percent of the market. 8/4/22 AM Trial Tr. 97:9–25 (Wichmann). And it would risk forgoing up to 40 percent of its total revenue—or $63.2 billion. 8/10/22 AM Trial Tr. 71:19–25 (Schumacher).

The Government contends that the incentives will change post-merger. This claim is based on Dr. Gowrisankaran's "vertical math" calculations, which found that if United forgoes all sales of Transparent Network to rival payers—thus incurring a loss of $[redacted] million in profits in 2026—

that loss would likely be offset by downstream gains in commercial health insurance markets. *See* PX-820 ¶¶ 242–51.

Dr. Gowrisankaran's testimony, however, is at odds with the unrebutted testimony of various United executives, who stated consistently their view that it is not in United's interests for Optum to abandon its multi-payer strategy. Witty, the CEO of UHG, was expressly asked at trial about this theory, and stated: "[O]f course, my responsibility is to maximize UnitedHealth Group's performance. That is maximized by developing great products, not just to the benefit of UHC but to all of our other clients. And the idea . . . that we would develop something or acquire it, preclude its use from others, and then somehow expect it to stay a high-quality asset, I think, is nonsensical." 8/10/22 PM Trial Tr. 26:24–27:16 (Witty). He even stressed that leveraging Optum to increase UHC's profits "would be a destruction of my whole fiduciary responsibility." *Id.* at 26:1–9; *see also id.* at 26:16–20 ("To do anything which unbalances [our capacity to work with non-UHC partners] would bring to an end the strategic direction of the company, and . . . it would at no level be consistent with what I regard my fiduciary responsibility is to UnitedHealth Group."). The Court concludes that this testimony—and the similar testimony of a number of other United executives—is far more probative of post-merger behavior than Dr. Gowrisankaran's independent weighing of costs and benefits.

In sum, the Court concludes that the Government has failed to meet its *prima facie* burden under its foreclosure theory of vertical harm.

VI. Conclusion

For all the above reasons, the Court enters judgment for Defendants, denies the Government's request for a permanent injunction, and orders that ClaimsXten be divested to TPG. An Order will be issued contemporaneously with this Opinion.

DATE: September 19, 2022

CARL J. NICHOLS
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, *et al.*,

Plaintiffs,

v.

UNITEDHEALTH GROUP INCORPORATED
and
CHANGE HEALTHCARE, INC.,

Defendants.

Civil Action No. 1:22-cv-0481 (CJN)

ORDER

This matter is before the Court after a bench trial. Upon review of the entire record and for the reasons set forth in the accompanying memorandum opinion, it is

ORDERED that the Government's request to enjoin the proposed merger of Defendant UnitedHealth Group Incorporated with Defendant Change Healthcare, Inc. is **DENIED**. It is further

ORDERED that Defendants **DIVEST** ClaimsXten to TPG Capital as proposed. And it is further

ORDERED that judgment be entered for Defendants.

This is a final appealable order.

The Clerk is directed to terminate this case.

DATE: September 19, 2022

CARL J. NICHOLS
United States District Judge

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Monday, September 19, 2022

Statement from Assistant Attorney General Jonathan Kanter on the District Court's Decision in U.S. v. UnitedHealth Group and Change Healthcare

Assistant Attorney General Jonathan Kanter for the Antitrust Division issued the following statement regarding the District Court's decision in U.S. v. UnitedHealth Group and Change Healthcare.

"We respectfully disagree with the court's decision and are reviewing the opinion closely to evaluate next steps. Protecting competition and access to affordable healthcare is of the utmost importance to the Antitrust Division and the Department of Justice. We are grateful to the Antitrust Division staff – the attorneys, economists, paralegals, and administrative professionals – who work tirelessly to uphold the value of competition."

Topic(s):
Antitrust

Press Release Number:
22-991

Component(s):
Antitrust Division

Updated September 20, 2022

Insight. Innovation. Transformation.

District Court Denies Request to Enjoin Acquisition of Change Healthcare Inc. by UnitedHealth Group Incorporated: Change Healthcare Inc: Announces Special Cash Dividend

September 20, 2022

NASHVILLE, Tenn.--(BUSINESS WIRE)--Sep. 20, 2022-- Yesterday, the U.S. District Court for the District of Columbia issued an opinion and final appealable order denying the request made by the U.S. Department of Justice and the States of New York and Minnesota for the Court to enjoin UnitedHealth Group Incorporated (NYSE: UNH) ("UnitedHealth Group") from acquiring Change Healthcare Inc. (Nasdaq: CHNG) (the "Company" or "Change Healthcare") pursuant to the proposed merger (the "Merger") between the Company and a wholly owned subsidiary of UnitedHealth Group, which will result in the combination of the Company and Optum Insight, a part of UnitedHealth Group. The opinion and final appealable order also require UnitedHealth Group and the Company to divest ClaimsXten to TPG Capital as proposed by UnitedHealth Group and the Company.

Today, the Company announced that it has declared a one-time special dividend of $2.00 in cash per each issued and outstanding share of common stock of the Company. The special dividend will be paid to stockholders of record of the Company's common stock as of immediately prior to the effective time of the Merger which pursuant to Nasdaq requirements will occur no less than ten (10) days from today, subject to the satisfaction of closing conditions. The special dividend will be payable on or about the first business day following the closing of the Merger.

About Change Healthcare

Change Healthcare is a leading healthcare technology company, focused on insights, innovation, and accelerating the transformation of the U.S. healthcare system through the power of the Change Healthcare platform. Change Healthcare provides data and analytics-driven solutions to improve clinical, financial, administrative, and patient engagement outcomes in the U.S. healthcare system. Learn more at changehealthcare.com.

Forward Looking Statements

This press release contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 with respect to the financial condition, results of operations and businesses of Change Healthcare. Some of these statements can be identified by terms and phrases such as "anticipate," "believe," "intend," "estimate," "expect," "continue," "could," "should," "may," "plan," "project," "predict" and similar expressions. Change Healthcare cautions readers of this press release that such "forward looking statements," including without limitation, those relating to the timing of the proposed merger, the one-time cash dividend and Change Healthcare's future business prospects, revenue, working capital, liquidity, capital needs, interest costs and income, wherever they occur in this press release or in other statements attributable to Change Healthcare, are necessarily estimates reflecting the judgment of Change Healthcare's senior management and involve a number of risks and uncertainties that could cause actual results to differ materially from those suggested by the "forward looking statements."

Factors that could cause Change Healthcare's actual results to differ materially from those expressed or implied in such forward-looking statements include, but are not limited to, the inability to complete the proposed merger due to the failure to satisfy the conditions to the completion of the proposed merger, including that a governmental entity may prohibit, delay or refuse to grant approval for the consummation of the transaction; risks related to disruption of management's attention from Change Healthcare's ongoing business operations due to the transaction; the effect of the announcement of the proposed merger on Change Healthcare's operations, results and business generally; the risk that the proposed merger will not be consummated in a timely manner, exceeding the expected costs of the merger; the occurrence of any event, change or other circumstances that could give rise to the termination of the merger agreement; macroeconomic and industry trends and adverse developments in the debt, consumer credit and financial services markets; uncertainty and risks related to the impact of the COVID-19 pandemic (including the rise of COVID-19 variant strains such as the Delta and Omicron variants) on the national and global economy, Change Healthcare's business, suppliers, customers, and employees; Change Healthcare's ability to retain and recruit key management personnel and other talent (including while the proposed merger is pending); Change Healthcare's ability to retain or renew existing customers and attract new customers; Change Healthcare's ability to connect a large number of payers and providers; Change Healthcare's ability to provide competitive services and prices while maintaining its margins; further consolidation in Change Healthcare's end-customer markets; Change Healthcare's ability to effectively manage its costs; Change Healthcare's ability to effectively develop and maintain relationships with its channel partners; Change Healthcare's ability to timely develop new services and improve existing solutions; Change Healthcare's ability to deliver services timely without interruption; a decline in transaction volume in the U.S. healthcare industry; Change Healthcare's ability to maintain access to its data sources; Change Healthcare's ability to maintain the security and integrity of its data; Change Healthcare's reliance on key management personnel; Change Healthcare's ability to manage and expand its operations and keep up with rapidly changing technologies; the ability of outside service providers and key vendors to fulfill their obligations to Change Healthcare; risks related to international operations; Change Healthcare's ability to protect and enforce its intellectual property, trade secrets and other forms of unpatented intellectual property; Change Healthcare's ability to defend its intellectual property from infringement claims by third parties; government regulation and changes in the regulatory environment; changes in local, state, federal and international laws and regulations, including related to taxation; economic and political instability in the U.S. and international markets where Change Healthcare operates; the economic impact of escalating

global tensions, including the conflict between Russia and Ukraine, and the adoption or expansion of economic sanctions or trade restrictions; litigation or regulatory proceedings; losses against which Change Healthcare does not insure; Change Healthcare's ability to make acquisitions and integrate the operations of acquired businesses; Change Healthcare's ability to make timely payments of principal and interest on its indebtedness; Change Healthcare's ability to satisfy covenants in the agreements governing its indebtedness; Change Healthcare's ability to maintain liquidity; the potential dilutive effect of future issuance of shares of Change Healthcare's common stock; the impact of anti-takeover provisions in Change Healthcare's organizational documents and under Delaware law, which may discourage or delay acquisition attempts, and other risks. For a more detailed discussion of these factors, see the information under the captions "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Change Healthcare's most recent Annual Report on Form 10-K filed with the Securities and Exchange Commission ("SEC") on May 26, 2022 as such factors may be updated from time to time in our periodic filings with the SEC.

Change Healthcare's forward-looking statements speak only as of the date of this press release or as of the date they are made. Change Healthcare disclaims any intent or obligation to update any "forward looking statement" made in this press release to reflect changed assumptions, the occurrence of unanticipated events or changes to future operating results over time.

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David Elliott
Enterprise Strategy & Investor Relations
205-907-5540
daelliott@changehealthcare.com

Katherine Wojtecki
External Communications
630-624-9142
Katherine.Wojtecki@changehealthcare.com

Source: Change Healthcare Inc.

Optum and Change Healthcare Complete Combination

EDEN PRAIRIE, Minn., Oct. 3, 2022: Optum, a diversified health services company, announced it has completed its combination with Change Healthcare.

The combined businesses share a vision for achieving a simpler, more intelligent and adaptive health system for patients, payers and care providers. The combination will connect and simplify the core clinical, administrative and payment processes health care providers and payers depend on to serve patients. Increasing efficiency and reducing friction will benefit the entire health system, resulting in lower costs and a better experience for all stakeholders.

# # #

About Optum

Optum is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone. With more than 210,000 people worldwide, Optum delivers intelligent, integrated solutions that help to modernize the health system and improve overall population health. Optum is part of UnitedHealth Group (NYSE: UNH). For more information, visit www.Optum.com.

UnitedHealth Group Investor Relations:
Zack Sopcak
(952) 936-7215
zack.sopcak@uhg.com

Optum Media Relations
Gwen Holliday
(202) 549-3429
gwen.m.holliday@optum.com

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, *et al.*, *Plaintiffs*, v. UNITEDHEALTH GROUP INCORPORATED and CHANGE HEALTHCARE, INC., *Defendants*.	Civil Action No. 1:22-cv-0481 (CJN)

NOTICE OF APPEAL

Notice is hereby given that the United States of America, joined by the States of New York and Minnesota, Plaintiffs in the above-named case, hereby appeal to the United States Court of Appeals for the District of Columbia Circuit from the final judgment entered in this action on September 19, 2022.

November 18, 2022

Respectfully submitted,

/s/ Elizabeth Odette
Elizabeth Odette
James W. Canaday
Jason Pleggenkuhle
Katherine Moerke
Office of the Minnesota Attorney General
Consumer, Wage and Antitrust Division
445 Minnesota Street, Suite 1400
St. Paul, Minnesota 55101-2131
Telephone: (651) 728-7208
Email: elizabeth.odette@ag.state.mn.us

Counsel for Plaintiff State of Minnesota

/s/ Eric D. Welsh
Eric D. Welsh (D.C. Bar No. 998612)
Jill C. Maguire (D.C. Bar No. 979595)
Travis R. Chapman
United States Department of Justice
Antitrust Division
450 Fifth Street, NW, Suite 4100
Washington, DC 20530
Telephone: (202) 598-8681
Email: eric.welsh@usdoj.gov

Counsel for Plaintiff United States of America

/s/ Christopher D'Angelo
Christopher D'Angelo (D.C. Bar No. 502220)
Olga Kogan
Elinor R. Hoffmann
Amy E. McFarlane
Benjamin J. Cole
New York State Office of the Attorney General
28 Liberty Street
New York, NY 10005
Telephone: (212) 416-8262
Email: olga.kogan@ag.ny.gov

Counsel for Plaintiff State of New York

CERTIFICATE OF SERVICE

I hereby certify that on November 18, 2022, a true and correct copy of the foregoing was served on all counsel of record via electronic notification.

/s/ Eric D. Welsh
Eric D. Welsh (D.C. Bar No. 998618)
U.S. Department of Justice
Antitrust Division
450 Fifth Street, NW, Suite 4100
Washington, DC 20530
Tel.: (202) 598-8681
Email: eric.welsh@usdoj.gov

Counsel for Plaintiff United States of America

COMMENTARY

Heather Landi, *TPG Capital Closes $2.2B Acquisition of Claims-Editing Business ClaimsXten,* FierceHealthcare.com (Oct. 7, 2022) (transaction closed October 4, 2022)

Andrew Cass, *A Timeline of UnitedHealth Group's Acquisition of Change Healthcare*, Becker's Payer Issues (Sept. 22, 2022)

Weighing Business and Expert Testimony

NEW YORK V. DEUTSCHE TELEKOM AG
439 F. Supp. 3d 179, 186-89, 248-49 (S.D.N.Y. 2020)
(excerpts)

VICTOR MARRERO, United States District Judge

Plaintiffs, the States of New York, California, Connecticut, Hawaii, Illinois, Maryland, Michigan, Minnesota, Oregon, and Wisconsin, the Commonwealths of Massachusetts, Pennsylvania, and Virginia, and the District of Columbia (collectively, "Plaintiff States"), acting by and through the respective Offices of their Attorneys General, brought this action against Deutsche Telekom AG ("DT"), T-Mobile US, Inc. ("T-Mobile"), Softbank Group Corp. ("Softbank"), and Sprint Corporation ("Sprint," and collectively with DT, T-Mobile, and Softbank, "Defendants") seeking to enjoin the proposed acquisition of Sprint by T-Mobile (the "Proposed Merger"). Plaintiff States claim that the effect of the Proposed Merger would be to substantially lessen competition in the market for retail mobile wireless telecommunications services (the "RMWTS Market" or "RMWTS Markets"), in violation of Section 7 of the Clayton Act, codified at 15 U.S.C. Section 18 ("Section 7"). Defendants counter that the Proposed Merger would in fact increase competition in the RMWTS Market and that Plaintiff States have thus failed to state a claim for relief.

The Court held a bench trial to adjudicate Plaintiff States' claim from December 9 to December 20, 2019 and heard post-trial closing arguments from both sides on January 15, 2020. The Court now sets forth its findings of fact and conclusions of law pursuant to Rule 52 (a) of the Federal Rules of Civil Procedure.

I. INTRODUCTION

Adjudication of antitrust disputes virtually turns the judge into a fortuneteller. Deciding such cases typically calls for a judicial reading of the future. In particular, it asks the court to predict whether the business arrangement or conduct at issue may substantially lessen competition in a given geographical and product market, thus likely to cause price increases and harm consumers. To aid the courts perform that murky function demands a massive enterprise. In most cases, the litigation consumes years at costs running into millions of dollars. In furtherance of their enterprise, the parties to the dispute retain battalions of the most skilled and highest-paid attorneys in the nation. In turn, the lawyers enlist the services of other professionals -- engineers, economists, business executives, academics -- all brought into the dispute to render expert opinions regarding the potential procompetitive or anticompetitive effects of the transaction.

The qualifications of litigants' specialists, impressive by the titles they have held and the tomes their CVs fill, can be humbling and intimidating. And those witnesses' authoritative views stated on the stand under oath in open court can leave the lay person

wondering whether word so expertly crafted and credentialed can admit room for error or even doubt. Together, counsel and experts amass documentary and testimonial records for trial that can occupy entire storage rooms to capacity.

Multiplying the complexity of antitrust proceedings, while also adding to the outlay of time and resources they demand, is the role of the federal government. In many cases, as occurred in the action at hand, the United States of America steps into the fray. Acting through the United States Department of Justice ("DOJ") or regulatory agencies, or both, the government intervenes to express its interest for or against the underlying transaction, filing objections or support, or imposing conditions that could affect its viability.

Perhaps most remarkable about antitrust litigation is the blurry product that not infrequently emerges from the parties' huge expenditures and correspondingly exhaustive efforts. Each side, bolstered by the mega records of fact discovery and expert reports it generates, as supplemented by the product of any governmental investigation and resulting action, offers the court evidence the party declares should guide the judge in reaching a compelling and irrefutable decision in the declarant's favor. In fact, however, quite often what the litigants propound sheds little light on a clear path to resolving the dispute. In the final analysis, at the point of sharpest focus and highest clarity and reliability, the adversaries' toil and trouble reduces to imprecise and somewhat suspect aids: competing crystal balls.

The case now before the Court follows the pattern. Plaintiff States contend that T-Mobile's merger with Sprint will likely stifle competition in the RMWTS Market, even in the short term, forcing consumers to pay higher prices for use of their cell phones. In support, they cite the results of their experts' spectral efficiency studies, engineering modeling, and computer-run data analytics. Defendants, similarly reinforced by their stellar cast of authorities, proclaim with equal conviction and no less intensity that after the merger, under a market newly energized by New T-Mobile's more vigorous competition, the prices consumers will pay for wireless services likely will not only not increase, but actually will decline. Accordingly, the parties' costly and conflicting engineering, economic, and scholarly business models, along with the incompatible visions of the competitive future their experts' shades-of-gray forecasts portray, essentially cancel each other out as helpful evidence the Court could comfortably endorse as decidedly affirming one side rather than the other.[1]

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The resulting stalemate leaves the Court lacking sufficiently impartial and objective ground on which to rely in basing a sound forecast of the likely competitive effects of a merger. But the expert witnesses' reports and testimony, however, do not constitute the only or even the primary source of support for the Court's assessment of that question. There is another evidentiary foundation more compelling in this Court's assessment than the abstract or hypothetical versions of the relevant market's competitive future that the adversaries and their experts advocate. Conceptually, that underpinning supports a projection of what will happen to competition post-merger that emerges from the evidence in the trial record that the Court heard, admitted through the testimony of fact witnesses, and evaluated with respect to its credibility and the weight it deserves.

How the future manifests itself and brings to pass what it holds is a multifaceted phenomenon that is not necessarily guided by theoretical forces or mathematical models. Instead, causal agents that engender knowing and purposeful human behavior, individual and collective, fundamentally shape that narrative. Confronted by such challenges, courts acting as fact-finders ordinarily turn to traditional judicial methods and guidance more aptly fitted for the task. Specifically, they resort to their own tried and tested version of peering into a crystal ball. Reading what the major players involved in the dispute have credibly said or not said and done or not done, and what they commit to do or not do concerning the merger, the courts are then equipped to interpret whatever formative conduct and decisive events they can reasonably foresee as likely to occur.

For this purpose, however, the courts rely less on the equipoise of mathematical computations, technical data, analytical modeling, and adversarial scientific assumptions that the litigants proffer. Rather, they apply the judge's own skills and frontline experience in weighing, predicting, and judging complex and often conflicting accounts of human conduct, those actions and inactions drawn from the factual evidence. In performing that function, courts employ various behavioral measures that even the most exhaustive and authoritative technical expert study could not adequately capture or gauge as a reliable prognosticator of likely events set in motion fundamentally by business decisions made by various live sources: relevant market competitors, other market participants, public agencies, and even consumers.

Evaluation of the likely competitive effects of a prospective business merger implicates these observations. The task provides the Court occasion to engage in such a prophetic role. To this end, the Court weighs what actions taken by the parties to the merger and other proponents could substantially influence consumer choices and thus affect competition and product pricing in the relevant markets.

In this context, several considerations emerge from the evidentiary record that the Court regards as especially relevant and compelling. Foremost among them is the plausibility and persuasiveness of particular witnesses' trial presentations based on various behavioral guideposts that the Court details in Section II.D.

During the two-week trial of this action the Court had ample occasion to observe the witnesses and assess their credibility and demeanor on the witness stand, and to consider the weight their testimony warranted in the light of the pointers referred to

here and articulated below. As elaborated, in crafting the framework for its decision, and applying the evidence and governing legal principles, the Court took those considerations into account. The Court adopted this course because it regards as a guiding principle the proposition that behavioral drives and motivational forces such as those suggested serve to actuate as well as to restrain personal and business practices. Hence, they can function as a forecasting device, providing the Court substantial guidance about how the corporate officers and companies involved in the case are likely to conduct themselves under particular market conditions prevailing after a merger.

The approach detailed above assists the Court's adjudication by shedding light on a basic question presented here that was intensely debated by the parties, and that is central to a resolution of their dispute: whether a deeply embedded pattern of commercial conduct closely and publicly associated with a company or executive is likely to be abandoned or substantially altered after a merger so as to openly embrace a materially conflicting course, especially in the short term.

More significant for the purposes of deciding the issues before the Court is another salient point. The considerations the Court references here as supplying persuasive guidance also figure as judicial stock-in-trade, encompassing things courts commonly weigh in rendering predictive rulings such as, for instance, the judgment calls they routinely make in determining whether a rational person would or would not behave in a particular way, or whether to grant or deny bail, or to impose a custodial sentence, where in each case the likelihood of the defendant's reoffending if released comes into question.

Weighing the evidence in the trial record, and mindful of the considerations described here, the Court rejects Plaintiff States' objections on three essential points. First, the Court is not persuaded that Plaintiff States' prediction of the future after the merger of T-Mobile and Sprint is sufficiently compelling insofar as it holds that New T-Mobile would pursue anticompetitive behavior that, soon after the merger, directly or indirectly, will yield higher prices or lower quality for wireless telecommunications services, thus likely to substantially lessen competition in a nationwide market. Second, the Court also disagrees with the projection Plaintiff States present contending that Sprint, absent the merger, would continue operating as a strong competitor in the nationwide market for wireless services. Similarly, the Court does not credit Plaintiff States' evidence in arguing that DISH would not enter the wireless services market as a viable competitor nor live up to its commitments to build a national wireless network, so as to provide services that would fill the competitive gap left by Sprint's demise. Accordingly, the Court concludes that judgment should be entered in favor of Defendants and Plaintiff States' request to enjoin the Proposed Merger should be denied.[28]

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[28] Because the Court concludes that Plaintiff States have not proven Defendants violated Section 7, it need not evaluate whether enjoining the Proposed Merger would be in the public interest. *See* Chiste v. Hotels.com L.P., 756 F. Supp. 2d 382, 407-08 (S.D.N.Y. 2010) ("Injunction is not a separate cause of action; it is a remedy.").

. . .

CONCLUSION

Having been tasked with predicting the future state of the national and local RMWTS Markets both with and without the merger, and relying on both the evidence at trial and the various judicial tools available, the Court concludes that the Proposed Merger is not reasonably likely to substantially lessen competition in the RMWTS Markets. Despite the strength of Plaintiff States' prima facie case, which might well suffice to warrant injunction of mergers in more traditional industries, a variety of considerations raised at trial have persuaded the Court that a presumption of anticompetitive effects would be misleading in this particularly dynamic and rapidly changing industry. T-Mobile has redefined itself over the past decade as a maverick that has spurred the two largest players in its industry to make numerous pro-consumer changes. The Proposed Merger would allow the merged company to continue T-Mobile's undeniably successful business strategy for the foreseeable future.

While Sprint has made valiant attempts to stay competitive in a rapidly developing and capital-intensive market, the overwhelming view both within Sprint and in the wider industry is that Sprint is falling farther and farther short of the targets it must hit to remain relevant as a significant competitor.

Finally, the FCC and DOJ have closely scrutinized this transaction and expended considerable energy and resources to arrange the entry of DISH as a fourth nationwide competitor, based on its successful history in other consumer industries and its vast holdings of spectrum, the most critical resource needed to compete in the RMWTS Markets. DISH's statements at trial persuade the Court that the new firm will take advantage of its opportunity, aggressively competing in the RMWTS Markets to the benefit of price-conscious consumers and opening for consumer use a broad range of spectrum that had heretofore remained fallow.

The Court remains fully mindful that among its various likely prospects, one possibility a merger of this magnitude raises is that of a less competitive future in the RMWTS Markets. However remote, that concern must be taken seriously. The Court, however, does not believe that such a possibility is reasonably likely in light of the numerous considerations discussed above. Accordingly, the Court concludes that Plaintiff States have failed to prove a violation of Section 7 and thus declines to enjoin the acquisition of Sprint by T-Mobile.

III. ORDER

For the reasons stated above, it is hereby

ORDERED that the request of plaintiffs, the States of New York, California, Connecticut, Hawaii, Illinois, Maryland, Michigan, Minnesota, Oregon, and Wisconsin, the Commonwealths of Massachusetts, Pennsylvania, and Virginia, and the District of Columbia, for an injunction pursuant to Section 7 of the Clayton Act, 15 U.S.C. Section 18, to restrain the proposed acquisition of Sprint Corporation by T-Mobile US, Inc. is DENIED, and the Clerk of Court is directed to enter judgment in

favor of defendants Deutsche Telekom AG, T-Mobile US, Inc., Softbank Group Corp., and Sprint Corporation.

The Clerk of Court is directed to terminate any pending motions and to close this case.

SO ORDERED.

November 17, 2022

UNITED STATES V. SABRE CORP.
452 F. Supp. 3d 97 (D. Del. 2020),
***vacated*, No. 20-1767, 2020 WL 4915824 (3d Cir. July 20, 2020)**
(excerpt[1])

[LEONARD P.] STARK, U.S. District Judge

INTRODUCTION

The United States Department of Justice ("DOJ" or "government") filed this expedited antitrust action seeking to permanently enjoin the proposed acquisition by Defendants Sabre Corporation and Sabre GLBL Inc. (collectively, "Sabre") of Defendants Farelogix Inc. ("Farelogix") and Sandler Capital Partners V, L.P. ("Sandler") (collectively with Sabre, "Defendants"). Sabre and Farelogix both play roles, which are described in great detail below, in the airline travel industry. The government contends that allowing Sabre to acquire Farelogix, and eliminate Farelogix as an independent entity, would harm competition, and thereby violate Section 7 of the Clayton Act, 15 U.S.C. § 18. DOJ contends Farelogix is an innovative disruptor in the market for "booking services," a market historically dominated by just three global distribution systems ("GDSs"), including Sabre, who have tried to stifle innovation in a market in which they earn billions of dollars annually.

The Court held an eight-day bench trial in January and February 2020. After the trial, both sides submitted detailed proposed findings of fact as well as opening and answering briefs.

Pursuant to Federal Rule of Civil Procedure 52(a), and having carefully considered the entire record in this case, the arguments of the parties, and the applicable law, the Court concludes that DOJ has failed to meet its burden of proof. Therefore, the Court will enter judgment for Defendants and against the government. The Court will not enjoin Sabre's proposed acquisition of Farelogix.

. . .

O. Dr. Nevo's Analysis Is Unpersuasive

192. DOJ relies on the economic expert analysis of Professor Aviv Nevo of the University of Pennsylvania and its Wharton School of Business. Dr. Nevo is well-credentialed, including having served as the Deputy Assistant Attorney General for Economic Analysis at the Antitrust Division of the Department of Justice, and has testified on behalf of DOJ and the Federal Trade Commission in other merger review cases. In this case, however, his analysis was flawed and, ultimately, unpersuasive.

193. Dr. Nevo testified that he followed "a standard multistep approach," which he described as starting by "learning about the industry and the market realities because

1. Record citations and some footnotes omitted

July 7, 2020

they were really kind of the key input into what I do later." (Nevo Tr. 880) Dr. Nevo emphasized the importance of learning about the particular market he was analyzing, stating "it is important to ground the analysis in the facts of the industry, to really understand what is going on . . . . This ultimately is a practical analysis that is aimed to answer a question, and for that I really have to understand the market and the reality."

194. After he felt he understood the market realities, Dr. Nevo followed a "three-step approach:

> First, you define the relevant antitrust market . . . [T]hen I go and evaluate the competitive effect. And then, finally, I look to see if there's any mitigating factors that could offset these competitive effects.

195. Unfortunately, Dr. Nevo did not instill confidence at even the first step of this process: gaining knowledge and familiarity with the airline industry.

196. Dr. Nevo opined that there are relevant product markets for "booking services."

197. According to Dr. Nevo, "booking services" include: (1) transmitting an airline offer to a travel agency or aggregator; (2) receiving or processing an order or booking; and (3) receiving or processing changes to the order.

198. Witnesses, including those with lengthy service in the airline industry ecosystem, consistently testified that "booking services" is not a term they use or have heard and, more importantly, that there is no standalone "booking services" product that either Sabre or Farelogix has ever offered for sale.

199. Dr. Nevo had to acknowledge that Sabre has not provided "booking services" in a commercial transaction in the United States; therefore, he is "separat[ing]" out "booking services" functionality from the services that Sabre actually sells through its GDS platform.

200. At trial, Dr. Nevo was unable to provide a clear answer as to which of Farelogix's products other than FLX OC (if any) comprise what he considers the "booking services" product.

201. Dr. Nevo was unable to determine a value or price for either Sabre's or Farelogix's "booking services." When Dr. Nevo was asked the price attributable to the booking services functionality within Sabre's GDS platform, he explained that "Sabre has not offered it in the U.S. I believe there is no price." When asked the value of the "booking services" functionality within the Sabre GDS, Dr. Nevo testified that he "did not quantify what [the] value is" and that it "was not part of [his] analysis." When Dr. Nevo was asked whether he compared the value of the "booking services" functionality in the Sabre GDS to the value of the "booking services" in FLX OC, he testified: "That is not something that I've offered, no."

202. In attempting to identify and confirm the relevant product market, Dr. Nevo applied the hypothetical monopolist test, which assumes that the hypothetical monopolist controls all the relevant products in the market for the given geography, then asks whether the hypothetical monopolist would profitably impose a small price

increase (i.e., a small but significant and non-transitory increase in price, or "SSNIP") on those products. (Horizontal Merger Guidelines § 4.1.1 ("Guidelines")) If so, the market is a relevant market.

203. Dr. Nevo calculated that a five percent SSNIP on OTA booking services would be $0.10. He then considered whether an airline would accept the SSNIP and adjust its fares to reflect the higher costs, or reject the SSNIP and stop using OTA booking services. Dr. Nevo concluded that an airline would accept a SSNIP because it would be more expensive for an airline to forgo distribution through OTAs than accept the SSNIP. To reject a SSNIP, the airline would need to be able to persuade travelers booking through OTAs to switch to other distribution channels, or sell additional tickets to different travelers through other channels.

204. Dr. Nevo calculated that a SSNIP on TTA services would be $0.11. A SSNIP on TTA services is smaller relative to the average price of airline tickets booked through TTAs, and business travelers are relatively less price sensitive, so they are unlikely to shift in response to a small price increase. TTAs are a critical sales channel for airlines, who would rather pay a SSNIP than pull out of all TTAs.

205. The Court does not find Dr. Nevo's SSNIP analysis persuasive, for reasons explained elsewhere in this Opinion. (See, e.g., infra FF 215-16)

P. The Relevant Product Market For OTAs Has To Include Airline.com

206. Dr. Nevo excluded from his relevant product market all the airline tickets that are sold directly by airlines to end-user travelers. That is, Dr. Nevo excluded airline.com from the relevant market. The Court finds, however, that airline.com has to be included in the relevant market, at least with respect to the OTA market.

207. Airline.com accounts for approximately half of all airline tickets sold to leisure travelers in the United States.

208. Airlines believe they can succeed in shifting bookings from the indirect channel (which involves OTAs and TTAs) to the direct sales channel (i.e., airline.com).

209. [Redacted]

210. Chris Wilding, who has negotiated as many as 100 GDS agreements with airlines on behalf of Sabre, testified that airline websites are "one of the primary competitors that we face as a GDS" and explained that Sabre continues to see "a point of [market] share shift from the GDS channel to the dot com," on average, every year.

211. The competition between OTAs and airline websites has increased with the rise of metasearch sites that provide direct channel results alongside OTA results. [Redacted] Metasearch sites may direct the consumer to the OTA website or the airline's website – in the latter instance, the sale is a direct channel sale. The metasearch site may even permit a consumer to complete a booking through the airline's website without leaving the metasearch site.

212. Fareportal co-CEO Werner Kunz-Cho testified that there is competition between OTAs and the direct channel via metasearch sites like Google Flights.

213. Defendants' economics expert, Dr. Kevin Murphy of the University of Chicago, opined persuasively, and consistent with the record, that airlines have recognized that much of their revenues derived through sales via OTAs can be replaced

by sales through airline websites. For an airline, the "closest alternative" to distribution through an OTA is distribution through its own website.

214. Dr. Murphy opined that airline direct sales have exerted significant competitive pressure on GDS fees. Aside from the Amadeus and Travelport GDSs, airline.com is the biggest constraint on Sabre's GDS fees.

215. Even Dr. Nevo agreed that airline.com serves as a competitive constraint on Sabre's GDS. But in conducting his SSNIP analysis, Dr. Nevo could not (and did not even attempt to) determine whether airline.com was a bigger competitive constraint on Sabre's GDS than is FLX OC.

216. Dr. Nevo's SSNIP tests assume that an airline confronted with a hypothetical price increase has only two choices: pay the increase or walk away. As Dr. Murphy explained, however, Dr. Nevo's assumption "ignores" that airlines also have the "ability to withhold content or not reach a deal" with a GDS and instead try to steer traffic from OTAs to airline.com.

Q. U.S. Point Of Sale Is Not The Relevant Geographic Market

217. Bookings made through travel agents located in the United States are referred to by Dr. Nevo as "U.S. point of sale." To Dr. Nevo, an OTA has a U.S. point of sale if its IP address has a U.S. address. A TTA has a U.S. point of sale if it is physically located in the U.S.

218. Dr. Nevo opined that there is a relevant market for "booking services" with a U.S. point of sale because "[i]t's not practical for an airline to substitute away from a U.S. point of sale." Airlines cannot easily induce travelers to switch from booking through U.S. travel agencies to booking through travel agencies in other parts of the world, and they cannot easily replace sales to travelers in the United States with sales to travelers in other countries.

219. Sabre's GDS business has a strategy for the U.S. market and appears to separately track its market share for U.S. point of sale and rest-of-world point of sale. For certain airlines, Sabre's GDS charges a lower price for U.S. point-of-sale bookings as compared to rest-of-world point-of-sale bookings.

220. However, DOJ failed to persuade the Court that U.S. point of sale—that is, travel agencies located in the U.S.—is the relevant geographic market. The reasons Dr. Nevo gave for his opinion are unsupported by the record.

221. Dr. Nevo said that his geographic market is based on "who the customer for the product is." But, as Dr. Nevo recognized, Farelogix's customers for FLX OC are airlines. Thirteen of 15 FLX OC customers are airlines based outside of the United States. Yet the point of sale Dr. Nevo used for his relevant market is not where the airline using FLX OC is based, as one would assume if the market is based on "who the customer" is. Instead, Dr. Nevo's point of sale is where the travel agent—with whom Farelogix has no relationship, and who does not use FLX OC—is based.

222. Dr. Nevo further explained that the geographic market for technology products "depends on how they're priced," i.e., whether it is a product "that you can buy in the U.S. that has a different price than if you buy it, for example, in Israel." But Dr. Nevo provided no evidence that the transaction fee for FLX OC varies by the location of the travel agency that purchases a ticket.

R. DOJ Did Not Prove It Is Entitled To A Presumption Of Competitive Harm

223. DOJ contends that Dr. Nevo's market analysis gives rise to a presumption that the proposed merger will lead to competitive harm. The Court disagrees.

224. Dr. Nevo measured market concentration using the Herfindahl-Hirschman Index ("HHI"). The HHI is a standard measure used in economic literature and is calculated by computing the share of each firm in the market, squaring the shares, and summing them. (Guidelines § 5.3) An industry with an HHI over 2,500 is considered highly concentrated, and a merger that causes an increase in HHI of more than 200 points raises significant competitive concerns. (Guidelines § 5.3)

225. In calculating shares for his alleged market for booking services sold through OTAs, Dr. Nevo calculated that Farelogix had 3.9% market share in 2018, while Sabre had 48.0% market share. Using Sabre's projections for 2020, Dr. Nevo calculated that Farelogix would have 12.5% market share in 2020, while Sabre would have 43.7% market share. Using 2018 data, Dr. Nevo calculated a post-merger HHI level of 4,268, with a post-merger change in HHI of 371. Using Sabre's projections for 2020, he calculated a post-merger HHI of 4,465, with a change in HHI of 1,093. These calculations would support a presumption of competitive harm, as they all exceed the standards set out in the Guidelines.

226. In calculating shares for his alleged market for booking services sold through TTAs, Dr. Nevo calculated that Farelogix had 0.1% market share in 2018, while Sabre had 54.8% market share. Using Sabre's projections for 2020, Dr. Nevo calculated that Farelogix will increase to 6.4% market share in 2020, while Sabre would drop to 51.1% market share. Using 2018 data, Dr. Nevo calculated a post-merger HHI level of 3,895, with a post-merger change in HHI of 6. Using Sabre's projections for 2020, he calculated a post-merger HHI of 4,085, with a change in HHI of 657. These calculations would support a presumption of competitive harm, as all but the post-merger change based on 2018 data exceed the standards set out in the Guidelines.

227. Dr. Murphy identified flaws in Dr. Nevo's HHI analyses.

228. With respect to the OTA market, Dr. Nevo excluded all sales made through airline.com. If Dr. Nevo's calculations using 2018 data are corrected so that airline direct channel sales are included in his alleged market for booking services sold through OTAs, the result is a post-merger HHI level of 1115 and a change in HHI of 19. If Dr. Nevo's calculations using Sabre's 2020 projections are corrected so that airline direct channel sales are included in his alleged market for booking services sold through OTAs, the result is a post-merger HHI level of 1127 and a change in HHI of 53. All four of these numbers fall below the Guidelines criteria (i.e., 2500 and 200) for presumptive competitive harm.

229. With respect to the TTA market, Dr. Nevo attributed all sales from GDS passthrough to Farelogix, not to any GDS. However, when an NDC-enabled sale is made through a GDS in a passthrough, it is the GDS that maintains the connection as well as the commercial relationships with travel agencies and airlines; the NDC provider (such as Farelogix) does not replace the GDS but, instead, acts as an upstream, vertical complement to the GDS. It is the GDS, not Farelogix, that gets paid for this passthrough transaction, as even Dr. Nevo recognizes. Consequently, the sale through

GDS passthrough is more properly understood as a sale by the GDS, not by Farelogix. 230. If Dr. Nevo's calculations using 2018 data are corrected so that GDS passthrough sales are credited to the GDS, not the NDC API supplier, the result is an HHI level of 3,895 and the HHI change is just 6. If Dr. Nevo's calculations using Sabre's 2020 projections are corrected in the same manner, the result is an HHI level of 3,898 and an HHI change of 19.12 This is ambiguous support for a presumption of harm in the TTA market, as 3,895 and 3,898 exceed the Guidelines criteria, but 6 and 19 do not.

. . .

CONCLUSION

The Court recognizes that the outcome here may strike some, including the litigants, as somewhat odd. On several points that received a great deal of attention at trial—whether Farelogix is a valuable company enjoying relative success in the market, whether Sabre and Farelogix compete, whether Sabre understands GDS bypass is a threat, whether Sabre stands to lose revenue even from the expansion of GDS passthrough, and Sabre's motivation for its proposed acquisition of Farelogix—the Court is more persuaded by DOJ than by Defendants. This is largely due to the surprising lack of credibility on these points of certain defense witnesses, including Sabre CEO Menke, Sabre deal leader Boyle, and Farelogix CEO Davidson.

Despite these findings and conclusions, however, Defendants have won this case. This is because the burden of proof was on DOJ, not Defendants. Defendants opted to tell the Court a story that is not adequately supported by the facts, but it was their ***choice*** whether to do so, and their failing does not determine the outcome of this case. Instead, it is DOJ which, under the law, has the ***obligation*** to prove its contention that the Sabre-Farelogix transaction will harm competition in a relevant product and geographic market. DOJ failed. It based its case on the expert analysis of Dr. Nevo, but that analysis—including Dr. Nevo's explanation and defense of it—was simply unpersuasive. Unlike Defendants' evidentiary failings, DOJ's are dispositive.

Under our laws, and in our (regulated) market economy, private entities like Sabre and Farelogix are generally free to enter into agreements and relationships with one another, whether or not the government prefers that they do so. If DOJ is to get the Court to enjoin such a transaction, it must meet its burden of proof. Here, the government has not done so. Accordingly, the Court must enter judgment for Defendants.

. . .

ORDER

At Wilmington this 7th day of April, 2020:

For the reasons stated in the Opinion issued this same date, IT IS HEREBY ORDERED that judgment is entered FOR Defendants and AGAINST Plaintiff.

IT IS FURTHER ORDERED that, because the Opinion was issued under seal, the parties shall meet and confer and provide the Court a proposed redacted version, consistent with their submission earlier today, no later than April 8, 2020 at 10:00 a.m. Thereafter, the Court will release a public version of its Opinion.

July 7, 2020

IT IS FURTHER ORDERED that the parties shall meet and confer and, no later than April 14, 2020, submit a joint status report, advising the Court as to what, if anything, remains to be done in this case before it is closed.

July 7, 2020