UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

PLAINTIFFS' PROPOSED FINDINGS OF FACT: PHASE I

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I. FACTUAL BACKGROUND

A. The Defendants

1. Anthem, Inc. is a health insurance company headquartered in Indianapolis, Indiana. PX0125 at 39. Anthem is a member of the Blue Cross Blue Shield Association ("BCBSA")—an association of separate insurance companies—and holds the exclusive license to use both the Blue Cross and Blue Shield brands in all or part of 13 states, and the Blue Cross brand in one additional state. PX0125 at 3.

2. Anthem offers a range of health insurance products, including medical, disability, dental, vision, and Medicare Advantage insurance. PX0125 at 52. With 38.6 million members enrolled in its medical insurance plans, Anthem is one of the largest health insurers in the United States. PX0125 at 3. One in nine Americans has health coverage through an Anthem plan. PX0309 at 33; PX0367 at -321. Approximately [redacted] of Anthem's members are in its National Accounts segment, Pogany 4/29/16 Dep. 87:20–24, 88:18–25, which Anthem defines as insurance sold to multi-state employers with more than 5,000 eligible employees with at least five percent of employees located outside the company's headquarters state. PX0125 at 51; PX0127; Trial Tr. 11/21/16, 225:17–20 (Swedish).

3. Cigna Corp. is a health insurance company headquartered in Bloomfield, Connecticut. PX0284 at i. Cigna has approximately 15 million members, approximately 25 percent (or 3.75 million) of whom are in its National segment. PX0284 at 8, 49. Cigna defines the National segment as multi-state employers with 5,000 or more full-time employees. PX0284 at 8.

B. The Transaction

(i) Context of the transaction

4. In early 2014, Anthem's leadership reflected on a decade of consolidation in the health insurance industry and determined that there was "perhaps a single significant transaction

remaining." PX0039 at -950; Trial Tr. 11/21/16, 244:13–16, 247:17–24 (Swedish). Soon after, Anthem began talks with Cigna. Trial Tr. 11/21/16, 250:9–22 (Swedish); *see* PX0701 at 95.

5. Anthem's interest in acquiring Cigna eventually waned, however, due to concerns about pending litigation against the BCBSA, and the fact that "there were no signs of imminent industry consolidation" among its national competitors. PX0701 at 98. But Anthem's interest in Cigna was renewed when Humana began seeking a buyer. Trial Tr. 11/21/16, 255:24–257:24 (Swedish). Anthem's board of directors determined that the company did not want to be "left out of the remaining consolidation," PX0701 at 99, and Anthem began pursuing Cigna in earnest. Trial Tr. 11/21/16, 257:23–258:1 (Swedish).

6. On July 23, 2015, less than three weeks after Aetna and Humana agreed to merge, Anthem and Cigna signed a $54.2 billion merger agreement. Trial Tr. 11/30/16, 1445:4–7 (Schlegel); PX0120 at 1; DX0325 at -464.

(ii) The breakdown in Anthem and Cigna's relations

7. Tensions between Anthem and Cigna began even before the two companies had signed the merger agreement. In addition to squabbling about which CEO would lead the combined entity, Anthem and Cigna disagreed—and continue to disagree—over how best to integrate the two companies. PX0324 at -562. In early 2015, Anthem raised concerns that integration planning with Cigna was falling behind schedule. Trial Tr. 11/22/16, 323:14–18 (Swedish). Between December 2015 and the summer of 2016, Anthem and Cigna exchanged correspondence blaming each other for integration-related issues. *E.g.*, PX0002 at -390; PX0008. Anthem complained that integration efforts were "not currently on track" because the two companies were "not aligned on the timing of activities necessary to achieve a positive integration." PX0003 at -997. Cigna, reflecting on the "very different" business models of the two

companies, accused Anthem of ignoring recommendations by Cigna's management team to focus on developing a long-term strategy rather than "singularly" focusing on specific expense cuts. PX0007 at -736.

8. By July 2016, relations between Anthem and Cigna had deteriorated to the point that each company accused the other of breaching the merger agreement. Anthem accused Cigna of attempting to sabotage the merger and not using reasonable efforts to get the transaction approved. PX0019 at -788; PX0013 at -761. Cigna, meanwhile, suggested that Anthem's integration plans had departed from the original understanding between the two companies, PX0033 at -827–828, and claimed that Anthem breached the agreement by publishing a misleading advertisement about the merger in the Washington Post without its input and contacting Cigna customers without its consent. PX0034 at -830; *see also* Trial Tr. 11/22/16, 435:6–436:3 (Cordani); PX0029 at -810.

9. Relations between Anthem and Cigna remain difficult. Cigna's CEO testified at trial that Cigna is not "supportive" of certain of Anthem's integration strategies; that those strategies would be "extraordinarily disruptive in the marketplace"; and that they would "erode . . . pretty rapidly" the value of Cigna. Trial Tr. 11/22/16, 439:23–441:12 (Cordani).

C. Industry Background

(i) Sale of commercial health insurance

10. Health insurers sell commercial health insurance plans to two classes of consumers: individuals and employers. *E.g.*, PX0125 at 8; PX0284 at 1; [redacted] Employers are categorized as either "small group" or "large group" employers, both of which purchase health insurance for their employees and the employees' dependents. *See, e.g.*, Trial Tr. 11/21/16, 168:18–169:17 (Abbott); Goulet 9/29/16 Dep. 13:2–11.

11. Within the group of employers classified as "large group," the parties and other insurance industry participants recognize large, multisite employers (typically having 5,000 or more employees) as a distinct group they call "national accounts." PX0125 at 51; PX0284 at 8; Trial Tr. 11/21/16, 225:7–9 (Swedish).

12. The market for commercial health insurance for national accounts is dominated by four players: the "Blues" (including Anthem), United, Cigna, and Aetna. Trial Tr. 11/21/16, 109:24–111:9 (Abbott); PX0121 at -323 (describing the national accounts market as consolidated, and noting that there are four primary competitors for national accounts—United, Blues, Aetna, and Cigna); Martie 4/28/16 Dep. 180:23–181:21, 189:7–190:3, 190:10–191:25, 193:18–197:19; PX0259 at -678; Guilmette 5/3/16 Dep. 187:10–188:12; Mascolo (Wells Fargo) 10/20/16 Dep. 156:17–157:8; PX0221 at -488; *see also* PX0063 at -543. These four insurers are often referred to collectively within the healthcare industry as the "Big Four" or "BUCA." Trial Tr. 11/28/16, 853:17–854:10 (Dranove); Edwards (HealthSCOPE) 10/21/16 Dep. 114:8–14; Jackson (Gateway Health) 9/28/16 Dep. 69:1–10. Collectively, these four players account for 83 percent of the market for commercial health plans sold to national accounts. PX0063 at -543.

13. Health insurers typically organize their businesses around serving particular customer segments. Anthem and Cigna have different divisions for their products sold to individuals and to national accounts. Trial Tr. 11/22/16, 404:16–24 (Cordani); *e.g.*, PX0127 (Anthem); PX0284 at 8 (Cigna). Health insurers that sell to national accounts generally do so through a dedicated customer segment. Trial Tr. 11/21/16, 224:10–225:3 (Swedish); [redacted]; Hayes (Aetna) 10/6/16 Dep. 21:9–12, 22:18–23:9.

14. Employers of all sizes can purchase either fully-insured or self-insured plans, called "Administrative Services Only" ("ASO") plans. Trial Tr. 11/21/16, 69:2–23 (Abbott);

Martie 4/28/16 Dep. 226:20–25. Employers purchasing fully-insured plans pay premiums to their insurer for each covered life. Trial Tr. 11/21/16, 69:2–23 (Abbott). Premiums reflect expected medical expenditures, administrative costs, and insurer profits. The insurer bears the risk that medical claims will be higher than expected. Trial Tr. 11/21/16, 69:2–23 (Abbott); PX0484 at -423-3.

15. Most national accounts self-insure, which means they assume the risk of covered medical services used by their employees by paying their employers' medical costs directly. Trial Tr. 11/21/16, 69:5–70:4 (Abbott); Martie 4/28/16 Dep. 60:1–5; PX0484 at -423-3. Under ASO plans, health insurers manage the day-to-day administration of the employers' health plans and grant the employers' employees access to their medical network. Trial Tr. 11/21/16, 74:25–75:12 (Abbott); PX0284 at 3.

16. Payments from self-insured employers to insurers under ASO contracts are known as ASO fees. PX0484 at -426-2, -426-4. ASO fees may be a small fraction of a national account's total medical expenditures, but the fees form a major part of negotiations between insurers and national accounts. Trial Tr. 11/22/16, 572:22–573:1 (Kertesz); *see* Trial Tr. 11/21/16, 161:16–21 (Abbott).

17. Health insurers can negotiate for lower reimbursement rates (i.e., payments to healthcare providers) based on the size of their membership and the number of members the provider "expects to be channeled to [it]." Trial Tr. 11/21/16, 176:13–19 (Swedish).

18. When selecting health insurance, national accounts consider the costs of administration and care; size and quality of provider networks; ease of access; level of innovation, reporting and analytic capabilities; and the quality of the sales team. *See* Martie 4/28/16 Dep.

119:25–120:10; Bills 3/24/16 Dep. 114:19–115:5. Employers seek a network of doctors and hospitals near where their employees live and work. Martie 4/28/16 Dep. 125:9–15.

19. Generally, national accounts work with sophisticated consulting firms to compare the plans offered by health insurers. Trial Tr. 11/21/16, 63:25–64:17, 65:5–66:8 (Abbott). Historically, cost comparisons were driven primarily by reimbursement rates. Trial Tr. 11/21/16, 95:6–23 (Abbott); Trial Tr. 11/23/16, 703:8–23 (Thackeray). However, consulting firms have recently begun considering a "total cost-of-care measure," which takes into account other elements like network structures, plan design, and medical service utilization rates that impact medical costs. Trial Tr. 11/23/16, 703:8–23, 704:17–705:2 (Thackeray); Trial Tr. 11/21/16, 95:6–96:17 (Abbott).

(ii) Competition between four national health insurers for national accounts

20. National accounts purchase health insurance through a competitive bidding process, known as a request for proposal (RFP). *See* Martie 4/28/16 Dep. 44:6–22; Sharp (Aon) 10/6/16 Dep. 54:21–25, 55:2–25, 56:2–18. A consultant is involved in the vast majority of national account RFPs. Pogany 4/29/16 Dep. 34:15–23.

21. The RFP process begins with the employer and the consultant discussing the employer's objectives and developing a strategy to achieve those objectives. Trial Tr. 11/21/16, 80:3–82:15 (Abbott). The employer then decides which insurers to invite to bid and authorizes the consultant to issue an RFP. Trial Tr. 11/21/16, 83:5–84:14 (Abbott). Consultants usually present an RFP to more than one insurer. Trial Tr. 11/21/16, 88:7–8 (Abbott); Kilmartin (Mercer) 10/20/16 Dep. 164:7–12. It is "very typical" for the four national health insurers to bid on an RFP issued for a national account. Trial Tr. 11/23/16, 720:14–16 (Thackeray).

22. Once an insurer has submitted a bid in response to an RFP, the insurer can improve its bid by offering reduced ASO fees, better trend and performance guarantees, and add-on programs at reduced or no cost. Trial Tr. 11/22/16, 550:3–11 (Kertesz); [redacted]

23. Competition occurs throughout the entire RFP process—from the choice of insurers invited to bid to the ultimate insurer selection. *See* Trial Tr. 11/21/16, 80:3–81:19, 83:5–17, 84:1–14, 87:12–88:6 (Abbott); Sharp (Aon) 10/6/16 Dep. 92:19–22, 92:24–25; 93:2–6, 93:8–25, 94:2–9; [redacted] Insurer competition allows employers to obtain more favorable prices, provider networks, plan designs, and service levels. Mascolo (Wells Fargo) 10/20/16 Dep. 165:8–10, 165:8–166:16; Sharp (Aon) 10/6/16 Dep. 92:10–18; Lonsdale (Arthur J. Gallagher) 10/13/16 Dep. 76:14–77:15.

(iii) Background on the Blue Cross Blue Shield system

24. The BCBSA is an association composed of 36 independent insurance companies covering all 50 states, the District of Columbia, and Puerto Rico. PX0704 at -905-8, -905-10–11; Trial Tr. 11/21/16, 222:8–9 (Swedish). Through the BCBSA, these independent insurance companies collaborate and share information. *See, e.g.*, Bills 3/24/16 Dep. 41:4–13, 66:25–67:25, 77:1–12, 193:16–194:12; Pogany 4/29/16 Dep. 106:18–25, 132:8–133:17. As members of the BCBSA, the insurance companies agree to abide by a number of rules, including rules that significantly limit the extent to which they can compete against each other. *See, e.g.*, PX0122 at -344–52; Bills 3/24/16 Dep. 84:25–86:11.

25. Anthem is a member of the BCBSA and operates the "Blue" plans in its 14 states under several brands: Anthem Blue Cross, Anthem Blue Cross Blue Shield, Blue Cross Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross. PX0125 at 3.

26. Anthem's license to operate in 14 states makes it the largest Blue plan in terms of membership, followed by HCSC, which holds the Blue license in five states. Trial Tr. 11/21/16, 222:12–20 (Swedish). The majority of the remaining 34 Blues are authorized to use the Blue brand in all or part of one state, with a few covering two states. Trial Tr. 11/21/16, 222:12–25 (Swedish); PX0704 at -905-10–11.

27. The Blue Cross and Blue Shield brands are valuable, well-established, and well-recognized brands. Trial Tr. 11/21/16, 223:1–11, 223:15–224:1 (Swedish); PX0208 at -855-5 ("Blue Brands are the most recognized in the industry."); PX0144 at -493. Nearly one in every three Americans receives health insurance through a Blue Cross Blue Shield plan. PX0208 at -855-7. Anthem recognizes the value of the Blue Cross and Blue Shield brands and intends to keep using the brand. Trial Tr. 11/21/16, 223:1–11, 223:15–224:1 (Swedish).

28. As a member of the BCBSA, Anthem is bound by association rules, commonly referred to as the "Blue Rules," that govern and restrict the company's operations. *See, e.g.*, PX0125 at 32–33; Bills 3/24/16 Dep. 204:14–18.

a. No competition between the Blue plans

29. As licensees of the BCBSA, Anthem and the other 35 licensees are each granted a license to sell Blue-branded commercial health insurance in an "exclusive service area." Trial Tr. 11/21/16, 223:1–3, 234:2–235:13 (Swedish); PX0144 at -500; PX0159 at -594. Under the Blue Rules, the Blue plan covering the service area where an employer is headquartered is the only Blue plan allowed to quote that employer. Trial Tr. 11/21/16, 223:1–3, 234:2–235:13 (Swedish); PX0159 at -594; *see also* PX0144 at -501–502; PX0133 at -351; Bills 3/24/16 Dep. 84:25–86:2, 207:20–208:7.

30. Exclusive service areas ensure that no two Blues bid for the same account. Trial Tr. 11/21/16, 234:11–13 (Swedish); Bills 3/24/16 Dep. 208:23–209:15, 230:25–231:4.

b. Ceding accounts to other Blues

31. Blue plans can "cede" the exclusive right to bid on an account to another Blue plan. PX0144 at -502; Bills 3/24/16 Dep. 84:25–86:2, 207:20–209:15. Cedes are common, *see, e.g.*, PX0133 at -352-1–3 (identifying hundreds of cedes to and from Anthem); Weber 10/18/16 Dep. 9:23–10:3, 22:6–30:22, 30:24–31:6 (describing internal duties associated with ceding), and may be exchanged for other cedes, separate consideration, or just goodwill. See Bills 3/24/16 Dep. 296:2–298:7; PX0057 at -814; PX0133 at -352-1–352-3; PX0136 at -181–182; PX0176 at -531–534; PX0187 at -589–590; PX0205 at -832-1.

32. When deciding whether to cede an account to another Blue, Anthem considers not only the customer's interest but also [redacted] Bills 3/24/16 Dep. 224:5–25; *see also* Bills 3/24/16 Dep. 125:11–13 [redacted] 155:3–9 [redacted] [redacted] *See* Bills 3/24/16 Dep. 155:3–9; Weber 10/18/16 Dep. 280:3–20, 281:8–282:1, 282:11–284:20.

c. The BlueCard system

33. The BlueCard system allows Blue plan members to access other Blue plans' provider networks—and the provider discounts negotiated by those local Blue plans—when they seek medical care outside their plan's service area. PX0125 at 5; PX0144 at -511; Trial Tr. 11/21/16, 226:22–227:3, 227:11–24 (Swedish); *see also* [redacted]

[redacted] The BlueCard network system, also known as the "national Blue Card program," is the primary mechanism through which individual Blue plans such as Anthem are able to offer their members a national network. Trial Tr. 11/21/16, 226:22–227:3, 227:11–24 (Swedish); PX0216 at 29; PX0109 at -514-5–6. As such, it is the largest national provider network in the United States. PX0367 at -321; PX0208 at -855-24.

34. Local Blue plans charge "host" members BlueCard host fees for access to their network discounts and for the provision of "administrative" services like the "maintenance of enrollment information and customer service." PX0125 at 5, 10, 51. Host members are members of a Blue plan who receive healthcare services through the Blue network outside of their home plan's service area. *See* PX0125 at 51; Pogany 4/29/16 Dep. 89:1–11. In contrast with Anthem's host membership—in which a different Blue plan holds the account—Anthem's home membership refers to customers for which Anthem holds the actual account. Trial Tr. 11/22/16, 559:13–21 (Kertesz); PX0144 at -522.

35. BlueCard fees are a source of revenue for Anthem and go "straight to [its] bottom line." PX0037 at -812-5; *see also* PX0125 at 5, 51. In the past three years, Anthem's host membership has accounted for 14 to 14.2 percent of Anthem's medical members. PX0125 at 51. In the national accounts segment, approximately [redacted] of Anthem's [redacted] members are host members. Pogany 4/29/16 Dep. 87:20–88:3, 88:18–25.

36. When negotiating reimbursement rates with providers, [redacted] Pogany 4/29/16 Dep. 89:1–19.

d. The Best Efforts rule and its limitation on competition

37. The Blue Rules allow companies holding Blue licenses to compete against each other—to a limited extent—when using a non-Blue brand. *See* Trial Tr. 11/21/16, 237:22–238:19 (Swedish). This competition is strictly limited, however, by the "Best Efforts Rule," which controls how much of a Blue plan's revenue can come from products marketed under a non-Blue brand. Trial Tr. 11/21/16, 236:15–237:10 (Swedish).

38. The Best Efforts Rule has a local and a national component. Trial Tr. 11/21/16, 237:2–7 (Swedish); PX0039 at -957. The local component requires 80 percent of the revenue a Blue plan earns in its exclusive service areas to be generated under the Blue brand. Trial Tr. 11/21/16, 237:8–10 (Swedish); PX0039 at -957. For Anthem, this means that 80 percent of its revenue in the 14 Anthem states must come from Blue-branded plans. Trial Tr. 11/21/16, 237:8–10 (Swedish); PX0039 at -957. The national component requires Blue plans to generate at least two-thirds of their revenue or two-thirds of their enrollment under the Blue brand. Trial Tr. 11/21/16, 237:11–13 (Swedish); PX0039 at -957; PX0704 at -905-18.

39. A Blue plan that breaches the Best Efforts Rule has 120 days to submit a plan for coming into compliance with the BCBSA. PX0039 at -958; PX0701 at 75. The BCBSA will then decide whether to accept or deny the offending Blue plan's compliance plan. PX0701 at 75. If a Blue plan fails to comply with the Best Efforts Rule within 24 months of the BCBSA's approval of the compliance plan, the plan loses its Blue licenses and must pay a re-establishment fee of $98.33 per enrollee. PX0701 at 75. For Anthem, this would amount to approximately $2.9 billion in penalties. PX0039 at -957–958; PX0701 at 75.

40. Anthem is currently in compliance with the BCBSA's Best Efforts Rule; however, if the merger goes through, the combined company will be out of compliance on the day the deal closes. Trial Tr. 11/21/16, 237:14–21, 238:20–239:1 (Swedish); PX0704 at -905-20.

e. Consortium Health Plans

41. Consortium Health Plans is a non-profit organization of 21 Blue plans, including Anthem, Leonard (Consortium) 9/30/16 Dep. 17:21–25; Pogany 4/29/16 Dep. 93:17–21, 117:12–13, that was established with the goal of "making Blue Cross and Blue [S]hield . . . the carrier of choice for national accounts." Leonard (Consortium) 9/30/16 Dep. 15:25–16:12, 18:10–19:3; [redacted] *see also* Trial Tr. 11/29/16 1216:25–1220:16 (Kendrick). Consortium members work together to offer a "consistent national accounts value proposition" by coordinating marketing, servicing, and sales strategies among the Blue plans. Leonard (Consortium) 9/30/16 Dep. 16:19–17:2, 21:25–22:8; [redacted] Pogany 4/29/16 Dep. 95:8–17, 118:18–119:25; Bills 3/24/16 Dep. 54:12–17.

42. Twenty-one Blue plans, including Anthem, are members of the Consortium. Leonard (Consortium) 9/30/16 Dep.17:21–25; Pogany 4/29/16 Dep. 94:17–19, 117:12–13. All Consortium members are required to adhere to certain pricing practices, to devote resources to selling and retaining national accounts, and to share best practices with other Consortium plans. Leonard (Consortium) 9/30/16 Dep. 25:20–26:6.

(iv) Anthem's value proposition

43. Anthem has a strong presence and brand awareness for both its Anthem and Blue brands. Martie 4/28/16 Dep. 78:1–25; PX0367 at -322; PX0109 at -514-6. Anthem observed that, "Blue brands are the most recognized brands in the health care industry," PX0140 at -651, and "'Anthem Blue Cross Blue Shield' is the leading brand in [the healthcare] industry in [Anthem's] markets." PX0367 at -322. Anthem's name, separate from the Blue brands, also "has real value outside of [Anthem's] 14 blue states." PX0367 at -322.

44. Anthem's membership in the national BlueCard system allows it to offer members access to a broad provider network that includes 96 percent of hospitals and 91 percent of physicians in the United States. PX0367 at -321; PX0208 at -855-24; PX0309 at 37.

45. Anthem's sizable membership also allows it to offer advantageous provider reimbursement rates. *See* PX0208 at -855-26; Pogany 4/29/16 Dep. 89:12–19. Anthem's reimbursement rates are [redacted] of its markets. PX0121 at -318; *see also* PX0367 at -325 (noting that the Blue system has a reimbursement rate advantage in the majority of markets across the United States); PX0197 at -173 (stating that "Anthem leverages the size of [the BlueCard] network and the strength of its provider relationships to offer employers unprecedented value").

(v) Cigna's value proposition

46. Cigna has a reputation in the market for being innovative, flexible, and able to customize solutions to meet client needs. Guilmette 5/3/16 Dep. 48:22–49:16; Phillips 4/14/16 Dep. 174:3–8, 175:22–176:5; PX0109 at -514-8; *see also* Sharp (Aon) 10/6/16 Dep. 107:17–25, 108:2–109:4.

47. Cigna's value proposition is centered on aligning the incentives of insurers, providers, employers, and customers to improve health outcomes and lower total medical costs. Trial Tr. 11/22/16, 401:23–402:22, 415:7–421:5 (Cordani); Muney 4/6/16 Dep. 151:3–152:9; Manders 6/2/16 Dep. 267:18–21. Better health outcomes lower total medical costs by reducing the number of unhealthy employees needing treatment. *See* Sullivan 10/6/16 Dep. 87:5–11, 87:14–21; Mascolo (Wells Fargo) 10/20/16 Dep. 104:7–106:3; Bailey 4/12/16 Dep. 51:20–52:5.

48. Cigna has developed various innovative methods of aligning incentives including customer engagement, personalization of employer programs, and collaborations with providers.

PX0152 at -256–258. Cigna's customer engagement efforts focus on improving employee health through educational programs that reward a healthy lifestyle and promote management of chronic conditions. Trial Tr. 11/28/16, 774:22–24 (Smith); Guilmette 5/3/16 Dep. 103:8–104:24; Sullivan 10/6/16 Dep. 87:22–24, 88:2–7; PX0152 at -249–258. Cigna has over 100 mobile applications to help members manage their health. Trial Tr. 11/28/16, 779:6–9 (Smith).

49. Cigna works with employers to lower healthcare costs by offering personalized plans and developing innovative tools that suit clients' employee populations and demographic profiles. Sullivan 10/6/16 Dep. 89:2–90:12, 90:15–19. Cigna Compass, for example, is a digital tool that Cigna developed for [redacted] PX0109 at -514-8. Cigna Compass proved successful and the company has since made it available to other national accounts. Parr 9/28/16 Dep. 82:12–18.

50. Cigna is viewed as a market leader in its collaborative care arrangements. Parr 9/28/16 Dep. 47:9–11; Huggins 5/13/16 Dep. 124:11–125:11. These arrangements allow Cigna and providers to coordinate the provision of healthcare by sharing customer information, which helps providers form a more complete health profile of the patients they serve. Butler 4/29/16 Dep. 96:18–98:23, 100:23–101:6. Cigna has an organization-wide strategy to strengthen its provider collaborations, particularly through "value-based" reimbursement arrangements. Manders 6/2/16 Dep. 37:23–24; Evanko 3/29/16 Dep. 25:18–26:13, 28:19–30:8. A value-based reimbursement arrangement is one that pays providers for achieving certain targets of health outcomes. Trial Tr. 11/21/16, 282:7–283:6 (Swedish).

51. Collaborative arrangements, including value-based reimbursement arrangements, have been well-received in the healthcare industry and their use has increased significantly over the past few years. Butler 4/29/16 Dep. 108:10–17; see also [redacted]

[redacted] The trend towards more provider collaborations is likely to continue regardless of any changes to the Affordable Care Act. Trial Tr. 11/21/16, 97:14–22 (Abbott).

II. THE RELEVANT PRODUCT MARKET IS THE SALE OF COMMERCIAL HEALTH INSURANCE TO NATIONAL ACCOUNTS.

52. The relevant product market is the sale of commercial health insurance to national accounts. Trial Tr. 11/28/16, 858:12–859:13 (Dranove). This definition includes all fully-insured and self-insured health plans sold on or off exchanges to national accounts, such that the only alternatives would be forgoing group coverage altogether or attempting self-supply. Trial Tr. 11/28/16, 853:17–854:10, 858:12–859:13 (Dranove); *see also infra* Sections II.E., II.F.

53. A national account, as understood in the health insurance industry, is a large commercial employer with thousands of employees across multiple states. *See* Trial Tr. 11/21/16, 225:7–9 (Swedish) (agreeing that "national accounts" is an "understood term" in the health insurance industry); Trial Tr. 11/22/16, 403:8–14 (Cordani) (explaining that while technical definitions vary, it is "typically large commercial employers that span multiple states"). [redacted]

54. By virtue of their size and geographic dispersion, national accounts tend to have a number of unique needs and characteristics that set them apart from other customers and have led the industry to treat them as a separate economic entity. Because pricing and terms are determined through individual negotiations, insurers can identify and target national accounts based on their options and willingness to pay. *See infra* Section II.D.

A. The industry recognizes national accounts as a distinct market.

55. Anthem, Cigna, United, and Aetna recognize a national accounts market and have entire business units dedicated to national accounts. Trial Tr. 11/21/16, 224:14–16 (Swedish); Trial Tr. 11/22/16, 404:16–21 (Cordani); Guilmette 5/3/16 Dep. 43:16–24; Martie 4/28/16 Dep. 81:23–82:15, 83:11–24; Welch 4/29/16 Dep. 22:13–18; [redacted] Trial Tr. 11/22/16, 534:16–535:8 (Kertesz); PX0125 at 5; Hayes (Aetna) 10/6/16 Dep. 17:19–18:2; [redacted]

56. They have separate budgets, financial statements, and profit and loss responsibilities for national accounts. Trial Tr. 11/21/16, 224:17–25 (Swedish); Trial Tr. 11/22/16, 404:16–21 (Cordani); Trial Tr. 11/22/16, 534:23–535:8 (Kertesz); [redacted] PX0094 at -518; Hayes (Aetna) 10/6/16 Dep. 25:9–12; [redacted]

57. They regularly formulate strategies and plans specifically for the national accounts market. PX0284 at 19 (Cigna form 10-K); PX0260 at -324–328; PX0121 at -315, -323; PX0125 at 5; [redacted] These business plans can differ dramatically from the strategies of their local large group segments. *See, e.g.*, [redacted]

58. The large national insurers also have separate sales forces, account teams, and underwriters for national accounts. *See, e.g.*, Williams 3/24/16 Dep. 23:17–20; Bailey 4/12/16 Dep. 66:5–67:7; Guilmette 05/3/16 Dep. 73:14–74:14; Hayes (Aetna) 10/6/16 Dep. 24:15–17; [redacted] Jay 10/12/16 Dep. 12:18–23, 15:6–19; Cheslock 10/12/16 Dep. 20:8–14.

59. They separately calculate market shares for the national accounts market—identifying each other as their primary competitors. *See, e.g.*, PX0063 at -543 (Anthem); PX0191 at -336-5; PX0036 at -885 (Aetna); PX0264 at -929 (Cigna); [redacted]

60. [redacted] Consortium has "the overarching objective of . . . making Blue Cross and Blue Shield be the carrier of choice for national accounts," a mission it pursues by helping Blues meet the unique needs and demands of national accounts. Leonard (Consortium) 9/30/16 Dep. 15:25–16:12, 16:19–17:2, 17:21–25; 18:10–19:3; [redacted]

61. Similarly, Anthem's national accounts business unit was created to make it more competitive for national accounts. Trial Tr. 11/29/16, 1210:22–1211:17 (Kendrick). After closing the Wellpoint merger in 2004, Anthem executives separated national accounts from other large groups after determining that Anthem needed "to have a focus around a consistent go-to-market strategy" across the country since "bifurcating" decisions based on which state a customer was in "wasn't what the market was asking for." Trial Tr. 11/29/16, 1210:22–1211:17 (Kendrick).

62. In the 12 years since, Anthem executive Morgan Kendrick is not aware of leadership ever discussing putting the segments back together because of uncertainty or confusion about which customers qualify as national accounts. Trial Tr. 11/29/16, 1210:22–1211:17 (Kendrick). Nor is there evidence in the record suggesting that any such confusion exists within the health insurance industry. *See, e.g.*, Trial Tr. 11/21/16, 225:4–12 (Swedish).

63. Others in the industry recognize a national accounts market dominated by the Blues, United, Cigna, and Aetna. *See, e.g.*, Jackson (Gateway Health) 9/28/16 Dep. 69:1–10; [redacted]

[redacted] *see also* Martie 4/28/16 Dep. 184:23–185:2. As Cigna CEO David Cordani has told investors, "larger employers, by definition, know [Cigna], they know Anthem, they know United; they know Aetna. From that standpoint, *they know the market*." PX0281 at 8 (emphasis added); Trial Tr. 11/22/16, 406:8–21 (Cordani).

64. By the admission of Anthem's own CEO, "national account" is "an understood term" in the health insurance industry. Trial Tr. 11/21/16, 225:4–12 (Swedish); *see also* Sharp (Aon) 10/6/16 Dep. 89:25-90:14 (the industry is familiar with the term as a way to describe "large clients and to signify a level of service that is provided to those large clients"); Trial Tr. 11/22/16, 403:8–14 (Cordani) ("I think everybody in the space has a slightly different number, cutoff definition. But it's typically large commercial employers that span multiple states."); [redacted]

B. Focusing on employers with at least 5,000 employees to calculate market shares is economically appropriate and consistent with industry practice.

65. To calculate market shares for national accounts, it is reasonable to focus on sales to employers with at least 5,000 employees, at least five percent of which reside in another state. Trial Tr. 11/28/16, 859:24–860:19, 876:24–879:1, 877:2–878:13 (Dranove). This approach is economically sound—in fact, conservative— and in alignment with industry consensus that a multi-state employer with 5,000-plus employees is a national account. *See infra* ¶ 68.

66. While price-discrimination markets could be defined around individual employers, it is appropriate and more practical to look at national accounts in the aggregate, the vast majority of which have very similar needs and "by and large need to be serviced by the big four national insurers." Trial Tr. 11/28/16, 859:24–860:19 (Dranove); Trial Tr. 12/2/16, 2239:5–2240:5

(Dranove). Doing so affords insight into the "average impact" across this set of employers. Trial Tr. 11/28/16, 859:24–861:8 (Dranove).

67. Although there are employers outside this definition with similar needs that would also be harmed by the merger, the "lines start to get fuzzy" as the size threshold is lowered, capturing more and more employers with different needs and characteristics than the rest of the group. Trial Tr. 11/28/16, 859:24–860:19, 1043:16–23 (Dranove).

68. Defendants both recognize 5,000 employees as a meaningful threshold for identifying national accounts, regardless of their specific circumstances or demands. *See, e.g.*, PX0125 at 51; PX0284 at 8. The definitions adopted to calculate market shares are very similar to those used by Anthem and Cigna in the ordinary course of business to identify national accounts. *Compare* Trial Tr. 11/28/16, 859:24–29, 876:24 (Dranove) *with* PX0125 at 51; PX0284 at 7. The second test, with a 5,000-employee threshold and five percent out-of-state geographic screen, is "virtually identical to what Cigna does and also very, very similar to what Anthem does in terms of how they define national accounts." Trial Tr. 11/28/16, 876:24–879:1 (Dranove).

69. While other insurers identify national accounts using slightly different thresholds, both candidate markets are nonetheless consistent with industry usage, capturing only employers who would qualify as national accounts by most or all standards. *See* Trial Tr. 11/28/16, 877:2–878:13 (Dranove). All accounts meeting either threshold used by Dr. Dranove would also qualify under the 3,000-employee, purely size-based definitions used by Aetna [redacted] *See* [redacted] Hayes (Aetna) 10/6/16 Dep. 22:18–23:2. Many would also meet the definition of [redacted], which applies a 3,000-employee threshold with a geographic screen specific to [redacted] and Humana. [redacted] Trial Tr. 11/29/16, 794:1–10 (Bierbower).

70. Dr. Fowdur's criticism of Dr. Dranove's product market definition is not correct because she conflates two separate issues: product substitutability and buyer characteristics. Trial Tr. 12/2/16, 2237:4–21 (Dranove). It is appropriate to study a merger through a price discrimination lens when customers have common needs and "prices are determined on a customer-by-customer basis." Trial Tr. 12/2/16, 2237:22–2239:4 (Dranove). In price discrimination markets, the Horizontal Merger Guidelines allow for the aggregation of customers that have "common needs and can be served by a common set of suppliers." Trial Tr. 12/2/16, 2239:5–2239:17 (Dranove). The needs of aggregated customers do not have to be identical. Trial Tr. 12/2/16, 2239:18–2239:25 (Dranove). Here, national account customers have common health insurance needs, particularly "strong networks throughout most of United States." Trial Tr. 12/2/16, 2239:18–2240:5 (Dranove). And national accounts can be served by a common set of suppliers: "by and large [they] need to be serviced by the big four national insurers...they're all looking to the big four." Trial Tr. 12/2/16, 2239:18–2240:5 (Dranove).

71. Contrary to Dr. Fowdur's criticism, defining the product market around employers with 5,000 employees or more is conservative because Dr. Dranove's calculations exclude the harm to employers with 3,000 to 5,000 employees even though some such employers may actually be harmed by the merger. Trial Tr. 12/2/16, 2240:6–2242:13 (Dranove). For any large employers with 3,000 to 5,000 employees with similar characteristics to national accounts with 5,000 employees or more, "the consequences of the merger . . . would be similar." Trial Tr. 12/2/16, 2240:18–2242:13 (Dranove). Dr. Dranove selected the 5,000 employee cutoff "to be respectful of how the industry refers to national accounts." Trial Tr. 12/2/16, 2242:14–2242:21 (Dranove).

72. Dr. Fowdur's criticism that Dr. Dranove's product market definition is limited to the 26 insurers that received CIDs is not correct. Dr. Dranove's product "market definition includes all carriers." Trial Tr. 12/2/16, 2245:14–2245:23 (Dranove). This includes the national insurers, plus all regional insurers, third-party administrators ("TPAs"), and private exchanges. Trial Tr. 12/2/16, 2247:14–20 (Dranove). A national account facing a hypothetical monopolist in Dr. Dranove's product market has only two alternatives: stop purchasing health insurance or "essentially go into the business of becoming an insurer" through direct contracting. Trial Tr. 12/2/16, 2247:21–2248:1 (Dranove). For "bluffing" to undermine this market definition, "national accounts employers would have to successfully bluff all current and future sellers of insurance into believing that they were not going to buy insurance in response to a SSNIP." Trial Tr. 12/2/16, 2246:4–2246:14 (Dranove).

C. National accounts are a distinct set of customers with common characteristics.

73. By virtue of their size and geographic dispersion, national accounts have extensive needs and objectives for their health benefit plans that together set them apart from other segments. *See, e.g.*, Trial Tr. 11/21/16, 76:17–78:6 (Abbott); Martie 4/28/16 Dep. 81:23–82:15, 83:11–24; Welch 4/29/16 Dep. 22:13–23:12, 25:10–23; Kehaly 4/28/16 Dep. 29:5–11, 29:21–30:10; [redacted]

Bailey 4/12/16 Dep. 66:12–68:2; PX0036 at -885.

74. Anthem considers national accounts one of "seven different customer types" and has admitted that "one of the keys to [its] success has been [its] focus on these distinct customer types, which better enables [it] to develop benefit plans and services that meet [its] customers' unique needs." PX0125 at 5; *see also* Trial Tr. 11/22/16, 534:5–536:16 (Kertesz).

75. Randall Abbott, who assists Fortune 750 companies at the national consulting firm Willis Towers Watson, *see infra* Section II.C.i, testified that his clients generally look for a well-regarded national organization with financial stability and a long-term reputation in the marketplace; a broad national network of providers; the best possible financial arrangements; sophisticated technology and continuing innovation to reduce costs and improve employee health; a broad portfolio of services; an ability to customize products and services; and a high level of service and attention from a strong account team. Trial Tr. 11/21/16, 73:24–77:9 (Abbott). With Abbott's help, each client typically identifies up to 20 objectives for an RFP, ranging from reducing cost and complexity to enhancing wellness and engagement through customized offerings. Trial Tr. 11/21/16, 91:11–18 (Abbott).

76. While each national account is somewhat unique, several common attributes set national accounts apart as a distinct customer group, including: (1) use of national consulting firms to guide them through an RFP process that is longer, more detailed, and less frequent than the process used for other customers; (2) need for a broad provider network spanning multiple states and MSAs, wherever employees live and work; (3) emphasis on customized products and services; (4) demand for innovations that will improve employee health and reduce total costs; and (5) expectation of high level of attention and service.

(i) Most national accounts enlist large national consulting firms to aid them in decisions about health plan design and insurer selection.

77. National accounts typically rely on consultants to guide them through the RFP process and insurer selection. *See, e.g.*, Pogany 4/29/16 Dep. 34:15–23; Martie 4/28/16 Dep. 52:2–12; Bailey 4/12/16 Dep. 66:12–67:7; PX0094 at -517; [redacted]

78. The vast majority of national accounts—90 percent by some estimates—turn to three national consulting firms in particular: Aon Hewitt, Willis Towers Watson, and Mercer. *See* PX0121 at -324; *see also* Martie 4/28/16 Dep. 48:21–49:3; Sharp (Aon) 10/6/16 Dep. 181:7–21; Trial Tr. 11/21/16, 66:9–12 (Abbott). Unlike the more localized brokers and consultants used by other types of employers, these national firms "are typically not geographically bound." PX0094 at -518. Rather, they "deploy their best consultants from wherever they are based and . . . utilize centralized national centers of expertise to drive RFPs and strategy." PX0094 at -518.

79. Retention of a major national consultant is such a defining characteristic of national accounts that several insurers have adapted their definition of "national accounts" to reflect it. Anthem cuts its threshold in half, to 2,500 employees, for employers using Aon Hewitt, Mercer, or Willis Towers Watson, PX0144 at -499, [redacted]

see also [redacted]

80. Because national accounts work through such a distinct distribution channel, they can be easily identified and targeted based on common attributes and needs that national accounts share. *See, e.g.*, PX0144 at -499.

81. Consultants help national accounts through RFP processes that are longer and more detailed than those undergone by smaller employers. *See* Trial Tr. 11/21/16, 80:3–82:20, 83:5–84:14, 86:15–89:18 (Abbott).

(ii) National accounts need strong provider networks across multiple states, wherever employees live and work, and highly value a broad national network.

82. National accounts require provider networks in all areas where their employees live and work. Trial Tr. 11/22/16, 404:13–15 (Cordani); Trial Tr. 11/22/16, 538:2–5 (Kertesz); Trial Tr. 11/21/16, 226:9–11 (Swedish); Martie 4/28/16 Dep. 125:9–15; Mascolo (Wells Fargo) 10/20/16 Dep. 65:15–17, 65:19–66:15; Kidd (Sodexo) 10/21/16 Dep. 20:21–21:8.

83. The breadth and complexity of a national account's network needs are often significant. It is not unusual for national accounts to have as many as 40 locations around the country. Many have hundreds, if not thousands, of locations across the country. *See* Trial Tr. 11/21/16, 68:14–69:1 (Abbott).

84. Consequently, national accounts typically seek an insurer with a broad national provider network spanning all or most of their domestic locations. *E.g.*, Trial Tr. 11/21/16, 78:8–79:3 (Abbott). As Cigna CEO David Cordani testified, in a perfect world, employers would partner with one insurer and "go on a multiyear journey." Trial Tr. 11/22/16, 530:10–531:1 (Cordani). While companies in the Fortune 25 or 50 often cannot get everything they need from one insurer, most in the Fortune 250 to 500 have just one insurer or one plus Kaiser. Trial Tr. 11/22/16, 530:10–531:1 (Cordani). Among the reasons for wanting one national insurer is that employers—especially those who buy in to incentives, engagement, and health improvement—increasingly want "more commonality in the programs, and it's next to impossible to get [that] if they have ten different medical insurers across the country." Trial Tr. 11/22/16, 529:13–530:2 (Cordani).

85. Having an insurer with a broad national network also simplifies administration and saves costs. Trial Tr. 11/22/16, 529:15-531:1 (Cordani) (testifying that "administratively it's quite complex for the employer" to manage more than a couple of insurers). For example, Kroger, a

national grocery store chain, uses one insurer "nationally to cover as many associates as possible" because doing so provides "administrative simplicity." Monti (Kroger) 10/17/16 Dep. 31:4–14. The more vendors Kroger works with, the more expensive the program is due to complexities such as the need for multiple data feeds to multiple insurers and additional communications to employees. Monti (Kroger) 10/17/16 Dep. 31:15–32:8. Similarly, Applied Industrial Technologies uses one national insurer to save "[m]anpower" that would be spent managing multiple relationships and coordinating care across the country. Loring (Applied) 9/30/16 Dep. 37:3–11, 37:21–38:12, 38:15–20, 38:22–24. As Applied Industrial Technologies' benefits manager, Kurt Loring, put it, with Cigna he only has "one person to interface with, it's one phone call" instead of "two, three, four, five phone calls to cover the same type of topic or have any discussions on adjudication of claims or how you deal with things across networks." Loring (Applied) 9/30/16 Dep. 37:21–38:12, 38:15.

86. Another reason national accounts emphasize access to a national provider network is the frequency with which national accounts' employees move and travel. Loring further testified, "I need talent in certain parts of the U.S., and so I need a homogenized benefit system in my world that enables you to go from your place in Washington, DC, to Cleveland, and I don't want you to have to worry about what insurance did I just get and what's covered and not covered, and how is this continuation of care going to be good for my wife or my spouse and my kids. I want that to be seamless. I want you focused on your job." Loring (Applied) 9/30/16 Dep. 40:14–41:4. Likewise, the benefits manager for Steel Dynamics testified that national networks have the advantage of mobility, the ability to access in-network providers "at a predictable discount, in different states, different regions, for traveling employees, employees that transfer, employees that are just moving from location to location, particularly." Record (Steel Dynamics) 10/19/16 Dep.

30:1–11; *see also* [redacted]

87. [redacted]

88. Even national accounts that once were willing to cobble together networks have increasingly concluded that doing so is not worth the added complexity. For example, [redacted] a [redacted] company with 50,000 employees across all 50 states, recently stopped offering regional products after realizing that they [redacted]. [redacted] replaced them with a national Blue Cross plan that has improved costs and administrative simplicity. [redacted] Likewise, [redacted] once offered a "full suite of competitors" but has since sought to narrow it down, driven by the complexity of managing and administering multiple relationships. Guilmette 5/3/16 Dep. 117:6–15. [redacted] *see also* PX0063 at -556 [redacted]

89. National accounts' strong demand for a national network and their disinclination to "cobble together the needed coverage" is the *raison d'être* of BlueCard, which enables Anthem and other Blues to effectively compete for national accounts. PX0216 at 42, PX0144 at -514; Drapkin 9/30/16 Dep. 72:6–9, 72:13, 73:18–22 (testifying that the BlueCard system is "necessary in order for the various Blues to serve national accounts"). Anthem considers the Blue network a "huge asset" and source of "significant leverage" with respect to national accounts. Trial Tr. 11/22/16, 537:11–20, 538:9–11 (Kertesz); PX0125 at 51–52; PX0144 at -514. Anthem and the Blues have told another federal court that "[a]bsent cooperation, Blue plans could not effectively service (and thus, would not compete effectively for) national employers." PX0216 at 42.

(iii) National accounts seek customized products and services more often and to a greater degree than other types of employers.

90. National accounts typically require more customization than other customers, on things ranging from plan designs and supplemental programs to data reporting and employee communications. *See, e.g.*, Trial Tr. 11/21/16, 76:17–78:6, 159:15–22 (Abbott); Guilmette 5/3/16 Dep. 73:14–74:14, 140:5–20; Welch 4/29/16 Dep. 25:10–18; Martie 4/28/16 Dep. 161:13–162:24; Bailey 4/12/16 Dep. 67:8–68:2; Parr 9/28/16 Dep. 18:3–7, 18:9, 18:12–19:3; PX0094 at -517; [redacted] Trial Tr. 11/28/16, 802:18–25 (Bierbower); Sharp (Aon) 10/6/16 Dep. 75:18–77:5, 77:21–25, 78:2–13.

91. By contrast, "[i]n the middle-market space, it tends to be much more streamlined services, packaging," with customers looking for "the fastest, easiest way to get things done," Sharp (Aon) 10/6/16 Dep. 75:18–77:5, 77:21–25, 78:2–13, and often "more comfortable with standardized types of programs." Trial Tr. 11/21/16, 76:17–77:9 (Abbott); *see also* Trial Tr. 11/28/16, 788:11–18 (Smith) (testifying that Cigna typically does not offer customization to clients with less than 1,000 or 2,000 enrollees).

92. To win and keep national accounts, Cigna strives to show that it is "flexible" and "can customize [its] solutions to the large complex employer needs in the national account space." Guilmette 5/3/16 Dep. 73:14–74:14, 140:5–20. For example, it offers premium clinical models customized to a client's specific needs, culture, and location, Parr 9/28/16 Dep. 235:25–237:7, and runs three dedicated care-management centers, each staffed with 400–800 doctors and nurses, that are focused on national accounts. Trial Tr. 11/28/16, 776:3–20 (Smith). It has developed and piloted a number of innovations and programs to fulfill specific customers' needs. *See infra* Section V.D.i.b.

93. [redacted] Martie 161:13–162:24; PX0155 at -947. Among the largest such investments underway as of April 2015 were [redacted]

(iv) National accounts demand more innovation and tend to be early adopters of new programs and tools.

94. National accounts also demand more innovation than smaller employers do, pushing the insurers to pursue and provide "the latest and greatest capabilities" that employers have heard about through their consultants. Martie 4/28/16 Dep. 84:4–25; *see also* Trial Tr. 11/22/16, 403:19–404:11 (Cordani); Trial Tr. 11/29/16, 1180:6–20 (Kendrick). By contrast, large group customers, especially at the lower end of the size range, are less interested in these offerings. Martie 4/28/16 Dep. 84:4–25; Trial Tr. 11/22/16, 403:19–404:11 (Cordani).

95. National accounts have demonstrated a unique strategic focus on health and productivity solutions for several reasons that trace back to other distinguishing characteristics.

See PX0094 at -517 (identifying this focus as a "Unique Characteristic[] of National Accounts"); *see also* Trial Tr. 11/21/16, 70:12–71:1, 73:24–75:12 (Abbott). Due to their large number of employees, national accounts have the most to gain from programs that could keep employees healthy at work and out of expensive situations such as emergency room visits or serious and costly diagnoses. *See* PX0094 at -517. And because they work with sophisticated national consultants that stay abreast of innovation and help them objectively assess programs and potential savings, *see supra* Section II.C.i, national accounts can better see the value of new or evolving programs. As a result, they likely are more willing to pay for them, so long as the price is outweighed by their ultimate savings.

96. National accounts are the industry's "innovation incubators," Trial Tr. 11/29/2016, 1180:6–20 (Kendrick), typically leading the way towards innovations that are then often deployed more broadly. *See, e.g.*, PX0094 at -518 (plan and network designs); Trial Tr. 11/22/16, 403:19–404:11 (Cordani) (citing to value-based programs, health engagement incentive programs, biometric screenings, and other innovative, cost-saving programs).

97. Innovation is a major dimension of competition for national accounts. Anthem now tries to win business by highlighting innovative measures, particularly in provider collaboration. PX0174 at -484–485, 494; *see also* Trial Tr. 11/29/16, 1199:19–1201:25 (Kendrick) (describing Anthem's focus on innovation within national accounts). And for a while Aetna struggled to retain national accounts because "their account teams were not really being consultative, not really helping [the clients] understand what was driving their costs, not bringing new solutions or innovation to them." Trial Tr. 11/28/16, 780:3–15 (Smith); *see also* Loring (Applied) 7/30/16 Dep. 41:9–21.

(v) National accounts expect and receive a higher level of service, experience, and attention from their insurers.

98. National accounts typically expect and receive greater attention and service from insurers during the RFP process and on a day-to-day basis once a contract is signed. They are more likely to require a dedicated customer service unit than large group customers, Trial Tr. 11/28/16, 802:22–25 (Bierbower), and often request more stringent service level guidelines than smaller customers. Martie 4/28/16 Dep. 86:25–87:8.

99. As the president of Cigna's global employer segment testified, consultants and employers "recognize that . . . a national account team is more likely to have that level of experience and expertise that's valuable to them." Guilmette 5/3/16 Dep. 73:14–74:14. These teams are "quite seasoned and experienced in dealing with large complex multi-site employers. So they know their way around the company. They understand the challenges associated with delivering a package of benefits to a population that's dispersed across the country." Guilmette 5/3/16 Dep. 73:14–74:14. And they are "very good at . . . serving those clients." Guilmette 5/3/16 Dep. 73:14–74:14; *see also* [redacted]

100. Large employers falling short of an insurer's definition of a national account sometimes request to be treated as national accounts to get better service from the national sales teams. Guilmette 5/3/16 Dep. at 72:10–23, 73:14–74:14; *see also* Martie 4/28/16 Dep. 87:22–88:10. [redacted]

[redacted]

[redacted]

D. National accounts can be profitably targeted for price increases.

101. As is in any price-discrimination market, pricing and terms are individually negotiated for each national account and are dependent on factors specific to the account. *See* Trial Tr. 11/21/16, 83:5–84:14, 89:1–18 (Abbott); Trial Tr. 11/23/16, 720:19–722:14 (Thackeray) (noting that the client industry, number of employees, number of potential members, disease prevalence, and utilization rates may all factor into the RFP); PX0043 at -752 [redacted]

[redacted]; *see also supra* Section I.C.i., II.C.

102. When negotiating with an account, insurers know the employer's name, its industry, its number of employees and where those employees are located by zip code, among other things. Trial Tr. 11/23/16, 720:19–722:14 (Thackeray). Based on that information alone, an insurer can not only identify national accounts but also infer its likely competition. *See, e.g.*, Guilmette 5/3/16 Dep. 171:6–172:7; PX0045 at -500 (Anthem "expect[s] competitive bids from [its] usual competition," and notes that Cigna would be very competitive).

103. The national insurers have ample market intelligence with which to decide how aggressive they should be for an account. They usually know how their discounts compare in a given area and can adjust their offers accordingly, with Anthem charging higher ASO fees where its discount advantage is greater. *See, e.g.*, Jay 10/12/16 Dep. 53:14–17, 53:19–56:1, 59:23–60:6, 60:9–11; Trial Tr. 11/23/16, 722:7–724:12 (Thackeray); PX0065 at -303, -305. And insurers often improve their offers after receiving feedback about competing offers. *See, e.g.*, Trial Tr. 11/22/16, 550: 3–11 (Kertesz); [redacted]

[redacted] PX0044 at -919–920. They also know the incumbent or top competitor for an account and adopt differing strategies depending on whom they are up against. *See, e.g.*, PX0147 at -843–44 (identifying competitors for national accounts in the pipeline); PX0043 at -752 (Anthem put "aggressive financial and performance commitments on opportunities where Aetna or Cigna are incumbents"); [redacted] PX0707 at -669–695 [redacted] PX0707 at -669–700.

104. Insurers typically offer better terms when they face significant competition. Kilmartin (Mercer) 10/20/16 Dep. 164:16–22 ("Carriers are more willing to take an aggressive position when they know there's competition in play."); Sharp (Aon) 10/6/16 Dep. 94:10–95:12; PX0043 at -752 [redacted] Kilmartin (Mercer) 10/20/16 Dep. 165:1–23; PX0154 at -538; PX0044 at -919–20 [redacted]

105. Pricing and terms for national accounts are set separately and independently from pricing and terms for other types of customers. PX0125 at 5 (each Anthem business unit, including National Accounts, is responsible for pricing and product design to provide value while balancing profitability with market share); PX0142 at -793-1–793-16; PX0154; *see also* Trial Tr. 11/22/16, 534:23–535:19 (Kertesz); [redacted] Insurers

can identify which customers are national accounts and charge them different prices or offer them different terms based on a variety of factors. *See, e.g.*, Trial Tr. 11/22/16, 540:20–22 (Kertesz).

106. Targeted national account customers cannot defeat a price increase by obtaining comparable health plan services indirectly through another customer; arbitrage is impossible. Trial Tr. 11/28/16, 860:20–861:8 (Dranove).

E. Both fully-insured and self-insured plans are properly included in the relevant product market.

107. It is appropriate, and in fact conservative, to include both fully-insured and ASO plans in the relevant product market. Trial Tr. 11/28/16, 858:12–859:13 (Dranove). Although fully-insured plans have a limited competitive impact on ASO plans, they compete as substitutes at the employee level when offered as an option (a common scenario for Kaiser's HMO). Trial Tr. 11/28/16, 858:12–859:13 (Dranove). National insurers do not divide their businesses around funding types, but rather around customer segments. *See, e.g.*, Trial Tr. 11/21/16, 246:4–11 (Swedish); Trial Tr. 11/30/16, 1722:25–1724:1 (DeVeydt); PX0123 at -122; Hayes (Aetna) 10/6/16 Dep. 74:21–75:5.

108. Excluding enrollment in fully-insured plans, such as Kaiser, would increase the market shares and concentration levels in the relevant market. Trial Tr. 11/28/16, 858:25–859:23, 899:19–900:2 (Dranove).

F. National accounts have no reasonably interchangeable alternatives to purchasing commercial health insurance.

109. Because the relevant market includes all forms of health insurance, national accounts faced with a small but significant, non-transitory increase in price, or SSNIP, have only two alternatives: self-supply by handling all aspects of the insurance product themselves or forgoing the purchase of group health insurance altogether. Trial Tr. 11/28/16, 861:9–865:21

(Dranove). Neither is a reasonable substitute for purchasing commercial health insurance. Trial Tr. 11/28/16, 861:9–865:21 (Dranove).

(i) Forgoing the purchase of health insurance is not a substitute for purchasing health insurance.

110. Dropping coverage and not buying health insurance is not a reasonably interchangeable substitute for buying health insurance and would not prevent a hypothetical monopolist from implementing a SSNIP. Trial Tr. 11/28/16, 861:9–865:21 (Dranove); Trial Tr. 12/2/16, 2248:2–4 (Dranove).

111. Large employers, including national accounts, virtually always offer health insurance. Trial Tr. 11/28/16, 861:9–865:21 (Dranove). Health benefits are important "to recruit and retain employee groups" and often "considered one of the top priorities" for that purpose. Trial Tr. 11/21/16, 156:4–14 (Abbott); *see also* Loring (Applied) 9/30/16 Dep. 15:15–20 ("We want to retain the best employees, and employees are looking to ensure that they have the ability to get access that's affordable to the healthcare."). National consultants testified that they were unaware of any employer that has dropped health benefits since the passage of the ACA. Trial Tr. 11/21/16, 124:17–25 (Abbott); Kilmartin (Mercer) 10/20/16 Dep. 188:22–24, 189:1–5, 189:8–9.

112. Dr. Dranove confirmed this conclusion by performing a "critical elasticity test." Trial Tr. 11/28/16, 863:18–865:21 (Dranove). Elasticity of demand measures the responsiveness of unit sales to changes in price. The more elastic the demand, the greater the loss in unit sales for a given price increase. Each lost sale carries a forgone profit on that unit, according to the seller's profit margin earned at the initial price. The hypothetical monopolist test is satisfied if actual elasticity is lower than critical elasticity. Trial Tr. 11/28/16, 863:18–865:21 (Dranove).

113. Using data from the insurers, Dr. Dranove measured critical elasticity as 1.18. Trial Tr. 11/28/16, 863:18–865:21 (Dranove). This means that for a five percent price increase to be

unprofitable to a hypothetical monopolist, about six percent of employers would need to simply drop coverage. Trial Tr. 11/28/16, 863:18–865:21 (Dranove). Based on peer-reviewed academic literature, Dr. Dranove concluded that the estimated actual elasticity is much lower—approximately 0.15—suggesting that few, if any, employers would drop coverage. Trial Tr. 11/28/16, 863:18–865:5 (Dranove). Because actual elasticity is less than critical elasticity, the hypothetical monopolist test is satisfied. Trial Tr. 11/28/16, 863:18–865:5 (Dranove).

114. Dr. Willig's criticism that Dr. Dranove's critical elasticity test looks at employers with 1,000 employees or more is a red herring. Large employers "rarely drop insurance as the prices go up." Trial Tr. 12/2/16, 2249:4–2250:17 (Dranove). And it is "well-understood in health economics that national accounts employers view health insurance benefits as critical to attracting employees, and they're not going to stop offering insurance in response to a 5 percent price increase." Trial Tr. 12/2/16, 2250:10–17 (Dranove).

(ii) Self-supply is not a reasonably interchangeable substitute for the purchase of commercial health insurance and does not belong in the relevant product market.

115. Self-supply, sometimes called direct contracting, is not a viable option for most national accounts. *See* [redacted] Contracting directly with a large number of doctors and hospitals requires a critical mass and density of members in a specific market. Trial Tr. 11/21/16, 121:25–122:9 (Abbott). As consultant Randall Abbott testified, to pursue such a strategy, an employer needs a "large number of employees or family members geographically concentrated to a degree that . . . would be of interest to the provider community. So it's going to, typically, be the purview of a very large employer or a modest-sized employer in a very, very small town." Trial Tr. 11/21/16, 121:25–122:9 (Abbott).

116. Boeing is an example of a national account that has contracted directly. But even Boeing has relied heavily on the national insurers and their broad provider networks outside certain areas. Trial Tr. 11/21/16, 122:10–22 (Abbott) (explaining that companies such as Boeing are contracting in a handful of areas where they have thousands of members "and then availing themselves of national networks elsewhere"); *see also* [redacted] Likewise, most employers that have contracted directly have done so for a small handful of procedures where there is high variability in price and quality under what is known as a "Centers of Excellence" approach. Trial Tr. 11/21/16, 123:3–124:16 (Abbott).

117. No national account has testified that it intends to fully replace a health insurer with self-supply. In fact, the only employer that was deposed in this case that has contracted directly testified it would *not* expand its provider contracting strategy beyond its core area, [redacted] because it would not be [redacted] or worthwhile in terms of cost savings. [redacted] While [redacted] was able to leverage its large number of lives to obtain better pricing in select [redacted] counties, it [redacted] needed. [redacted]

118. Direct contracting for select procedures is not reasonably interchangeable with the purchase of commercial health insurance. Trial Tr. 11/28/16, 1053:10–1054:3 (Dranove). Employers who contract directly for select procedures are "still buying virtually the whole kit and

caboodle of health insurance from the main insurance company [they're] doing business with." Trial Tr. 11/28/16, 1053:15–1054:3 (Dranove). They do not, and could not, substitute such direct contracts for the purchase of commercial health insurance. Trial Tr. 11/28/16, 1053:15–1054:3 (Dranove). At most, 20 percent of the healthcare dollar could be carved out in this fashion, and other evidence suggests that very few providers were in the position to accept these kinds of contracts at all. Trial Tr. 11/28/16, 862:11–863:17 (Dranove). This form of direct contracting is therefore well outside the relevant market and irrelevant to market share calculations. Trial Tr. 11/28/16, 1053:15–1054:3 (Dranove).

119. For these reasons, direct contracting is not a realistic choice for large employers. Even the companies that Dr. Fowdur identified as engaging in direct contracting are "doing the bulk of their insurance purchasing by going to insurers rather than self-supplying." Trial Tr. 12/2/16, 2248:14–2249:3 (Dranove).

III. THE RELEVANT GEOGRAPHIC MARKETS ARE BOTH THE 14 ANTHEM STATES AND THE UNITED STATES.

A. The 14 Anthem states and the United States are both relevant geographic markets because of how the Blue rules affect competition.

120. There are two components of an antitrust market: product market and geographic market. Trial Tr. 11/28/16, 846:25–847:4 (Dranove). The purpose of the geographic market component is to identify which sellers can be substituted to meet the needs of customers in particular geographies. Trial Tr. 11/28/16, 866:3–9 (Dranove). To determine the relevant geographic market, Dr. Dranove identified a candidate market and applied the hypothetical monopolist test. Trial Tr. 11/28/16, 866:10–12 (Dranove). Where, as here, a hypothetical monopolist could price discriminate, i.e., price differently based on customer location, it is

important to "focus on the customers and who is able to meet their needs." Trial Tr. 11/28/16, 866:19–22 (Dranove).

121. Dr. Dranove concluded that to properly assess the competitive effects of the merger, the relevant market should be defined as both the 14 Anthem states where Anthem has a Blue license and, separately, the United States. For customers located in the Anthem states, the merger will directly affect competition by eliminating one currently existing competitor. Trial Tr. 11/28/16, 866:19–867:2 (Dranove). It is appropriate to separately define a broader geographic market that includes the 14 Anthem states as well as the states where Anthem does not have a Blue license because the merger will result in additional competitive effects throughout the United States, as discussed below. Trial Tr. 11/28/16, 866:19–867:8, 871:20–872:4 (Dranove).

B. The 14 Anthem states are a relevant geographic market.

122. The 14 Anthem states are a relevant geographic market. Trial Tr. 11/28/16, 867:21–868:1 (Dranove). These states represent the area where there is direct overlap between Anthem and Cigna, as recognized by Anthem's head of integration, Dennis Matheis. Matheis repeatedly referred to those states as the "overlap markets." *E.g.*, Trial Tr. 11/30/16, 1483:8–11, 1524:12–22 (Matheis).

123. Because the merger eliminates head-to-head competition between Anthem and Cigna for accounts headquartered in the 14 Anthem states, this market has the greatest potential for direct competitive harm. Trial Tr. 11/28/16, 868:2–11 (Dranove).

124. The 14 Anthem states market satisfies the hypothetical monopolist test. Trial Tr. 11/28/16, 868:12–24 (Dranove). In response to a SSNIP, national accounts headquartered in the Anthem states have only two potential alternatives: forgo purchasing insurance or relocate their headquarters to a non-Anthem state. Trial Tr. 11/28/16, 868:12–24 (Dranove). As Dr. Dranove

testified, neither option is realistic. National accounts will not stop purchasing insurance in response to a SSNIP. Trial Tr. 11/28/16, 868:2–15 (Dranove). And it would be very unlikely for a national account to relocate its corporate headquarters because prices have increased by five percent. Trial Tr. 11/28/16, 868:2–24 (Dranove).

125. It is also appropriate to aggregate the 14 Anthem states because there is a "commonality of merger effect" across them: throughout this region, head-to-head competition between Anthem and Cigna will be eliminated. Trial Tr. 11/28/16, 869:22–870:4 (Dranove). Furthermore, while it may make sense to look at smaller markets under certain circumstances, aggregating smaller markets is not problematic "except under extraordinary conditions" where the two merging firms compete in different markets, which is not the case here. Trial Tr. 11/28/16, 869:22–871:1 (Dranove). The fact that Anthem's states are not all contiguous is immaterial because the merger removes competition between Anthem and Cigna wherever Anthem is licensed. Trial Tr. 11/28/16, 871:2–15 (Dranove).

126. Dr. Fowdur's criticism of Dr. Dranove's 14 Anthem state geographic market definition is not correct because Dr. Fowdur fails to account for where the merger will directly affect competition. Trial Tr. 12/2/16, 2250:20–2251:14 (Dranove). "[T]he purpose of defining the geographic market is to understand the area in which the proposed merger is going to affect competition." Trial Tr. 12/2/16, 2251:3–7 (Dranove). Here, the merger will affect competition in the states where Anthem and Cigna now compete directly with one another, i.e., in the 14 states where Anthem holds a Blue license. Trial Tr. 12/2/16, 2251:3–10 (Dranove). "For companies headquartered in those markets, this is effectively, slice business notwithstanding, a four to three merger." Trial Tr. 12/2/16, 2251:3–14 (Dranove).

127. Dr. Fowdur's criticism—that customers headquartered in the Anthem states could defeat a SSNIP by slicing for employees outside the Anthem states—is incorrect because Dr. Dranove's geographic market definition accounts for slicing. Trial Tr. 12/2/16, 2251:15–22 (Dranove). Dr. Dranove's 14 Anthem state market includes every insurer that sells to employers headquartered in the 14 Anthem states, including slice insurers who cover employees outside the 14 Anthem states. Trial Tr. 12/2/16, 2251:15–22 (Dranove).

C. The United States is a relevant geographic market.

128. The United States similarly constitutes a relevant geographic market for the sale of commercial health insurance to national accounts. Trial Tr. 11/28/16, 871:16–19 (Dranove). As with the 14-state market, the U.S. market satisfies the hypothetical monopolist test because national accounts will not forgo purchasing health insurance or move employers outside the United States in response to a SSNIP. Trial Tr. 11/28/16, 872:5–18 (Dranove).

IV. MARKET SHARES AND THE RESULTING HIGH LEVEL OF CONCENTRATION CREATE A PRESUMPTION THAT THE MERGER IS ANTICOMPETITIVE.

129. Market shares help assess the likely effects of a merger because they reflect the relative importance of firms in the market and the extent to which customers have alternatives. Trial Tr. 11/28/16, 874:9–16 (Dranove). Industry participants—including Anthem and Cigna—also calculate market shares to understand these issues. Trial Tr. 11/28/16, 874:17–21 (Dranove). For example, Anthem has analyzed the markets in the 14 Anthem states, concluding that it has a "strong market position," PX0367 at -322, and has described itself as a leader in national accounts based on its market share, PX0494 at -307.

A. It is appropriate to combine the Blues when calculating market shares.

130. As Dr. Dranove testified, it is appropriate to treat Blue plans as a single competitor for purposes of calculating market shares for several reasons.[1] Trial Tr. 11/28/16, 883:20–884:15 (Dranove). First, network strength is one of the most important factors for national accounts, and the Blues contribute to the strength of Anthem's network. Trial Tr. 11/28/16, 883:20–884:4 (Dranove). Indeed, Anthem's network is so strong because of "all of the Blue lives that they're responsible for, not just the Anthem Blue lives." Trial Tr. 12/2/16, 2260:22–2261:12 (Dranove). When national accounts consider their options "they obviously know that they can only choose the one Blue that's assigned to them in their territory." Trial Tr. 12/2/16, 2260:18–2261:6, 2261:13–18 (Dranove) (only one Blue can bid on any given customer, with the exception of California and a small part of upstate New York). Yet these national accounts "care about the strength of the entire Blue brand." Trial Tr. 12/2/16, 2260:22–2261:6 (Dranove).

131. Because of the importance of the Blue network—nationwide—Anthem views the market share of the Blues system as a whole when assessing its strength in the marketplace. PX0494 at -294. Anthem relies on the provider discounts of other Blue plans when bidding on national accounts. Trial Tr. 11/21/16, 90:1–16 (introducing PX0310), 107:24–108:20 (Abbott); PX0310 at -826. And as the BCBSA has recognized, "cooperation among Blue Plans has allowed them to create a new product that otherwise would not exist"—that is, the sale of a nationwide network to national employers. PX0216 at 42; Trial Tr. 11/21/16, 233:1–5 (Swedish). Absent that cooperation, "Blue Plans could not effectively service (*and thus, would not compete effectively*

[1] Because Anthem competes with a separate Blue Shield licensee throughout California, Blue Shield of California is treated as a distinct competitor from Anthem for the purposes of calculating market shares. Trial Tr. 11/28/16, 883:16–884:18.

for) national employers or federal employees." PX0216 at 42 (emphasis added); Trial Tr. 11/21/16, 233:16–22 (Swedish).

132. Second, under the Best Efforts rule, Anthem in effect controls ceded lives within its territories—that is, employees belonging to accounts headquartered in an Anthem state that have been ceded to a non-Anthem Blue. Trial Tr. 11/28/16, 883:20–884:8 (Dranove).

133. Third, from the perspective of customers, the 26 Blue plans are not separate competitors. Trial Tr. 11/28/16, 883:20–884:15, 991:22–992:21 (Dranove). Anthem initially said that it competes with other Blue plans. Status Hearing 10/18/16, 19:11–14. But as Anthem's CEO Joe Swedish testified, Anthem does not compete against other Blue plans in any area where it has an exclusive license. Trial Tr. 11/21/16, 235:10–13, 236:6–8 (Swedish). Likewise, Anthem does not compete against other Blue plans for national accounts. Outside of the Anthem states, if Anthem receives a "cede" from another Blue plan, the other Blue plan will have forfeited its right to bid on the account. Trial Tr. 11/21/16, 235:14–236:5 (Swedish); Weber 10/18/16 Dep. 237:15–19, 237:21–238:1, 268:3–6, 261:2–262:19.

134. Finally, Anthem has tried to characterize the BlueCard network as a "rental network." Trial Tr. 11/21/16, 34:25–35:2 (defense opening). But the company's CEO said that he has never called it a rental network. Trial Tr. 11/21/16, 227:4–12 (Swedish). And unlike a typical rental network, which depends on contractual relationships that may be terminated on short notice, the BlueCard network is the result of licensing agreements that Anthem and all other Blues must comply with by virtue of their Blue licenses. Trial Tr. 11/21/16, 227:25–228:5 (Swedish).

B. Market-share methodology

135. Insurers typically measure national-account market shares in terms of insured lives ("enrollment"), taking into account slight variations in how insurers define national accounts. For

example, Anthem accounts for its national-accounts membership using both home and host lives. Trial Tr. 11/22/16, 559:8–25 (Kertesz). An Aetna market-share analysis for national accounts recognized that Anthem defined national accounts as having 5000+ employee lives as compared to Aetna's definition of 3000+ employee lives. PX0036 at -885.

136. Consistent with industry practice, Dr. Dranove measured market shares based on enrollment. Trial Tr. 11/28/16, 878:20–879:1 (Dranove). Dr. Dranove used two alternative definitions of enrollment in a "national account" to calculate market shares: enrollment in plans sponsored by employers with more than 5,000 employees ("NA5") and enrollment in plans sponsored by employers with more than 5,000 employees and at least five percent of members residing outside of the state with the largest proportion of employees ("NA5G"). Trial Tr. 11/28/16, 876:24–878:13 (Dranove). Both definitions are consistent with how industry participants define the term. Trial Tr. 11/28/16, 878:15–19 (Dranove). Dr. Dranove used alternative definitions as "a robustness check" to ensure accuracy. Trial Tr. 11/28/16, 876:24–878:13 (Dranove).

137. The numerator of Dr. Dranove's share calculation is an insurer's number of national account enrollees who reside within the geographic market, which he calculated using enrollment data provided by insurers. Trial Tr. 11/28/16, 884:24–888:5 (Dranove). The denominator of Dr. Dranove's share calculation is an estimate of the total number of national-account enrollees who reside in the geographic market. Trial Tr. 11/28/16, 888:7–17 (Dranove). To be conservative, Dr. Dranove calculated the denominator as the larger of two alternative approaches. Trial Tr. 11/28/16, 888:18–21, 891:13–892:1 (Dranove). For the first approach, the denominator relies on publicly-available census data. Trial Tr. 11/28/16, 888:7–17 (Dranove). This approach captures small regional insurers that didn't otherwise appear in the data. Trial Tr.

11/28/16, 889:15–890:13 (Dranove). For the second approach, the denominator is the sum of all enrollment data produced by 26 insurers from which the United States was able to collect data. Trial Tr. 11/28/16, 888:7–17, 890:24–891:11 (Dranove).

138. Anthem's expert, Dr. Fowdur, criticizes Dr. Dranove's market-share denominator because the build-up approach excludes some small slice business in the Anthem states. Trial Tr. 12/2/16, 2254:20–2256:8 (Dranove). As Dr. Dranove explained however, Anthem's enrollment data shows small slice arrangements "constitute just a few percentage points of the total enrollment." Trial Tr. 12/2/16, 2254:20–2259:13 (Dranove). More importantly, it turns out that "the overwhelming majority of the slice data" he excluded was sliced between Anthem and the other three national insurers. Trial Tr. 12/2/16, 2254:20–2256:8 (Dranove). "[T]hey almost always sliced to the big four." Trial Tr. 12/2/16, 2254:20–2256:2 (Dranove).

139. In addition, Dr. Dranove explained that his approach to calculating market shares is conservative not only because he used the larger of two reasonable denominators, but also because the shares include Kaiser and Harvard Pilgrim. Trial Tr. 11/28/16, 891:13–892:1, 894:1–21 (Dranove). Including Kaiser is conservative for at least three reasons: first, while most national account customers self-insure, Kaiser's strongest product is a fully-insured HMO product; second, Kaiser has a limited geographic footprint and thus cannot offer customers access to a national provider network; and third, deposition testimony suggests that slice insurers do not constrain the pricing of national insurers competing to serve as a customer's primary insurer. Bailey 4/12/16 Dep. 215:16–216:3. Because of these differences, Kaiser doesn't compete against the "big four the way the big four compete against each other." Trial Tr. 11/28/16, 894:1–21 (Dranove). The same is true of Harvard Pilgrim, which has a "very large HMO presence." Trial Tr. 11/28/16, 894:1–21 (Dranove).

140. The principal method for measuring market concentration under the *Horizontal Merger Guidelines* is to calculate the Herfindahl–Hirschman Index (HHI). Trial Tr. 11/28/16, 937:14–25 (Dranove). The HHI is calculated by summing the squares of the individual firms' market shares. Trial Tr. 11/28/16, 937:14–25 (Dranove). "Both economic theory and empirical research tell us that, all else equal, the higher the HHI in the market, the higher prices are likely to be." Trial Tr. 11/28/16, 938:5–7 (Dranove). Higher HHIs can also make it "easier for firms to coordinate with each other to avoid head-to-head competition." Trial Tr. 11/28/16, 938:20–939:3 (Dranove). Under the *Horizontal Merger Guidelines*, a merger that results in an HHI above 2,500 with a change in the HHI of at least 200 points is presumptively anticompetitive. Trial Tr. 11/28/16, 939:11–21 (Dranove); HMG § 5.3. A market with an HHI greater than 2,500 is highly concentrated. Trial Tr. 11/28/16, 939:22–940:1 (Dranove); HMG § 5.3.

C. Market shares and concentration in the 14 Anthem states

141. The market shares and resulting concentration in the 14 Anthem states are presumptively anticompetitive under the *Horizontal Merger Guidelines* for both definitions of national accounts. Trial Tr. 11/28/16, 940:16–20 (Dranove). For the broader NA5 definition of national accounts that does not include the geographic dispersion screen, Anthem's share (combined with other Blues) is 41 percent, [redacted] Trial Tr. 11/28/16, 898:23–899:10, 941:11–17 (Dranove); PDX005 at 40.

142. For the stricter NA5G definition of national accounts that includes the geographic screen, Anthem's share is 40 percent, [redacted] Trial Tr. 11/28/16, 899:14–18, 941:11–20 (Dranove); PDX005 at 40. Further, without deciding whether ASO products alone constitute a well-defined market, Dr.

Dranove calculated that the market shares of Anthem and Cigna would be even larger using this measure, resulting in even larger post-merger HHIs and changes in HHI. Trial Tr. 11/28/16, 899:19–900:2, 941:11–24 (Dranove); PDX005 at 40.

143. Finally, *even if the Blues' shares were not aggregated*, the result of the merger would still put market concentration above the presumptive threshold in the Anthem states. Trial Tr. 11/28/16, 1169:10–17 (Dranove).

D. Market shares and concentration in the United States

144. The market shares and resulting concentration in the United States are also presumptively anticompetitive under the *Horizontal Merger Guidelines* for both of Dr. Dranove's definitions of national account customers. Trial Tr. 11/28/16, 991:22–992:14 (Dranove). For the broader NA5 definition of national accounts that does not include the geographic dispersion screen, Anthem's share (combined with other Blues) is 49 percent, [redacted], the post-merger HHI is 3,923, and the change in HHI is 832. Trial Tr. 11/28/16, 900:9–13, 991:22–992:14 (Dranove); PDX005 at 60.

145. For the stricter NA5G definition of national accounts that does include the geographic dispersion screen, Anthem's share is 49 percent, [redacted], the post-merger HHI is 3,883, and the change in HHI is 880. Trial Tr. 11/28/16, 900:14–22, 900:9–13, 991:22–992:14 (Dranove); PDX005 at 60.

V. THE MERGER WOULD SUBSTANTIALLY LESSEN COMPETITION FOR NATIONAL ACCOUNTS.

146. There are four "major" competitors for national account clients: Anthem, Cigna, Aetna, and United. PX0121 at -323; [redacted] Leonard (Consortium) 9/30/16 Dep. 17:2–11; Kilmartin (Mercer) 10/20/16 Dep. 122:15–17, 122:20–123:6 123:9–12; PX0259 at -678; Sharp (Aon) 10/6/16 Dep. 91:9–19; Guilmette 5/3/16 Dep. 186:3–9,

187:10–188:12; PX0221 at -488; *see* Monti (Kroger) 10/17/16 Dep. 34:10–35:7, 35:9–13; Kidd (Sodexo) 10/21/16 Dep. 20:21–21:8; Loring (Applied) 9/30/16 Dep. 28:18–21, 63:22–64:6; Record (Steel Dynamics) 10/19/16 Dep. 15:7–12, 37:2–5, 37:7. John Martie, formerly Anthem's president of national accounts and now president of integration for the Cigna acquisition, testified that the competitive landscape in the national accounts segment is "very" consolidated. Martie 4/28/16 Dep. 183:3–6, 183:18–25, 184:12–22, 185:14–186:10; PX0121 at -323 (showing that the national accounts market is already consolidated even without the Anthem-Cigna merger).

147. The market will be even more consolidated and national accounts will have even fewer options if Anthem acquires Cigna. *See* Martie 4/28/16 Dep. 190:10–191:25. [redacted] Aetna likewise evaluated this merger's impact on the national-accounts market and concluded: "Industry consolidation helps us." PX0117 at 24 (emphasis in original). Recognizing the limits of smaller competitors, Aetna predicted that after the merger, "[t]he big 3 players will share **85% of members**." PX0117 at 24 (emphasis in original).

148. Given the increased concentration, [redacted]

149. Dr. Dranove similarly concluded that "the merger will harm competition in the market for national accounts employers." Trial Tr. 11/28/16, 843:18–844:19 (Dranove). He

determined that the merger will harm employers headquartered throughout the United States, both in Anthem states and non-Anthem states. Trial Tr. 11/28/16, 844:20–845:1 (Dranove). The effects of this transaction could take a number of forms, including increased ASO fees, reduced quality, reduced service, and reduced innovation.

A. The merger would harm competition in the 14 Anthem states.

(i) Anthem and Cigna are particularly close rivals for national accounts.

150. In 2013, Anthem implemented a growth strategy that targeted just two insurers: Cigna and Aetna. Trial Tr. 11/22/16, 564:17–25, 575:24–576:7 (Kertesz). Before that, from approximately 2011 to 2013, Anthem's membership and profits were flat, and the company lost national accounts business. Trial Tr. 11/22/16, 564:17–565:5–7 (Kertesz). In 2011, Ken Goulet, then-president of Anthem's commercial business, wrote "I HATE losing to [Cigna]—we shouldn't—I look forward to getting back to winning!" PX0138 at -166.

[redacted] In 2012, Jerry Kertesz, vice president of new sales, stated that Anthem needed to be more aggressive and "Aetna and Cigna should not exist." PX0059 at -515. But Anthem was still reluctant to negotiate ASO fees with prospective customers. Trial Tr. 11/22/16, 562:4–14 (Kertesz). As a result, Anthem National Accounts' ASO fees generally were not competitive with those of other insurers. Trial Tr. 11/22/16, 561:11–14 (Kertesz); PX0048 at -711 [redacted] Also during this period, Anthem did not offer trend guarantees for new national accounts opportunities. Trial Tr. 11/22/16, 563:11–14 (Kertesz); *see* PX0048 at -712 [redacted]

a. Anthem offered trend guarantees to Cigna clients and monetary rewards to sales staff who won business from Cigna.

151. Anthem's two-part growth strategy involved offering trend guarantees to clients and "bounties" to its sales team. *See* PX0048 at -712; PX0049 at -0368. Anthem guaranteed a zero percent trend guarantee whenever the incumbent insurer was Cigna or Aetna. Trial Tr. 11/22/16, 575:24–576:7 (Kertesz); PX062 at -724. A trend guarantee caps the rate of increase of medical costs year over year and involves Anthem taking on some of its clients' medical risk. Martie 4/28/16 Dep. 138:9–25. Anthem was willing to take on more risk through a trend guarantee against Aetna or Cigna, but not United. Martie 4/28/16 Dep. 234:23–25, 235:5–236:16, 242:22–243:2. Anthem viewed this as a "very aggressive" tactic for competing against Cigna and Aetna. Trial Tr. 11/22/16, 577:7–17, 577:22–578:6 (Kertesz). Such guarantees are "extremely rare." Trial Tr. 11/21/16, 103:12–19 (Abbott). [redacted] Martie 4/28/16 Dep. 243:9–21, 244:2–20, 245:9–13. [redacted] Trial Tr. 11/22/16, 556:8–18 (Kertesz); PX0063 at -543.

152. [redacted] Martie 4/28/16 Dep. 173:6–174:2; *see also* PX0142 at -793-3 [redacted] PX0081 at -727 [redacted] PX0178 at -603–604 [redacted] PX0183 at -325–327, 333, 336–338 [redacted]

[redacted]

153. Anthem also implemented a "bounty program" to encourage its national accounts sales team to target opportunities in which Cigna or Aetna were the incumbent insurers. Trial Tr. 11/22/16, 580:20–581:13 (Kertesz); Martie 4/28/16 Dep. 260:2–10, 260:21–24, 262:11–25, 274:23–275:4. Anthem's intent was to "bury" Cigna and Aetna. PX0078 at -203. Sales representatives earned bonuses for winning business from Aetna and Cigna. Martie 4/28/16 Dep. 260:2–10, 262:11–25, 265:7–16; PX0049 at -368–369. Anthem did not implement a bounty program for any other insurer. Martie 4/28/16 Dep. 260:2–10, 260:21–24, 262:11–263:4; Trial Tr. 11/22/16, 580:20–581:13 (Kertesz). The bounty program was ultimately rescinded because Anthem concluded that it was easier to win business from Cigna and Aetna than it was to win business from United. Trial Tr. 11/22/16, 682:24–683:5, 683:12–14 (Kertesz); PX0143 at -549; Martie 4/28/16 Dep. 265:7–25; 272:14–275:6. Anthem's bounty program indicates that Anthem and Cigna compete in the same space, and that customers feel one could be replaced by another. Trial Tr. 11/28/16, 948:19–949:12 (Dranove).

b. Anthem and Cigna aggressively target each other today.

154. As of 2016, Anthem's national accounts segment continues to "aggressively target[]" Cigna customers through various financial incentives, including trend guarantees. Trial Tr. 11/22/16, 583:6–583:16 (Kertesz); PX0348 at -811; PX0140 at -662. [redacted]

[redacted]

4/28/16 Dep. 235:2–22, 236:5–16. [redacted]

[redacted] *See* PX0154 at -533 [redacted] -538–539 [redacted] Martie 4/28/16 Dep. 233:10–234:16. [redacted] PX0140 at -667.

155. [redacted]

c. Anthem and Cigna review enrollment and discount data to assess each other.

156. When Cigna bids on a national account, it receives a census file, which includes each employee's location, age, and gender. Trial Tr. 11/23/16, 719:10–13, 719:24–720:4, 722:7–14 (Thackeray). Cigna runs that information through its discount-comparison tool to determine how competitive it will be for the account. Trial Tr. 11/23/16, 722:15–723:19 (Thackeray). Cigna purchases the discount-comparison tool from Aon Hewitt, Trial Tr. 11/23/16, 723:5–13 (Thackeray), and looks specifically at the data from Aetna, United, and Anthem or the Blues to benchmark its own competitiveness for the account. Trial Tr. 11/23/16, 723:5–19 (Thackeray). Cigna does not compare its discounts to any other insurer's discounts. Trial Tr. 11/23/16, 723:5–24 (Thackeray).

157. For its part, [redacted] PX0065 at -303. [redacted] PX0065 at -303. [redacted] PX0065 at -303, 305. [redacted] PX0065 at -303, 305.

158. Cigna and Anthem sometimes received competitors' bid documents through a consultant that allowed them to gain insight into the competitors' bid strategy and better assess their competition. [redacted] PX0152 at -154, -156–436 [redacted] PX0388 at -253, -256 [redacted]; *see also* PX0349 at -866 [redacted]

d. Anthem and Cigna train their employees on how to win business from each other.

159. During 2015, at an annual training meeting for Anthem national accounts sales and account management personnel, Kertesz instructed his team to "be thinking about what we want to do to bury Cigna and Aetna. What is our strategy to take them out—claim big chunks soon." Trial Tr. 11/22/16, 581:15–582:11 (Kertesz); PX0077 at -877.

160. In 2015, Cigna likewise provided competitive intelligence training for its national account employees on Cigna's "top 3 competitors": Anthem, Aetna, and United. PX0231 at -302;

Drapkin 9/30/16 Dep. 378:10–18. *See also* PX0109 at -513, -514-1–514-18; Trial Tr. 11/23/16, 724:13–725:19 (Thackeray). The training on "Anthem and the Blues" offered guidance "to better …position Cigna against" a "top competitor." PX0109 at -513. Cigna's training characterized "Increasing Competition" from Anthem as a threat to Cigna. PX0109 at -514-5. Cigna also prepared a competitive-intelligence summary which assessed the "likely future moves" of Anthem, United, and Aetna. PX0270 at -115–117. [redacted]

e. Win/loss data demonstrates closeness of competition between Anthem and Cigna.

161. Dr. Dranove testified that win/loss data demonstrates that market shares understate the closeness of competition between Anthem and Cigna. In the normal course of business, insurers like Anthem and Cigna generate win/loss data that record the outcomes of RFPs. Trial Tr. 11/28/16, 951:5–18 (Dranove). Anthem uses SalesForce.com to track sales and win/loss data, which is the company's best source of win/loss data. Trial Tr. 11/29/16, 1282:10–14, 1284:1–1284:3 (Mathai). Broadly speaking, win/loss data is used to track account wins and losses and often captures information about the incumbent and ultimate winner. Trial Tr. 11/28/16, 951:19–952:4 (Dranove). Using this data, one can observe the frequency with which customers that previously purchased from one supplier switch to purchasing from another. Dr. Dranove analyzed Cigna's SalesForce.com data from 2011–2017, Anthem's iAvenue data from 2011–2013, and Anthem's SalesForce.com data from 2015–2017. Trial Tr. 11/28/16, 951:5–18 (Dranove).

162. Conditioning for incumbency, win-loss data shows that Anthem and Cigna are closer competitors than shares predict. This conditioning is appropriate because roughly [redacted]

[redacted] of accounts remain with their incumbent insurer. Kendrick 10/21/16 Dep. 64:5–10. If an incumbent loses, it is likely still one of the more highly ranked bidders for that contract. Trial Tr. 11/28/16, 952:5–12 (Dranove); *see, e.g.*, Loring (Applied) 9/30/16 Dep. 42:8–23, 43:1–45:20 (explaining that when Cigna won the Applied account, Anthem, the incumbent, was the only other finalist).

163. Based solely on market shares for national accounts in the Anthem territories, Anthem is predicted to win [redacted] of the contracts where Cigna is the incumbent and loses. Trial Tr. 11/28/16, 952:20–953:14 (Dranove); PDX005 at 46–47. Cigna's SalesForce.com win/loss data from 2011–2017, however, shows that Anthem wins [redacted] of such contacts, more than market shares predict. Trial Tr. 11/28/16, 952:20–953:14 (Dranove); PDX005 at 46–47.

164. Based on Cigna's market share for national accounts in the Anthem territories, Cigna is predicted to win [redacted] of the contracts when Anthem was the incumbent and lost. Trial Tr. 11/28/16, 953:25–954:8 (Dranove); PDX005 at 46–47. In reality, Anthem's iAvenue loss data establishes that Cigna wins [redacted] of such contracts, "again showing that Cigna was a closer competitor than just the market shares alone would indicate." Trial Tr. 11/28/16, 953:25–954:11 (Dranove); PDX005 at 46–47.

165. Shares predict that when Cigna wins an account, "[redacted] of the time they should win it from Anthem." Trial Tr. 11/28/16, 954:12–954:18 (Dranove); PDX005 at 46–47. But Cigna's SalesForce.com win data from 2011–2017 shows that when Cigna wins an account, about [redacted] of the time Cigna wins it from Anthem. Trial Tr. 11/28/16, 954:19–955:3 (Dranove); PDX005 at 46–47.

166. Based on Anthem's overall market share for national accounts in the Anthem territories, it is predicted to win [redacted] of the contracts when Cigna was the incumbent and lost. Trial Tr. 11/28/16, 952:20–953:14 (Dranove); PDX005 at 46–47. But Anthem's SalesForce data from 2015–2017 shows that, when Anthem wins a contract from an incumbent, Cigna was the incumbent almost [redacted] of the time. Trial Tr. 11/28/16, 954:21–955:3 (Dranove); PDX005 at 46–47.

167. Dr. Dranove concluded that because Anthem and Cigna are winning business from and losing business to each other more than shares predict, his HHI calculations and structural analysis actually understate the competitive significance of the merger because market shares understate the closeness of competition between the merging firms. Trial Tr. 11/28/16, 953:19–24 (Dranove).

168. Anthem's economic expert, Dr. Israel, concluded the opposite—that Anthem and Cigna are not particularly close rivals—but his analysis contains measurement errors that affect the results. Trial Tr. 12/2/16, 2269:16–2271:14 (Dranove). Most notably, Dr. Israel analyzed all commercial accounts to reach this conclusion, which is "not only the wrong market, but also the data set is just not populated as well. There's a lot of missing values which he treated as simply [meaning] Anthem wasn't present." Trial Tr. 12/2/16, 2271:20–2272:17 (Dranove). Focusing on the national-account bid data, which is the correct product market and has fewer missing values, "the relationship between Anthem's presence and Cigna's bid becomes statistically meaningful in exactly the way you would expect. Anthem's presence was associated with lower Cigna bids." Trial Tr. 12/2/16, 2271:15–19 (Dranove). By using an appropriate threshold for covered lives to focus on the national account product market, Dr. Dranove finds a statistically significant relationship between Anthem's presence and Cigna's bid, a relationship that Dr. Israel erroneously

claimed did not exist in the data. Trial Tr. 12/2/16, 2272:7–2273:24 (Dranove). Dr. Dranove also concluded that when focusing on ASO fees, Cigna's presence affected Anthem's bid. Trial Tr. 12/2/16, 2274:5–23 (Dranove).

169. Dr. Dranove also concluded that Dr. Israel's regressions analyzing the effect of Cigna's competitive presence on Anthem's bids suffer from measurement error. Trial Tr. 12/2/16, 2274:2–23 (Dranove). Dr. Israel's regression purporting to show no relationship between the relative differences in Anthem's and Cigna's discounts and their bids also suffers from measurement error and "attenuation bias." Trial Tr. 12/2/16, 2275:2–2277:11 (Dranove). The "measurement of discounts is very, very noisy. It's imperfect. And Dr. Israel commented himself on this." Trial Tr. 12/2/16, 2275:2–2277:11 (Dranove). After accounting for the measurement error by restricting the regression to Anthem's medical ASO fee, Dr. Dranove reveals a statistically significant relationship between the parties' relative discount differentials and their bids, demonstrating that Dr. Israel's analysis was not robust. Trial Tr. 12/2/16, 2277:20–2279:2 (Dranove).

170. Dr. Israel's regressions measuring the effect of Cigna's competition against Anthem also failed to account for contract terms like trend guarantees. Trial Tr. 12/2/16, 2130:20–24 (Israel). [redacted] PX0154 at -544. [redacted] PX0154 at -539.

171. Finally, Dr. Israel's win/loss calculations are biased because they included bidding results from after the merger announcement, when Anthem was using the merger to prevent Cigna from gaining business from it. Trial Tr. 12/2/16, 2126:10–2127:20 (Israel).

(ii) The merger would eliminate significant head-to-head competition between Anthem and Cigna.

172. Anthem and Cigna have continued to compete for national accounts clients since their merger was announced. *See* PX0224 (Cigna won the [redacted] account over Anthem in August 2015); Trial Tr. 11/23/16, 737:20–738:13 (Thackeray); Smith 5/5/16 Dep. 165:10–20; *see also* Trial Tr. 11/22/16, 583:9–16 (Kertesz). [redacted] Schell 10/12/16 Dep. 198:1–199:1. According to Jerry Kertesz, Anthem's vice president of new national accounts sales, Anthem will "continue to aggressively target Cigna in the national accounts segment" if the merger is not consummated. Trial Tr. 11/22/16, 583:17–20 (Kertesz).

173. This head-to-head competition is nothing new. [redacted] PX0346 at -198–199-2. [redacted] PX0346 at -199-2. [redacted] PX0346 at -199-3, [redacted] PX0346 at -199-4. [redacted] PX0346 at -199-4.

174. [redacted] *See* PX0175 at -616 [redacted] PX0322 at -260 [redacted] PX0190 at -186, PX0058 at -011 [redacted] PX0141 at -446–447

[redacted] PX0046 at -262–265 [redacted] PX0163 at -468 [redacted] Schell 10/12/16 Dep. 165:24–166:23. [redacted] PX0050 at -784, PX0044 at -919–920; Martie 4/28/16 Dep. 289:3–291:14.

175. [redacted] switched from Cigna to Anthem in [redacted] even though Cigna [redacted] PX0069; PX0052 at -711; PX0255 at -102; PX0051 at -634 [redacted] PX0052 at -711. [redacted] And Cigna and Anthem engaged in a "dogfight" over fees offered to [redacted] Trial Tr. 11/23/16, 733:12–734:15 (Thackeray); Guilmette 5/3/16 Dep. 75:7–76:24; PX0100. Cigna won the account even though Anthem's fees were [redacted] Guilmette 5/3/16 Dep. 76:25–77:9; PX0100; PX0234 at -646 (Cigna won not on price but for "the value we bring"). When trying to win [redacted] in [redacted], Anthem [redacted] to try and "eliminate Cigna and potentially more (or all) of Aetna from consideration." PX0174 at -466. *See also* PX0356 at -821.

176. [redacted] PX0047 at -078–80. [redacted] PX0045 at -500. [redacted] Schell 10/12/16 Dep. 189:4–190:16, 192:23–193:24, 195:19–197:18.

177. Anthem and Cigna also competed vigorously for the Applied Industrial Technologies account in 2015. Loring (Applied) 9/30/16 Dep. 44:16–45:20. Applied issued an RFP to Anthem, Cigna, United, and Aetna after nearly ten years with Anthem. Loring (Applied) 9/30/16 Dep. 16:3–10, 30:19–22, 31:15–18, 31:20–23. After notifying Anthem and Cigna that they were the finalists, Applied solicited revised bids from the two companies. Loring (Applied) 9/30/16 Dep. 42:8–23, 43:1–45:20. Cigna won the account [redacted] *see also* PX0172 at -510; PX0173 at -014. [redacted]

178. If Anthem acquires Cigna, Applied likely will have only two options, the merged entity and Aetna, because United's network could not meet Applied's requirements as of mid-2015. Loring (Applied) 9/30/16 Dep. 20:14–17, 64:4–6, 87:24–7. Loring explained that as a result

of the proposed merger, there will be "one less nationwide carrier that is in the marketplace, and therefore the ability for me to . . . bargain in good faith and negotiate in good faith with those carriers and have them fear what are others doing, there's only going to be [the merged Anthem-Cigna and Aetna]. And I'm sure as there's only two, there are a lot of people like me out there trying to buy national insurance. If those two always run into each other, they know exactly what's being offered. With three, it's a little more complex. Four it gets better. Five I like more." Loring (Applied) 9/30/16 Dep. 56:1–16. Loring further explained that trying to bluff insurers by claiming to have more options than he actually did would amount to negotiating in bad faith and not be effective. Loring (Applied) 9/30/16 Dep. 56:17–57:13, 57:16–58:3.

179. Three months before the merger was announced and facing significant head-to-head pressure from Anthem, [redacted] Trial Tr. 11/23/16, 734:18–737:17 (Thackeray); PX0256 at -889–891; PX0227 at-144–146; PX0229 at -617–620. David Guilmette, Cigna's president of global employer and private exchanges, wanted to win a piece of the [redacted]

180. Cigna competes with, and wins against Anthem and the Blues, even when it is at a discount disadvantage. *See* Trial Tr. 11/23/16, 730:11, 731:3–732:11 (Thackeray); [redacted] Trial Tr. 11/23/16, 732:15–733:9 (Thackeray); [redacted]

[redacted]

181. Anthem and Cigna also compete on service offerings. [redacted] PX0056 at -706; Schell 10/12/16 Dep. 187:23–188:22. [redacted] Cigna noted when competing for [redacted] against Anthem in 2015 that although it may not be able to compete with Anthem on price, "Anthem has not offered [redacted] 'anything like what Cigna does for coaching and engagement.'" PX0237 at -773. [redacted]

182. Cigna and Anthem compete head-to-head on private exchanges just as aggressively as when they compete off exchange. [redacted]

[redacted]

B. The merger will also harm competition throughout the United States.

183. The merger will substantially lessen competition for the sale of commercial health insurance to national accounts throughout the United States. Just as other Blue plans help Anthem win accounts headquartered inside the 14 Anthem states, [redacted] Anthem helps other Blue plans win accounts headquartered outside those states. *See supra* I.C.iii.c (The BlueCard system), I.C.iii.e (Consortium Health Plans).

184. In addition to the static and dynamic harm in the 14 Anthem states (which of course are part of the all U.S. market), the merger will also have additional harm unique to the non-Anthem territories. Trial Tr. 11/28/16, 990:12–991:2 (Dranove).

185. One form of harm unique to the all U.S. market is the loss of head-to-head competition for "ceded" accounts. Currently, Anthem competes for national accounts headquartered outside its service area through "cedes" from Blue plans. Bills 3/24/16 Dep. 84:25–86:11, 207:20–208:7; *see also, e.g.,* PX0136 at -181–182 (discussing a potential cede). Anthem

has obtained cedes to compete for national accounts in non-Anthem states where Cigna was the incumbent, such as [redacted]. PX0056 at -706–708 (showing that Anthem sought the permission of the Blue licensee in [redacted]); PX0135 at -312–315 (showing that Anthem sought the permission of the Blue licensee in [redacted], in part to compete against Cigna). The merger would eliminate head-to-head competition for such accounts. Trial Tr. 11/28/16, 992:22–993:13, 993:14–22 (Dranove).

(i) The merger would discourage Anthem from competing as aggressively with Cigna because Anthem profits when other Blue plans win.

186. Unlike Cigna today, when other Blues win an account, Anthem benefits both by earning BlueCard fees and by gaining additional host membership to use as bargaining leverage in provider negotiations. Anthem earns BlueCard fees when members of other Blues seek medical care within the Anthem states. Weber 10/18/16 Dep. 109:13–110:4, 272:1–3, 272:5–13; Bills 3/24/16 Dep. 231:21–233:4. In 2014 alone, Anthem earned [redacted] in BlueCard fee revenue from other Blue plans, Plante 6/16/16 Dep. 216:12–218:2; PX0148 at -981; PX0123 at -122; PX0208 at -902-32, and [redacted] in profit from BlueCard fees, only [redacted] than the [redacted] in profits that Anthem earned on its own national ASO business. PX0123 at -122. BlueCard fees are highly profitable as its revenue drops "[s]traight to [the] [b]ottom [l]ine," PX0037 at -812-5, and its direct expenses represent [redacted] of BlueCard revenue. Plante 6/16/16 Dep. 103:20–105:20.

187. Recognizing the potential profits at stake, Anthem has guidelines for rescinding cedes and developed a BlueCard pricing algorithm to estimate potential BlueCard fees from prospective accounts. *See* PX0129 (discussing the need to run a cede request through the "BlueCard pricing algorithms" to "estimate the BlueCard fees"). When Anthem rescinds a cede, Anthem forfeits the host fees from the other Blue without any guarantee that it will win the

account it now has received the right to bid on. Weber 10/18/16 Dep. 237:15–19, 237:21–238:1, 238:3–6, 261:2–262:19.

188. Consequently, before rescinding a cede, Anthem weighs the financial ramifications of host revenues versus the relative expense of writing a new account, Weber 10/18/16 Dep. 236:1–237:9, 238:7–25, 239:2; PX0037 at -812-5; PX0128 at -076, as it has concluded that in certain instances, it is more profitable for Anthem to renew a cede request and gain BlueCard fees than it is to pursue the account. PX0128 at -076. *See also* Trial Tr. 11/30/16, 1729:3–9 (DeVeydt). In one striking example, when evaluating a cede request from [redacted] PX0071 at -578. Another Anthem executive added, [redacted] PX0068 at -471.

189. Anthem believes that cedes to other Blues should only be rescinded [redacted] Weber 10/18/16 Dep. at 282:11–284:20, [redacted] PX0177 at -958.

190. [redacted] Pogany 4/29/16 Dep. 223:12–224:5. [redacted] *See* Pogany 4/29/16 Dep. 223:12–224:5; Pogar 3/30/16 Dep. 375:2–18 [redacted]

(ii) The merger would enhance coordination between Cigna and non-Anthem Blue plans.

191. If Anthem is allowed to acquire Cigna, Anthem will be in the untenable position of having to both collaborate and compete with other Blues. Blue CEOs serve together on the BCBSA board and often meet to discuss business issues. *Compare* Trial Tr. 11/21/16, 267:5–269:19 (Swedish) *with* Trial Tr. 11/21/16, 269:21–271:22 (Swedish); *see also* Trial Tr. 11/28/16, 998:19–1000:1 (Dranove) (Anthem receives competitively sensitive information about other Blues through the BCBSA). [redacted], PX0145 at -288, and it will continue to need the support of other Blues post merger to help maintain compliance with the best efforts rule, increasing its dependence on other Blues. Trial Tr. 11/30/16, 1425:8-1426:1, 1442:12-1443:24 (Schlegel); PX0134 at -234–235.

192. Thus, Anthem would not want to take actions post-merger that would threaten its relationships with the other Blues. [redacted] PX0134 at -234–235. [redacted] PX0145 at -298. [redacted] PX0187 at -586–590, PX176 at -531–534. [redacted] Bills 3/24/16 Dep. 296:2–297:14; PX0170 at 337–338. [redacted] Weber 10/18/16 Dep. 240:14–241:10; 241:12–23, 242:10–242:10, 243:1, 272:14–273:21, 274:3–275:5.

193. Following the merger announcement, Swedish also described other Blues as "Nervous Nellies" due to their concern about the deal. Trial Tr. 11/21/16, 258:24–259:7 (Swedish); PX0151 at -685. [redacted] PX0189 at -944. Swedish had in-person meetings with five Blue Plan CEOs, including the CEOs of HCSC and Florida Blue. Trial Tr. 11/21/16, 259:10–20, 260:21–261:5 (Swedish). According to contemporaneous e-mails, the first discussion point for these meetings emphasized that "the transaction makes Anthem a stronger player long-term, which advantages the Blue System overall." PX0195 at -792–93; PX0323 at -220–21.

194. [redacted] PX0038 at -347, [redacted] PX0132 at -589–590, Weber 10/18/16 Dep. 240:14–24, 241:8–10, 241:12–23; 242:10–24, 243:1, 266:13–267:7, 274:3–275:5. [redacted] PX0132 at -590. [redacted] PX0085 at -472.

195. Through its membership in the BCBSA, Anthem also has extensive contact with other Blue plans. Its employees participate on more than 70 work groups with other plans, including work groups dedicated to national accounts. *See* PX0204 at -425–439. Anthem's CEO,

Joe Swedish, is a member of the Association's board. Trial Tr. 11/21/16, 221:10–222:5 (Swedish). He also participates in several subcommittees, including one with eight other Blue CEOs that is responsible for overseeing the Association's national accounts program, Trial Tr. 11/21/16, 267:5–13 (Swedish); that discusses national accounts strategy, Trial Tr. 11/21/16, 267:23–268:17 (Swedish) (*confirming* Swedish 5/16/16 Dep. 172:15–18); and that shares "national account insights" Trial Tr. 11/21/16, 268:18–269:7 (Swedish). Swedish testified that given the sensitive and strategic issues that are discussed in these meetings, he would not want his competitors in attendance. Trial Tr. 11/21/16, 270:6–14 (Swedish). Yet, this merger results in that very situation: If the merger goes through, *he* will be Cigna's CEO, and he will be attending those meetings with the Blue plans that Anthem says it will purportedly be competing against. Trial Tr. 11/21/16, 270:15–23 (Swedish) (confirming Swedish's plans to attend the meeting); Trial Tr. 11/21/16, 263:10–19 (Swedish) (discussing one-on-one meetings with other Blue plans where the "overriding topic" was purportedly that Anthem would compete against them "in all markets with the Cigna brand").

196. Given this relationship, Dr. Dranove testified that the merger would likely enhance coordination between Cigna and non-Anthem Blue plans. Trial Tr. 11/28/16, 994:21–995:14, 1000:2–12 (Dranove). And given the centrality of national accounts to the BCBSA's business and the size of the Cigna brand, this conflict of interest cannot be resolved simply through firewalls, as Swedish suggests. Trial Tr. 11/21/16, 271:2–22 (Swedish). Indeed, Anthem views the other Blues as "comrades in arms" to help compete against non-Blues insurers. Pogany 4/29/16 Dep. 122:21–123:18. And just as Anthem has worked to help other Blue plans win national account business in the past—*see* Trial Tr. 11/21/16, 276:23–277:2, 277:17–279:12 (Swedish) (discussing Raytheon); PX0076; PX0055 at -347–348 [redacted]

[redacted] Anthem intends to continue offering that help if the merger goes through, Trial Tr. 11/21/16, 279:14–16 (Swedish)—reinforcing the inherent conflict of interest and the likelihood of coordinated effects in non-Anthem states.

197. Anthem's participation in Consortium Health Plans is another avenue for coordination post-merger. The Consortium allows over 20 Blue plans to work together to sell national business. *See supra* Section I.C.iii.e. After the merger, Anthem's CEO, Joe Swedish, will also become Cigna's CEO, thereby allowing Cigna to participate in the Consortium through Anthem, even though Cigna will be competing against other Blue plans in non-Anthem states for national account customers. *See* Trial Tr. 11/21/16, 270:15–19 (Swedish).

(iii) The Best Efforts rules would further exacerbate the merger's anticompetitive effects.

198. The Best Efforts rules imposed by the Blue Cross and Blue Shield licensing agreements further limit Anthem's ability to compete with the Cigna brand. *See* Trial Tr. 11/28/16, 996:16–997:8 (Dranove) (under the "Best Efforts" requirements, 80 percent of Anthem's local revenue needs to be Blue-branded, and two-thirds of Anthem's national revenue needs to be Blue-branded).

199. If the merger is allowed to proceed, Anthem intends to remain a Blue Cross and Blue Shield licensee. Trial Tr. 11/21/16, 223:15–21 (Swedish); Trial Tr. 11/30/16, 1423:2–7 (Schlegel). Anthem values its relationship with the other Blues and would not "consider leaving [the BCBSA] under any circumstances." Trial Tr. 11/21/16, 223:15–21 (Swedish). Thus, it will still be subject to the Best Efforts rules. Trial Tr. 236:20–23 (Swedish); *see also* PX0700 at -285–287.

200. Anthem has determined, however, that as soon as the merger closes, it will be in violation of these rules due to the amount of Cigna's (non-Blue brand) revenue and customers outside of the 14 Anthem states. Trial Tr. 11/21/16, 237:11–21 (Swedish); Trial Tr. 11/30/16, 1411:6–19 (Schlegel); PX0079 at -206 (estimating pro forma combination with Cigna results in only 52.9 percent Blue revenue on day one and estimating that to reach compliance, it would have to reduce its non-Blue "grossed up" revenue (adjusting for ASO business) by $13.8 billion). In the history of the BCBSA, no Blue "has, to date, fallen below the threshold of compliance. So this has not been something that anybody has gone through." Trial Tr. 11/30/16, 1426:18–1427:3 (Schlegel). Post-merger, Anthem would have to submit a Best Efforts compliance plan to BCBSA's "Brand Enhancement and Protection Committee"—headed by Blue CEOs—and if the committee approves, the plan will be referred to the entire BCBSA board for approval. Trial Tr. 11/30/16, 1425:4–1426:1 (Schlegel).

201. To get back in compliance, Anthem intends to rebrand as many Cigna accounts based in the 14 Anthem states as possible. Trial Tr. 11/21/16, 240:24–241:6, 241:20–21 (Swedish) (*confirming* Swedish 5/16/16 Dep. 135:24–136:7); Trial Tr. 11/28/16, 996:16–997:8 (Dranove); Trial Tr. 11/30/16, 1600:1–21 (Matheis). PX0125 at 33–34; PX0079 at -206 (Anthem estimated that to comply with the national Best Efforts rule, the combined company would need to [redacted]; *see also* Trial Tr. 11/22/16, 429:9–14 (Cordani). Another Anthem executive confirmed that "rebranding" Cigna customers into Blue-branded customers is high on Anthem's list of ways to come into compliance with the Best Efforts requirements. Trial Tr. 11/30/16, 1414:4–1415:24, 1417:9–22, 1429:19–1430:21, 1431:1–9 (Schlegel).

202. Anthem's intent to rebrand Cigna lives to Blue lives—nicknamed "Bias Blue"—will likely diminish Cigna's strength in the non-Anthem states by converting Cigna lives to Blue lives. Trial Tr. 11/22/16, 430:17–432:12 (Cordani). "Bias Blue" will reduce customer choice by "unwinding" the Cigna product. Trial Tr. 11/22/16, 434:5–435:5; 436:18–437:11; 499:19–500:17 (Cordani). "Bias Blue" would also make other Blue plans stronger, while making Cigna weaker. Trial Tr. 11/22/16, 432:13–19; 433:12–434:4 (Cordani); PX0014 at -764. Dr. Israel's opinions on the competitive effects of the merger do not account for the Blues' best efforts rules and what it will mean for Cigna's network. Trial Tr. 12/2/16, 2110:4–10 (Israel).

203. Anthem has noted that it has a period of two years to come into compliance. Trial Tr. 11/21/16, 238:24–239:5 (Swedish). Anthem's plan to comply with the Best Efforts rules, however, relies on projections by an executive who, admittedly, does not know how his plans will be implemented or whether they may be successful. Trial Tr. 11/30/16, 1427:16–1428:16 (Schlegel). Further, Anthem's plan to rebrand Cigna business in the 14 Anthem states creates additional problems, *see* Trial Tr. 11/22/16, 429:15–432:19 (Cordani); Trial Tr. 11/28/16, 996:16–997:24 (Dranove), and Cigna customers are already objecting to this change. In an e-mail to Christopher Hocevar of Cigna, [redacted], expressed concern about Cigna being rebranded under the Anthem brand. "I hope Cigna will continue to trade under this name and not be forced to take Anthem[']s," [redacted] wrote, "Cigna is too strong a company to limit your marketing to certain geographic areas." PX0099 at -119; *see also* Trial Tr. 11/22/16, 493:4–494:6 (Cordani).

204. Cigna clients and consultants have expressed concern about the future of the Cigna brand after the merger. *See* PX0098 at -487 ([redacted] told Cigna it was concerned about the merger in part because it appeared there was "serious friction between the parties if not

a lack of trust, respect and effective collaboration," and that the company did not invite Anthem to bid on their account because of concerns about Anthem's care management and technology); PX0105 at -038 (an Arthur J. Gallagher consultant informed Cigna that the merger announcement was "[h]orrible news" and she expected to be "pummeled with questions and worries."); PX0285 (Cigna clients raised "tough questions" about how their accounts would be handled after the merger, including what Cigna's future network would consist of, and whether they would retain the Cigna brand).

205. Assuming that Anthem rebrands Cigna to Blue, it is unclear what aspects of the Cigna product, if any, will be retained. Trial Tr. 11/30/16, 1429:25–1430:25 (Schlegel). Unless a company enters into separate contracts with Cigna and Blue-Anthem, once a company's headquarters is rebranded Blue, the entire company will likewise be rebranded from Cigna to Blue. Trial Tr. 11/30/16, 1433:1–1436:12 (Schlegel).

206. If Anthem fails in its efforts to comply with the Best Efforts rules, it could lose its Blue Cross and Blue Shield licenses, in which case it would lose its ability to operate under the Blue brands and would have to pay a [redacted] "re-establishment fee" (amount as of December 31, 2014) to BCBSA to fund the establishment of a new Blue plan in Anthem's territories. PX0704 at -27; PX0125 at 33–34; Trial Tr. 11/30/16, 1423:8–1424:2 (Schlegel). Anthem would also have to assist the new Blue taking over its service area. Trial Tr. 11/30/16, 1423:8–1424:2 (Schlegel); PX0704 at -27.

207. If rebranding Cigna business inside the 14 Anthem states is not sufficient to satisfy the Best Efforts rules, or if Anthem's current plan changes (at the objection of Cigna customers or for any other reason), Anthem's alternate route to compliance with the Best Efforts rules is to freeze or reduce Cigna revenue and customers outside the 14 Anthem states—a solution Anthem

has already contemplated and one that it has implemented in its past operation of non-Blue brands. *See* PX0079 at -208; PX0145 at -288. In a February 2015 presentation for Project Confluence, Anthem noted that "National Best Efforts Restricts Growth Post Compliance." PX0079 at -208. After achieving compliance with the national best efforts rule, "NewCo must manage total revenue growth to not outpace Blue revenue growth." PX0079 at -208. To maintain compliance, NewCo "can only grow $1 outside Blue states for every $2 growth inside the Blue states." PX0079 at -208. Compliance with the national best efforts rule would restrict "growth activities outside Blue states," including "[b]idding for Commercial accounts." PX0079 at -208.

208. If Anthem rebrands Cigna accounts Blue, Anthem may not be able to achieve the claimed benefits of the merger. Trial Tr. 11/28/16, 997:9–16 (Dranove). When Cigna loses lives its ability to collaborate with providers is diminished. *See* Trial Tr. 11/22/16, 430:12–16 (Cordani). Dr. Dranove testified that "as lives are bled from Cigna and become Anthem's lives, Cigna becomes a much less important player in the eyes of providers, and it might not have the ability to expand its collaborative care and other arrangements the way it's doing today." Trial Tr. 11/28/16, 997:9–24 (Dranove).

209. Anthem has not reevaluated its plans to comply with Best Efforts requirements since spring 2016 when Cigna stopped working on integration planning with Anthem. Trial Tr. 11/30/16, 1412:21–1413:22, 1431:25–1432:8 (Schlegel).

C. Anthem can profitably weaken the Cigna brand.

(i) Anthem modeled and determined it can profitably weaken the Cigna brand.

210. Anthem studied whether the acquisition "would still make economic sense" even if compliance with Best Efforts would require Anthem to limit Cigna's growth. Trial Tr. 11/30/16, 1444:20–1446:4 (Schlegel). Anthem called this approach "the constrained case," and it assumed

Cigna's growth would be reduced from eight percent to six percent. Trial Tr. 11/30/16, 1445:23–1448:9 (Schlegel). Anthem concluded that, even if Cigna's growth is constrained post-merger, the combined company would remain "[p]rofitable, and with very attractive growth prospects." Trial Tr. 11/30/16, 1448:12–19 (Schlegel).

(ii) Anthem has shown it can profitably weaken an acquired company: UniCare.

211. Anthem's acquisition and dismantling of UniCare provides an instructive parallel to the Cigna deal. In 2004, Anthem merged with WellPoint and gained a non-Blue commercial product called UniCare, which "was established to compete against other Blue plans outside of [Anthem's] 14 Blue states," just as Anthem intends to use the Cigna brand post-merger. PX0192 at -667; Trial Tr. 11/28/16, 1000:16–24 (Dranove); Trial Tr. 11/30/16, 1404:24–1405:1, 1449:13–21 (Schlegel); Trial Tr. 11/30/16, 1718:4–13 (DeVeydt). Anthem viewed UniCare as a good prospect for expansion due to its "innovative products" and "the technology and systems infrastructure in place to offer flexible administrative capabilities." PX0184 at -696-8.

212. But UniCare soon became part of a larger tension between Anthem (WellPoint) and the BCBSA and other Blue plans. *See* Trial Tr. 11/28/16, 1000:16–1001:9 (Dranove). One Anthem document describes the company as deciding to "[f]reeze UniCare expansion" in 2006 as part of a strategic focus to "[i]ncrease cooperation and WellPoint influence by improving WellPoint's relationship with BCBSA staff and other Blue Plans." PX0145 at -288. In a 2008 presentation for a meeting with Anthem's Executive Leadership Team (ELT), UniCare was described as "[a]ntagonistic to other Blues" such that retaining it would mean a "[c]ontinued adversarial relationship with the Blues," but selling it would "[e]liminate[] source of friction with other Blues." PX0202 at -8, -9, -18.

213. In 2008, Anthem announced that it planned to transition all remaining UniCare customers to Anthem or, if located outside Anthem's service area, to the local Blue plan, by April 1, 2009. PX0185 at -904. The stated reason for the change was a "highly competitive environment." PX0185 at -904. But, as Anthem admits, UniCare ultimately failed "due to lack of scale and the *abrasion with other Blues*." PX0041 at -715 (emphasis added); PX0042 at -410–411; *see also* Trial Tr. 11/29/16, 1221:14–24 (Kendrick); Trial Tr. 11/30/16, 1453:4–14 (Schlegel) (one reason to sell UniCare was to retain "[p]ositive to relations with HCSC and other Blues plans."); PX0186 at -627 (internal UniCare memorandum stating Anthem was "[t]ransitioning Unicare business to Anthem in Blue states so as not to compete against ourselves.").

214. Compared to Cigna, UniCare was "virtually unknown," yet its presence in the non-Anthem states was sufficient to cause abrasion with the Blues. Trial Tr. 11/30/16, 1721:11–1722:8 (DeVeydt). Anthem's former CFO, Wayne DeVeydt, testified that competing with the Cigna brand in the non-Anthem states will likely have the same effect. Trial Tr. 11/30/16, 1718:17–20, 1717:25–1718:3 (DeVeydt).

D. The merger will reduce innovation throughout the country.

(i) Anthem and Cigna offer distinct value propositions to their customers.

215. Though Anthem and Cigna compete aggressively for national accounts, they have historically approached customers with differing value propositions.

a. Anthem's value proposition: low reimbursement rates

216. Anthem's value proposition has focused primarily on using its significant volume to achieve low reimbursement rates. When Anthem negotiates with providers, it does so with the strength of its own membership as well as the members of unaffiliated BCBS plans that live and reside in the area (i.e., BlueCard lives). Pogany 4/29/16 Dep. 89:1–19; Pogar 3/30/16 Dep.

299:14–300:13; PX0167 at -768; PX0166 at -700. In 2014, Ken Goulet, Anthem's then-president of Anthem's commercial business, wrote that [redacted] PX0367 at -321–322.

217. Anthem's larger market share gives it a significant advantage in negotiating provider rates. Pogany 4/29/16 Dep. 222:19–223:11; Kehaly 4/28/16 Dep. 75:18–76:25; PX0367 at -325 (noting that the BCBS system has a discount advantage in the majority of markets across the United States.); PX0109 at -514-5. Dr. Dranove agreed with a Cigna executive that, "Anthem's strategy is to provide a low-cost product or what they called a Wal-Mart approach." Trial Tr. 11/28/16, 979:23–980:18 (Dranove).

218. Having focused primarily on maintaining the lowest rates, however, Anthem has struggled to innovate successfully, and has lagged behind other national insurers. PX0109 at -514-7–514-8. Cigna observed that Anthem's "[c]ustomer-centric shift has been slow"; among factors contributing to this slowness, Cigna noted that certain technologies were missing and that Anthem had a "[h]istory of claim and customer-service issues." PX0109 at -514-7. As of May 2012, though Anthem (then Wellpoint) was [redacted] PX0157 at -344–16. [redacted] PX0157 at -344–16.

b. Cigna's value proposition: innovation to reduce the total cost of care

219. To compete with Anthem's provider rates, Cigna has focused on innovation. Dr. Dranove testified that "collaborative accountable care, working interactively, kind of a true collaboration between insurer and provider, that's new and exciting. It's something that Cigna was in on the ground floor on a decade ago." Trial Tr. 12/2/16, 2302:10–22 (Dranove).

220. Cigna is innovating because it cannot compete and grow its business using provider discounts alone. Trial Tr. 11/28/16, 968:16–22 (Dranove). When David Cordani became Cigna's CEO, he determined that Cigna had an incentive to innovate; evidence suggests this strategy has been successful. Trial Tr. 11/28/16, 984:6–21 (Dranove). Competition was important in driving Cigna's innovation. Trial Tr. 11/28/16, 984:22–985:5 (Dranove).

221. Even Anthem has recognized this. Anthem's head of provider contracting for national accounts testified that "if you don't have strong discounts, you need to either achieve strong discounts or be creative." Trial Tr. 11/30/16, 1668:20–1669:4 (Drozdowski). And Anthem has said that since it tends to "have the best overall discount position in the market . . . [its] competitors have a strong incentive to be more aggressive and flexible" with value-based programs as compared to Anthem. PX0374 at -168. Many competitors do not have the same discounts that Anthem has, and to compete they have to find other ways to bring value to customers. Trial Tr. 11/30/16, 1666:25–1667:11 (Drozdowski).

222. Because Cigna has typically not had the lowest reimbursement rates, Cigna has focused on "every lever" that could "drive savings and . . . control medical costs." Trial Tr. 11/23/16, 710:8–14, 712:16–21 (Thackeray); DX0324 at -237; PX0095. Those levers include programs on case management, programs focused on helping the chronically ill comply with their treatment plans, "[k]eeping the healthy and at risk from becoming sicker," and "[v]alue based partnerships with health care professionals and hospitals." DX0324 at -237; Trial Tr. 11/23/16, 711:8–712:21 (Thackeray). [redacted]

223. These efforts appear to have been working: Cigna's clients have achieved the lowest medical-cost trend among the four national insurers. DX0334 at 3; Trial Tr. 11/28/16, 771:9–772:11 (Smith). Through "medical management, health and wellness, chronic condition support . . . [and] pay-for-value" programs, Cigna removed $1.4 billion from its clients' medical cost trend over a three-year period. Trial Tr. 11/28/16, 775:6–15 (Smith); DX0334 at 11.

224. Cigna's efforts have also made it a strong competitor for national accounts. Trial Tr. 11/22/16, 406:19–407:21 (Cordani); Trial Tr. 11/23/16, 712:16–713:7 (Thackeray); Sullivan 10/6/16 Dep. 246:17–19, 246:22–25. Cigna "beat sales projections . . . for 2017 in the national account space." Trial Tr. 11/28/16, 781:20–782:7 (Smith). [redacted] believes "Cigna is the gold standard in the industry" and is "so far ahead of [A]nthem in many ways." PX0099 at -118–119.

225. If this merger is blocked, Cigna will continue to innovate, invest, and grow. Trial Tr. 11/22/16, 444:17–447:13, 454:6–8, 456:2–8 (Cordani). In fact, Cigna's CEO testified that the company would accelerate value-based care, and is well-positioned to do so. Trial Tr. 11/22/16, 445:4–24 (Cordani). For example, in January 2017 Cigna plans to launch a new product, SureFit, that will provide "a lot more flexibility at an individual level to take high performance clinical programs, collaborative accountable care relationships, take the network that works best for them with a lot of benefit flexibility." Trial Tr. 11/22/16, 445:25–447:8 (Cordani).

226. The following sections address in greater detail two areas where Cigna has been particularly innovative: provider collaborations and client and customer engagement.

(1) Provider collaborations

227. Cigna was one of the first national insurers to collaborate with providers. Trial Tr. 11/28/16, 979:23–980:18 (Dranove). Cigna was an early leader in transitioning from traditional

fee-for-service arrangements into value-based reimbursement arrangements. When Cigna presented the concept to investors in 2009, Cigna's CEO testified, "you could have heard a pin drop . . . because it was so different at that time." Trial Tr. 11/22/16, 389:14–390:7 (Cordani). Today, Cigna's provider collaborations are viewed as more robust and flexible than those of Anthem. Trial Tr. 11/28/16, 982:11–21 (Dranove).

228. Cigna currently has an organization-wide strategy to strengthen its provider collaborations, particularly through value-based reimbursement arrangements. Manders 6/2/16 Dep. 37:19–38:5; Evanko 3/29/16 Dep. 25:18–26:13, 28:6–30:8.

229. "78 percent of [Cigna's provider collaborations] showed improvements in quality under a pay-for-value model." Trial Tr. 11/28/16, 772:23–774:1 (Smith); DX0334 at 11. Cigna achieves this success by making available "an extensive amount of shared data" to physicians and rewarding them for "improvements in quality period-over-period and improvement in quality compared to their given market, their metropolitan area." Trial Tr. 11/28/16, 774:2–15 (Smith). Dr. Charles Smith, Cigna's chief medical officer for national accounts, believes that all physicians are asking for data about their patients, and that this is "an especially important component of the pay-for-value models." Trial Tr. 11/28/16, 774:16–24 (Smith). Cigna has more than "300 hospital collaborative and nearly 100 specialty collaborative, like oncology, orthopedics." Trial Tr. 11/28/16, 779:14–18 (Smith). Dr. Smith testified that these provider collaborations "are doing extremely well on their financial and quality metrics." Trial Tr. 11/28/16, 779:19–23 (Smith). Cigna has designed innovative provider collaborations in an attempt to take market share from Anthem. *See* PX0617 (Cigna internal e-mail noting that they "look forward to inflicting damage on the [redacted]" and that a former Cigna, now Anthem employee will "lose at [Cigna's] hand and lose he will. So it shall [be] written. So it shall be done.").

230. Cigna's investments in value-based arrangements with providers have been coupled with efforts to influence consultants and national accounts to look at and quantify the total medical cost, a measure which more accurately reflects Cigna's value proposition—and thus its efforts to compete. PX0588 at -426; Muney 4/6/16 Dep. 151:3–152:9. The consulting firms are beginning to support this new method of measurement. Trial Tr. 11/21/16, 96:10–97:1 (Abbott). And as the consulting firms have moved towards comparing medical insurers using risk-adjusted per member, per month measures, Cigna has been "supportive of the market moving in this direction because [it] feel[s] that [it] would fare well with this type of analysis." Trial Tr. 11/23/16, 708:15–709:14 (Thackeray).

231. Another way that Cigna has innovated is in rewarding providers for improving care. Cigna's chief medical officer, Dr. Alan Muney, explained that Cigna was an innovator in the market when it introduced a collaborative care arrangement where insurers pay providers for care coordination. Muney 4/6/16 Dep. 80:11–21. An important component of Cigna's collaborative care arrangements is a care coordination fee, Muney 4/6/16 Dep. 79:3–80:3, 80:11–21, 126:17–127:6, which participating providers can use to invest in infrastructure aimed at improving the quality and lowering the cost of care. Leopold 3/29/16 Dep. 80:7–81:25. In contrast with Cigna, Anthem negotiates its care coordination fee with providers on a case-by-case basis. Leopold 3/29/16 Dep. 56:15–59:6, 83:16–84:3.

232. Cigna has also been more willing to share data with providers. When discussing providers' need for [redacted] in connection with provider collaborations, Anthem recognized that Cigna has developed a [redacted] Anthem further recognized that Anthem is [redacted] PX0385 at -231–232.

233. Colin Drozdowski, Anthem's vice president of national provider solutions, and Dr. Israel both referenced Anthem's "Q-HIP" program, a pay-for-performance program, as an example of how Anthem is innovating. *See* Trial Tr. 11/30/16, 1634:8–16:37:17 (Drozdowski); Trial Tr. 12/1/16, 1976:20–1978:16, 2029:21–2030:2 (Israel); *see also* Trial Tr. 12/2/16, 2299:21–2300:5 (Dranove). Dr. Dranove views Q-HIP as an example where Anthem innovated in response to innovative competition from other health insurers. Trial Tr. 12/2/16, 2299:21–2300:22 (Dranove). And while Anthem and Cigna both offer pay-for-performance programs, Cigna continues to differentiate itself through innovation. Anthem's Q-HIP is "more of a top-down approach where Anthem has a set of measures" imposed upon providers. Trial Tr. 12/2/16, 2299:21–2300:3 (Dranove). Conversely, "Cigna's is more flexible" in that Cigna "will adjust their quality metrics more according to their interactions with providers." Trial Tr. 12/2/16, 2299:21–2300:9 (Dranove).

234. Deposition testimony from healthcare providers confirms these views. The CEO of New West Physicians testified that it has the best collaborative care relationship with Cigna because Cigna is "more open and more transparent" in sharing data. Benton (New West) 10/20/16 Dep. 23:2–7, 24:25–25:4. Cigna shares "invaluable" data that shows New West how it compares against national and market benchmarks relating to quality and efficiency. Benton (New West) 10/20/16 Dep. 25:5–26:13. Cigna has also worked with physicians to design reports New West considers "sophisticated" and "actionable." Benton (New West) 10/20/16 Dep. 35:20–36:20. In contrast, for New West, Anthem is "the worst" collaborative care partner because "they're not transparent." Benton (New West) 10/20/16 Dep. 25:5–8. Unlike Cigna, Anthem does not offer comparisons to national or market benchmarks, but only to Anthem's own internal benchmarks. Benton (New West) 10/20/16 Dep. 25:5–26:13. New West has tried repeatedly to explain to

Anthem that New West needs to be compared to "best-known medical practice[s]," rather than Anthem's internal measures. Benton (New West) 10/20/16 Dep. 25:5–26:17. Anthem's response: "Well, this is the way the contract works, and we can't change it." Benton (New West) 10/20/16 Dep. 26:14–23.

235. [redacted] With Anthem's Q-HIP program, by comparison, [redacted]

236. The former CEO of Southern New Hampshire Health System, a member of Granite Health, testified that Cigna shares claims data with Granite providers, and providers' ability to track and implement procedures to deal with high-risk patients enables lowered medical costs. Wilhelmsen (Southern New Hampshire Health System) 10/14/16 Dep. 40:2–41:6. Through this value-based collaboration with Cigna, Granite Health has benchmarked over 20,000 patients in four years, resulting in cost reduction and higher-quality care. Wilhelmsen (Southern New Hampshire Health System) 10/14/16 Dep. 45:24–46:20. Anthem, however, has not been similarly willing to provide claims data necessary for Granite Health to perform medical management. Wilhelmsen (Southern New Hampshire Health System) 10/14/16 Dep. 52:3–5, 52:7–16.

237. Cigna's Delivery System Alliances (DSAs) are another "very important development" that contrasts with the way other insurers have been working with providers. Trial Tr. 11/28/16, 975:19–23 (Dranove). DSAs are partnerships between individual healthcare systems and an insurer like Cigna. Trial Tr. 11/28/16, 976:19–24 (Dranove). DSAs involve sharing both

upside and downside risk to manage total population health. Trial Tr. 11/28/16, 977:4–15 (Dranove). DSAs promote "focused relationships between just Cigna and one provider at a time" and have "the potential to bend the cost curve." Trial Tr. 12/2/16, 2302:10–2303:14 (Dranove). Unlike Cigna's DSAs, Anthem's provider collaborations use the same value-driven form contract with multiple providers. Trial Tr. 12/2/16, 2302:10–2303:8 (Dranove).

238. DSAs are a joint-venture type of approach to a value-based relationship. Muney 4/6/16 Dep. 136:1–8. [redacted]

239. Cigna also has specialty collaborative care models in the pilot phase and patient care collaborations in the trial phase. Muney 4/6/16 Dep. 131:19–132:1, 132:22–133:11.

240. In contrast to Anthem's model, which focuses on patient-centered medical home arrangements and high-performance networks, Cigna Collaborative Care is "based on a collaborative model" and focuses on the "entire population." PX0109 at -514-9. Cigna's program is "based on proven overall program results – not cherry picked or pilots." PX0109 at -514-9.

241. In its bid for the [redacted] account, Cigna noted that it "was the first national Health Plan to receive NCQA [National Committee for Quality Assurance] Physician and Hospital Quality (PHQ) Certification of its program and its process [and] [i]n 2011 remained the only National Health Plan to achieve this certification for both physician and hospital quality." PX0152 at -235.

242. The trend towards value-based care is likely to continue regardless of any changes that might be made to the Affordable Care Act. Trial Tr. 11/21/16, 97:14–22 (Abbott).

243. Dr. Israel incorrectly claims that the merged firm will have more incentive to innovate. Trial Tr. 12/2/16, 2304:8–2305:19 (Dranove). The record shows that Cigna has a history of successful innovation despite its smaller size relative to Anthem. Trial Tr. 12/2/16, 2305:10–19 (Dranove). There is no evidence that Cigna needs more volume to facilitate more provider collaborations. As Dr. Dranove testified, "[d]espite Cigna's current size, it's very active in provider collaborations and is rolling them out all across the country. Size has been no obstacle." Trial Tr. 12/2/16, 2308:21–2309:5 (Dranove). And competition is crucial in driving these collaborations: "[t]he less competition, the less incentive to roll these [provider collaborations] out." Trial Tr. 12/2/16, 2309:6–9 (Dranove).

(2) Client and customer engagement

244. Cigna recognizes that most consumers "are not aware that behaviors and lifestyles have a large impact on [their] health outcomes." Trial Tr. 11/22/16, 393:11–23 (Cordani). In response, Cigna promotes customer engagement by focusing on awareness, incentives, and support programs. Trial Tr. 11/22/16, 393:11–394:9 (Cordani). This is another area where Cigna has used innovation to compete against other insurers like Anthem in important ways that would be lost as a result of the merger.

245. For example, Cigna collects "biometric indicators that people should know, health risk assessments, basic understanding of the behaviors and history, and then take[s] that information and share[s] it back with an individual to [help them] better understand what they could do to either stay healthy, lower their health risks, or improve their outcomes." Trial Tr. 11/22/16, 393:11–394:7 (Cordani). Indeed, Cigna sometimes offers free biometric screenings

"because we can prove that everybody's better off as a result of the screenings." Trial Tr. 11/22/16, 394:10–23 (Cordani).

246. Within the health insurance industry, Cigna was an early adopter of using a "Net Promoter Score" to measure customer satisfaction and obtain customer feedback. Trial Tr. 11/22/16, 395:13–396:5 (Cordani). While it is common for retail companies to measure customer satisfaction, Cigna's CEO testified "it's not so common in our industry." Trial Tr. 11/22/16, 395:13–396:5 (Cordani).

247. Cigna engages with its client's employees to improve health by developing programs that reward certain behaviors and educate employees about various health issues and management of chronic conditions. Guilmette 5/3/16 Dep. 103:8–104:24; Sullivan 10/6/16 Dep. 87:22–24, 89:2–7. Cigna works with employers to lower healthcare costs developing personalized plans based on the types of products that best serve the client's employee population and demographic profile. Sullivan 10/6/16 Dep. 89:2–90:12, 90:15–19.

248. Cigna's chief medical officer, Dr. Smith, testified that Cigna has been a "leader in helping members improve their health." Trial Tr. 11/28/16, 774:22–24 (Smith). Cigna curates over 100 mobile apps to help members engage to actively manage their health. Trial Tr. 11/28/16, 779:6–9 (Smith). Members can even "connect to Cigna's digital platform" through monitoring devices, such as Fitbit. Trial Tr. 11/28/16, 779:10–13 (Smith).

249. As noted above, Cigna distinguishes itself from other insurers by focusing on an employer's total medical costs rather than fee-for-service. Total cost of care is a "new and innovative" outcome-focused approach that seeks to measure the overall effectiveness of the healthcare system at managing the cost of healthcare services. *See* Sharp (Aon) 10/6/16 Dep. 107:17–25, 108:2–25, 109:2–4. This approach allows Cigna to promise lower aggregate costs

despite having lower discount rates because it is easily integrated into Cigna's customer engagement, personalized programs, and collaborative arrangements system. Trial Tr. 11/23/16, 713:1–7 (Thackeray); Trial Tr. 11/28/16, 781:20–782:7 (Smith); Welch 4/29/16 Dep. 191:2–193:1; PX0243 at -075–076; Manders 6/2/16 Dep. 267:15–21; PX0374 at -168.

250. Cigna backs up its promises to improve population health by taking on risk in the form of performance guarantees. Welch 4/29/16 Dep. 194:18–195:5.

251. Cigna's commitment to client and customer engagement helps employers manage their total medical cost by keeping more employees healthy and thus reducing service utilization rates. *See* Sullivan 10/6/16 Dep. 87:5–11, 87:14–21; Mascolo (Wells Fargo) 10/20/16 Dep. 104:7–106:3; Bailey 4/12/16 Dep. 51:20–52:5. Its "message is being very well received" and Cigna "beat sales projections . . . for 2017 in the national account space." Trial Tr. 11/28/16, 781:20–782:7 (Smith); *see* Welch 4/29/16 Dep. 198:19–200:13.

252. As an example, a discount-based analysis for one employer would recommend slicing the Cigna-employee account to [redacted], for an annual savings of [redacted]. PX0095 at -138; Trial Tr. 11/23/16, 715:14–21 (Thackeray). However, Cigna's innovative programs more than made up for the unit-cost differential, leaving Cigna as the low-cost insurer from a total-cost perspective. PX0095 at -138; Trial Tr. 11/23/16, 715:22–716:9 (Thackeray).

253. One Cigna customer, a large global financial service company, saved 17 percent on its medical costs for the employees covered by Cigna when it dropped two lower-discount insurers, including Anthem. PX0095 at -140-4; Trial Tr. 11/23/16, 716:19–22, 717:5–718:9, 718:13–719:6 (Thackeray).

(ii) Like Cigna, Anthem relies on innovation to compete, when it is disadvantaged on provider rates

254. In Colorado, where Anthem considered itself to have a provider rate position that was similar to that of Cigna's and United's, Michael Ramseier, Anthem's president and general manager of Anthem Blue Cross Blue Shield in Colorado, proposed that "[i]n order to win…we need to transform from a commodity to a value leader." PX0373 at -316. According to Pam Kehaly, Anthem's president of the west region, Anthem's decision to enter into a profit-sharing arrangement in Aurora, Wisconsin, was similarly motivated by a tough competitive environment and Anthem's desire to increase its market share. Kehaly 4/28/16 Dep. 170:8–19, 171:11–14. Kehaly also testified that Anthem looks for creative ways to acquire membership when it lacks a clear price advantage. Kehaly 4/28/16 Dep. 82:4–11.

(iii) Cigna's innovations drive Anthem to innovate.

255. Anthem conducts [redacted] Cheslock 10/12/16 Dep. 35:4–22.

256. Anthem makes strategic changes based on the success of its competitors. PX0048 at -711–713. In an e-mail exchange among Anthem executives in April 2012, [redacted]. PX0048 at -711. Anthem believed there was a need [redacted], including considering using [redacted] PX0048 at -712.

257. In [redacted], Anthem's vice president of national provider solutions recognized that while [redacted] PX0376. Anthem's vice president of national provider solutions

testified that in the last three or four years, Anthem has worked hard to improve its value-based initiatives. Trial Tr. 11/30/16, 1669:11–1670:14.

258. Anthem now tries to win business by highlighting innovative measures, particularly in provider collaboration. PX0174 at -484–485, 494; *see also* Trial Tr. 11/29/16, 1199:19–1201:25 (Kendrick) (describing Anthem's focus on innovation within national accounts).

259. In March 2016, Anthem continued to follow Cigna's innovation. Cigna coaching app, Coach, was [redacted]. PX0350 at -876–878. [redacted]. PX0350 at -881-001–007.

260. Anthem [redacted] notes that Anthem [redacted] PX0351 at -867–868.

261. Anthem's Enhanced Personal Health Care (EPHC) program is the "umbrella of Anthem's value-based offerings" in Anthem states. PX0109 at -514-9. EPHC is "[m]ainly comprised of PCMH arrangements for high risk population." PX0109 at -514-9. As of September 2015, EPHC covered 40 arrangements and 40 percent of the PCPs on Anthem's network. PX0109 at -514-9. Outside the Anthem states, Anthem offers Blue Distinction Total Care (BDTC), a network of HPNs. PX0109 at -514-6, 9.

262. Anthem's Blue Priority narrow network plans are considered part of Anthem's ACO offerings. PX0109 at -514-6. "Providers must invest in technology and infrastructure to participate" in these networks. PX0109 at -514-6.

263. Anthem was motivated to [redacted] PX0572 at -129. [redacted] Internal Anthem e-mails show that in May 2016, Anthem learned that [redacted] PX0572 at -130. Anthem spoke with [redacted] about [redacted] PX0572 at -129. [redacted]

264. In an e-mail from Anthem National Accounts executive John Hastings to Anthem executive Gary Earl recounting a meeting Anthem had had with [redacted], Hastings wrote: [redacted] PX0165. Hastings also noted that in order for Anthem [redacted] it will need to [redacted] PX0165.

265. Anthem has also developed its level-funded program in response to customer demand for Cigna's level-funded program. Trial Tr. 12/2/16, 2301:10–25 (Dranove); *see generally* Soumakis 4/13/16 Dep. 98:25–99:18, 100:23–101:11; PX0505 at -337; Kehaly 4/28/16 Dep. 55:10–19; PX0466 at -552; Brown (Arthur J. Gallagher) 10/14/16 Dep. 40:13–41:12, 41:14–15.

(iv) Cigna continues to innovate even though competitors have been able to catch up.

266. Cigna's innovations are often "payer agnostic," meaning Cigna innovates even though it recognizes non-Cigna customers also benefit. PX0683 at -447. For example, when Cigna enters into a provider collaboration that drives the provider "to practice care differently to yield a better outcome, as it relates to quality and affordability," that improved care will not be restricted to only Cigna customers. Manders 6/2/16 Dep. 170:12–171:13. Rather, Cigna continues to innovate even though it understands Cigna innovations "benefit all carriers" through improved health outcomes for all patients. Manders 6/2/16 Dep. 171:2–24.

267. In a presentation dated October 2014, Cigna acknowledges that "[a]lthough [it] does not enjoy the dominance it once held with respect to health and wellness, the company is still regarded as a leader and strong innovator in this area." PX0686 at -825-6. The presentation states that, for Cigna to win more business, "Cigna must strive to retain its lead as being the most innovative company and continue to introduce unique product/plan designs that no other carrier offers (e.g., Cigna's level funding product)." PX0686 at -825-7.

268. As one example of its efforts to retain its lead, internal Cigna e-mails indicate that in Colorado, Cigna was taking steps to provide data to its Collaborative Accountable Care organizations, which Anthem and United were already providing, to "remain competitive." PX0652 at -326.

(v) The merger will reduce competition between Anthem and Cigna to innovate.

269. In part, given the extensive efforts to innovate described above, Dr. Dranove concluded that the merger will lead to long-term "dynamic effects," including impacts on quality and innovation. Trial Tr. 11/28/16, 845:2–7 (Dranove).

270. If Cigna is acquired by Anthem, it will occupy a different position in the marketplace and have less incentive to innovate. Trial Tr. 11/28/16, 968:18–969:2 (Dranove). Innovation is risky and costly. Trial Tr. 11/28/16, 979:8–14 (Dranove). As explained above, Anthem has had less of an incentive to innovate than Cigna because it is the discount leader and had less market share to gain (because it was already in a strong position). Trial Tr. 11/28/16, 979:8–22 (Dranove). Although Anthem has innovated to some degree, to a large extent this has been in response to Cigna's innovations. Trial Tr. 11/28/16, 983:4–15 (Dranove).

271. Even in the best-case scenario, Cigna's next innovation may be lost in the event of a merger because the "incentive to innovate is muted." Trial Tr. 11/28/16, 980:23–981:9 (Dranove). But this best-case scenario may not be not realistic because the merged firm will struggle to maintain Cigna's collaborative relationships if the merged firm begins "shoving discounts down the throats of providers." Trial Tr. 11/28/16, 980:23–981:18 (Dranove). Provider collaborations may not survive if the merged firm drives down provider reimbursements. Trial Tr. 11/28/16, 985:6–19 (Dranove).

272. Differences in corporate culture could also prevent Anthem and Cigna from effectively combining their strengths. Trial Tr. 11/28/16, 985:6–19 (Dranove). Anthem is also a "large company that historically has been slower to innovate," and there is no indication that they "suddenly become fleet-footed." Trial Tr. 11/28/16, 985:6–19 (Dranove).

273. Anthem's "Bias Blue" integration strategy puts the innovation Cigna has brought to the marketplace at risk and reduces the ability for Cigna to innovate in the future. Trial Tr. 11/22/16, 441:2–14; 447:14–451:15 (Cordani). For example, David Cordani, Cigna's CEO, testified that if the merger goes through, Cigna's planned launch of its new product, SureFit, may not be successful in the non-Anthem states. Trial Tr. 11/22/16, 445:25–448:15 (Cordani). This is because "to the extent the Cigna client portfolio is largely migrated or transitioned to a Blue branded portfolio, then it would extract the lives outside of the 14 states that tie to those clients, then that would decrease dramatically the relationships I have with physicians, which would take my growing collaboratives and turn them into shrinking collaboratives." Trial Tr. 11/22/16, 447:14–25 (Cordani).

274. If Anthem invokes the affiliate clause, when renegotiating with providers, it will cause some provider abrasion. Trial Tr. 11/30/16, 1602:13–15 (Matheis). This might make it more difficult for Anthem to collaborate with providers in the short-run. Trial Tr. 11/30/16, 1607:8–23 (Matheis).

275. Industry participants are concerned about the potential loss of innovation. In preparing for a meeting with Anthem and Cigna about the company post-merger, Jim Winkler, chief innovation officer at Aon Health, wrote "I really think this transaction is bad for the marketplace, and bad for our clients (it kills innovation, and disrupts a lot of near term market progress)." PX0583 at -339.

276. Post-merger, Anthem's heightened market power will damage value-based arrangements with providers. Colin Drozdowski, Anthem's national provider solutions vice president, testified that provider collaborations are about being able to work together to win or lose as partners and require trust between providers and insurers. Trial Tr. 11/30/16, 1663:5–

1664:7 (Drozdowski). In an e-mail from October 2012, Drozdowski recognized that Anthem's [redacted] PX0374 at -168. Drozdowski's testimony confirmed that if Anthem is too aggressive seeking provider discounts, it can amplify tension with providers. Trial Tr. 11/30/16, 1666:6–9 (Drozdowski).

277. Anthem has testified that it can attain significant medical savings by moving Cigna customers to Anthem rates where Anthem rates are lower, and by moving Anthem customers to Cigna rates where Cigna rates are lower. Trial Tr. 11/30/16, 1482:14–1485:3 (Matheis). [redacted]

278. [redacted] PX0075 at -293. [redacted] PX0075 at -293–294. In declining the position, Wenners expressed concern that NewCo's planned approach to provider collaboration "will perpetuate existing challenges," that NewCo "will not be as effective or fast-moving" as was hoped. PX0075 at -293. To illustrate his concern, Wenners highlighted a recent example where Anthem had conflicting strategic plans to both introduce new forms of provider-collaborations on one hand, and on the other to "drop the hammer" on providers by negotiating better rates. PX0075 at -293–294. In addition, [redacted] PX0075 at -294. In one recent example, [redacted]

[redacted] PX0075 at -294. [redacted]

[redacted] PX0075 at -294.

279. New West Physicians, a primary care group practice, may withdraw from some of its value-based collaborative care arrangements if the insurers stop evolving their programs. Benton (New West) 10/20/16 Dep. 27:19–21, 27:23, 27:25–28:9. New West Physicians is more likely to continue working with "true partners," as opposed to insurers who have a "'[t]his is the way it is, take it or leave it' attitude." Benton (New West) 10/20/16 Dep. 27:25–28:16. At present, New West Physicians identified Cigna and United as the best candidates for continued value-based partnerships. Benton (New West) 10/20/16 Dep. 28:17–21, 28:23. New West Physicians also noted, however, that it lacks this "give-and-take" relationship with Anthem. Benton (New West) 10/20/16 Dep. 26:18–23, 28:25–29:10, 29:13.

(vi) The merger will reduce innovation by other insurers.

280. The incentive to innovate is reduced when fewer firms compete. Trial Tr. 11/28/16, 988:7–15 (Dranove). The merger will eliminate "one of the more innovative firms in the marketplace." Trial Tr. 11/28/16, 988:16–22 (Dranove). This will affect the ability of other firms to innovate because "insurers learn from each other. They adopt best practices." Trial Tr. 11/28/16, 988:23–989:5 (Dranove).

281. Health insurers learn from each other's innovations. *See* [redacted] Pogar 3/30/16 Dep. 271:25–272:16, 276:16–278:6. For example, in California, health insurers compete to offer the best value-based care programs. [redacted]

[redacted]

282. Similarly, in 2013, Anthem, Cigna, and United all approached New West Physicians about value-based care. Benton (New West) 10/20/16 Dep. 56:21–57:16. Aetna, as the most recent insurer to implement value-based care with New West in 2016, "learned from all the mistakes of the other carriers." Benton (New West) 10/20/16 Dep. 54:11–55:3.

283. Competition has been an important incentive for Cigna to enter into collaborative initiatives that help reduce total medical costs despite its unit disadvantages, and Cigna also competes against other insurers in the terms it offers providers for these value-based initiatives. *See supra* Section V.D.i.b. [redacted] Because the merger will reduce Cigna's and Anthem's innovations, *see supra* Section V.D.v, the merger will also reduce innovation by other insurers.

E. Economic testimony supports the conclusion that the merger will lead to substantially higher prices for many Anthem and Cigna customers.

284. Dr. Dranove testified that the merger will lead to "static harm" resulting in higher health insurance premiums and ASO fees. Trial Tr. 11/28/16, 845:2–7 (Dranove). Using a merger simulation, Dr. Dranove concluded that static harm in the Anthem states is $219.7 million. Trial Tr. 11/28/16, 959:24–960:18 (Dranove). He found static harm of $383.8 million using an Upward Pricing Pressure (UPP) analysis. Trial Tr. 11/28/16, 959:24–960:18 (Dranove). When

incorporating the fact that win/loss data suggests that Anthem and Cigna are close competitors, Dr. Dranove predicts $930.3 million in static harm using UPP. Trial Tr. 11/28/16, 959:24–960:18 (Dranove).

285. Even assuming all $515 million in claimed SG&A efficiencies are cognizable, Dr. Dranove predicts $153 million of static harm using a merger simulation, $319.5 million using UPP analysis, and $857.7 million incorporating the fact that win/loss data suggests that Anthem and Cigna are close competitors. Trial Tr. 11/28/16, 959:24–960:18 (Dranove).

286. Dr. Willig's claim that it is inappropriate to use market shares to access competitive effects in a market with differentiated products is not correct. Many industries in the United States involve differentiated products. Trial Tr. 12/2/16, 2256:19–2257:4 (Dranove). In differentiated products markets, "shares are a useful first step." Trial Tr. 12/2/16, 2256:19–2257:4 (Dranove). The next step under the merger guidelines is to test whether shares accurately portray the effects of the merger by conducting a diversion analysis. Trial Tr. 12/2/16, 2257:5–17.

287. Diversion analysis captures how often customers switch from one product to their next-closest substitute. Trial Tr. 12/2/16, 2280:5–21 (Dranove). Because national accounts are "trying to play the top bidders against each other," the impact of this merger occurs in situations where Anthem and Cigna are both among the top bidders. Trial Tr. 12/2/16, 2280:22–2281:12 (Dranove). This holds true for both sealed-bid and open-outcry auctions. Trial Tr. 12/2/16, 2283:5–2284:2 (Dranove). Economic auction literature proves that "there's an equivalency between all these different types of auction. Open outcry, sealed bid, they all generate roughly the same outcomes, and anything you might say about what makes one auction tick will apply to any other type of auction." Trial Tr. 12/2/16, 2283:6–2284:2 (Dranove).

288. Therefore, it is important to determine how often Anthem and Cigna are the top two bidders. Trial Tr. 12/2/16, 2280:22–2281:12 (Dranove). Anthem and Cigna track wins, losses, and incumbency in the regular course of business, but the win/loss data does not indicate how often they were the top two bidders. Trial Tr. 12/2/16, 2281:13–2282:16, 2285:12–18 (Dranove).

289. To identify how often Cigna was one of the top bidders when Anthem won, and vice versa, Dr. Dranove conditioned his analysis on incumbency by focusing on situations where the customer switched away from the incumbent. Trial Tr. 12/2/16, 2281:13–2282:16 (Dranove). This is reasonable because if Anthem or Cigna "bid and lost and they were the incumbent, they were more likely to be second and third than they were to be fourth or fifth." Trial Tr. 12/2/16, 2281:13–2282:16, 2285:12–24 (Dranove) ("the incumbent doesn't lose because it's not well-liked. It loses because somebody jumped over them.").

290. Because Dr. Israel fails to condition on incumbency, he treats every instance where Anthem or Cigna bid and lost as if it had finished second. Trial Tr. 12/2/16, 2281:13–2282:16, 2284:11–2285:2416 (Dranove). Dr. Israel's merger simulation model also incorrectly assumes that customers know the insurer's reservation price, which is not realistic. Trial Tr. 12/2/16, 2291:11–2293:10 (Dranove).

291. Nonetheless, even using the merger simulation relied on by Dr. Israel the merger is likely to have substantial static price effects absent efficiencies. Trial Tr. 12/2/16, 2285:12–2286:8 (Dranove). Both Dr. Dranove and Dr. Israel "predict there will be price effects in the absence of substantial efficiencies." Trial Tr. 12/2/16, 2295:17–20 (Dranove).

VI. ENTRY AND EXPANSION WILL NOT PREVENT THE MERGER'S LIKELY HARM.

A. United and Aetna would not prevent the merger's likely harm.

292. Although United and Aetna are both significant national insurers, their presence in the market is not sufficient to prevent the merger's likely harm.

293. While United has the second-highest market share in national accounts, PX0063 at -543, [redacted]

294. Aetna's national accounts business has also struggled. Between 2009 and 2015, Aetna lost two million national accounts members. Hayes (Aetna) 10/6/16 Dep. 94:23–96:15; PX0036 at -885; PX0356. During that period, Aetna experienced turnover in account management teams, failed to innovate, and did not properly explain costs to clients. Trial Tr. 11/28/16, 780:3–15 (Smith). Aetna's president of national accounts, Cain Hayes, testified that Aetna's losses allowed Anthem to expand its share of the national accounts segment. Hayes (Aetna) 10/6/16 Dep. 96:2–15; PX0036 at -885. The evidence suggests that Aetna's trajectory in the national accounts market remains pointed downward. [redacted]

B. Regional and local insurers would also not prevent the merger's likely harm.

295. Because of the limited geographic reach of their provider networks, regional and local health insurers are generally unable to compete with national insurers to serve as a national account's primary or exclusive plan. *See, e.g.*, Trial Tr. 11/21/16, 84:15–23 (Abbott); Kehaly 4/28/16 Dep. 30:18–31:3.

(i) Kaiser Permanente

296. Kaiser is located in California, Hawaii, Georgia, Colorado, the mid-Atlantic, and the Northwest. [redacted] Although Kaiser owns an ASO product, the vast majority of its membership is enrolled in its fully insured HMO products. [redacted] Kehaly 4/28/16 Dep. 68:10–13; Welch 4/29/16 Dep. 45:21–46:2. [redacted]

297. Accordingly, national accounts with locations beyond Kaiser's limited geographic footprint cannot look to Kaiser to serve as their exclusive health insurer. *See, e.g.*, Trial Tr. 11/21/16, 84:15–20 (Abbott) ("[B]ecause they, generally, have a limited footprint, they would be bidding on a portion."); [redacted] To ensure that all of its employees have in-network provider access, a national account that offers Kaiser generally must also offer a national health insurer. *See* [redacted] Trial Tr. 11/28/16, 944:21–945:14

(Dranove) (Kaiser is generally "not going to win [the] auction" for a national account's entire business).

298. Anthem and Cigna admit that Kaiser only sporadically and minimally impacts their national accounts businesses. Anthem's former president of national accounts, John Martie, estimated that, from 2011 to 2015, [redacted]. Martie 4/28/16 Dep. 11:7–14, 198:9–199:17. (For context, Anthem currently has approximately 550 national accounts clients. Trial Tr. 11/29/16, 1257:5–6 (Mathai).) Further, David Guilmette, Cigna's head of national accounts, testified that Cigna does not lose entire national accounts to Kaiser because Kaiser is unable to offer health plans in every location in which national accounts have employees. Guilmette (Cigna) 5/3/16 Dep. 113:12–114:3.

(ii) Harvard Pilgrim

299. [redacted]

The national insurers similarly dismiss Harvard Pilgrim as a competitor for national accounts. Anthem's ordinary-course documents characterize Harvard Pilgrim as a [redacted] PX0500 at -075. Aetna's head of national accounts, Cain Hayes, testified that he was unfamiliar with Harvard Pilgrim and could not recall any instance in which it competed with Aetna to serve as a national account's exclusive health insurer. Hayes (Aetna) 10/6/16 Dep. 211:24–212:23: 283:16–284:12.

300. [redacted]

(iii) Humana

301. Humana, despite being one of the largest health insurers in the country, no longer competes for new national accounts. Trial Tr. 11/28/16, 794:11–13 (Bierbower). As Randall Abbott testified, Humana is "not a national player with a network breadth and depth to fall in the national category." Trial Tr. 11/21/16, 109:22–110:6 (Abbott); *see also, e.g.*, Martie 4/28/16 Dep. 11:7–14, 199:18–200:4 [redacted]

(iv) Other regional and local insurers

302. Other regional and local health insurers likewise do not compete with Anthem, Cigna, United, or Aetna to serve as a national account's primary or exclusive insurer. Trial Tr. 11/28/16, 944:21–945:14 (Dranove).

303. ***Tufts.*** The former head of Anthem's national accounts business, John Martie, could not recall [redacted]. Martie 4/28/16 Dep. 11:7–14, 197:2–15. Neither could Aetna's president of national accounts. Hayes (Aetna) 10/6/16 Dep. 284:2–7.

304. ***Medical Mutual of Ohio.*** Martie (of Anthem) also could not recall whether Anthem [redacted]. Martie 4/28/16 Dep. 11:7–14, 196:10–197:1.

305. ***Provider-sponsored plans.*** Randall Abbott, of Willis Towers Watson, testified that his clients do not offer provider-sponsored plans as an option independent from a national health plan. Trial Tr. 11/21/16, 120:22–121:14 (Abbott). Instead, his clients may "access[] them through the major health plans." Trial Tr. 11/21/16, 121:1–2 (Abbott). That is, "several of the large national health plans" have brought provider-sponsored plans "into their network," and then offer those plans to national accounts "within the [national health plans'] network configuration." Trial Tr. 11/21/16, 121:3–10 (Abbott).

C. "Slicing" does not constrain national accounts pricing, and is increasingly disfavored by national account customers.

(i) Slicing is not a competitive constraint.

306. In general, employers that offer multiple health plans—sometimes called "slicing"—do so not to discipline ASO fees from any single plan, but rather, to provide employees in particular geographic locations an additional option. Trial Tr. 11/28/16, 837:7–18 (Bierbower); Guilmette 5/3/16 Dep. 134:2–6. In fact, Cigna's head of national accounts testified that he could not recall a single instance in which a national account adopted a slice approach to discipline ASO fees. Guilmette 5/3/16 Dep. 133:18–134:1, 134:7–15*; see also* Trial Tr. 11/23/16, 726:22–727:10 (Thackeray) (testifying that "ASO fees are not the driving factor" that causes a national account to slice).

307. Indeed, to the extent slicing impacts national accounts pricing, it may ultimately *increase* a national account's total ASO fees, due to the use of so-called "rating bands." When Anthem competes for a new account and "think[s] there's a chance" of winning only "a portion of the membership rather than all the membership," it provides "pricing that is segmented into rating bands." Trial Tr. 11/22/16, 546:5–12 (Kertesz). Such pricing amounts to a volume discount: the more members Anthem covers, the lower the fee. Trial Tr. 11/22/16, 546:13–20 (Kertesz). Cigna

uses the same approach. Trial Tr. 11/23/16, 726:22–727:8 (Thackeray). [redacted]

(ii) National accounts are consolidating insurers.

308. Over the past 20 years, there has been a trend among national accounts away from "slicing" and towards consolidation—that is, selecting a single major insurer with a national network. Trial Tr. 11/21/16, 78:11–79:19, 86:4–14 (Abbott); *see also* Trial Tr. 11/28/16, 807:17–24 (Bierbower); Trial Tr. 11/22/16, 590:23–591:3, 591:17–21 (Kertesz) (consolidation of insurers within the national accounts segment is happening in the marketplace); PX0063 at -556 [redacted]; PX0103 at -988 ("Even the slices have gone away over the years."); [redacted] Martie 4/28/16 Dep. 257:10–258:4; [redacted]

309. Cigna's CEO testified that slice business has declined due to the benefits of using a single insurer, Trial Tr. 11/22/16, 528:13–531:1 (Cordani), which allows an employer to obtain better discounts, lower administrative costs or premiums, and greater administrative simplicity. *See* Trial Tr. 11/28/16, 808:9–809:2 (Bierbower); *see also supra* Section II.C.ii.

310. The disadvantages to slicing include the "frictional costs" of managing additional data interfaces, communication materials, ERISA filings, contract negotiations, technology interfaces, and data security protections, as well as the risk of change and disruption. Trial Tr. 11/21/16, 71:2–72:3; 111:17–112:5 (Abbott). Anthem's head of new sales for national accounts,

Jerry Kertesz, explained that the "administrative requirements of slicing business, dealing with one carrier or two carriers, is a burden on the benefit representatives of a company. So it's easier to deal with one carrier than two, two carriers than three, three carriers than four." Trial Tr. 11/22/16, 589:6–19 (Kertesz). Accordingly, Kertesz admitted that "it's rare" for a national account "to offer more than two medical carriers" in a slice arrangement "unless [it is] very, very large." Trial Tr. 11/22/16, 588:2–12 (Kertesz).

311. Anthem has sought to hasten the trend toward consolidation. In 2014, Anthem implemented a strategic alignment bonus to incentivize the "total elimination" of Cigna, Aetna, and United from Anthem's existing national accounts and facilitate consolidation. Trial Tr. 11/22/16, 579:4–11 (Kertesz).

312. The trend towards consolidation was a factor in Humana's decision to exit the national accounts space because, when national accounts eliminated regional players in favor of a single national carrier, Humana—itself a regional player—was unable to compete. Trial Tr. 11/28/16, 807:17–808:13 (Bierbower).

D. Third-party administrators will not prevent the merger's harm to national accounts.

313. Third-party administrators work with brokers and employer groups to develop specific plan designs and adjudicate claims. Benedict 9/21/16 Dep. 28:25–29:2, 29:5–16. They typically do not own their own provider networks and instead must rent networks from other health insurers. *See* Trial Tr. 11/21/16, 117:8–25 (Abbott); Trial Tr. 11/22/16, 583:21–584:1 (Kertesz). TPAs whose primary rental networks are regional in scope would have a "very difficult" time competing for a national account. Schmidt (Meritain) 10/20/16 Dep. 121:15–18.

314. Three of the BUCA insurers rent their national provider networks to TPAs. Anthem rents its network—including access to the national BlueCard network—to TPAs. Trial Tr.

11/22/16, 584:2–4 (Kertesz). Cigna's national networks—the Open Access Plus and the PPO networks—are both offered to its TPA partners. Benedict 9/21/16 Dep. 30:11–20, 30:23–31:7. Aetna rents its network to certain TPAs. Hayes (Aetna) 10/6/16 Dep. 271:10–16. [redacted]

(i) National accounts generally do not use TPAs as their primary or exclusive health insurer.

315. Consultants testified that the vast majority of national accounts do not use TPAs, with Aon estimating that "[l]ess than 1 percent" of its 1,100 clients do so. Sharp (Aon) 10/6/16 Dep. 91:20–22; *see also* Trial Tr. 11/21/16, 116:13–25 (Abbott); Kilmartin (Mercer) 10/20/16 Dep. 167:1, 167:4–5; [redacted]

316. National accounts themselves confirmed that TPAs are not a competitive option for them. *See, e.g.*, Monti (Kroger) 10/17/16 Dep. 96:25–97:10, 97:12–13, 109:8–110:18; Record (Steel Dynamics) 10/19/16 Dep. 28:14–29:15, 29:17–18.

317. TPAs are not even offered as an option on the national private exchanges. *See* Trial Tr. 11/21/16, 187:10–20 (Abbott) (Willis Towers Watson's OneExchange); Sharp (Aon) 10/6/16 Dep. 47:6–9 (Aon's Active Health Exchange); [redacted]

(ii) National insurers typically do not compete with TPAs for national accounts.

318. Between [redacted], Anthem [redacted]. Martie 4/28/16 Dep. 11:7–14, 197:22–198:8. The head of Cigna's national accounts business knew [redacted] where Cigna lost a national account client to a TPA. Guilmette 5/3/16 Dep. 13:2–5, 13:16–19,

111:19–113:11. [redacted]

319. TPAs "infrequently" compete with Cigna, Benedict 9/21/16 Dep. 77:14–78:2, and Cigna tends not to bid on opportunities in which the customer is looking for a TPA or a TPA-like provider. Trial Tr. 11/22/16, 522:19–523:12 (Cordani).

320. When Anthem, Cigna, and Aetna rent their national networks to TPAs, they preclude those TPAs from competing against them for national accounts opportunities.

321. Anthem includes non-compete provisions in its TPA rental agreements. Trial Tr. 11/22/16, 584:8–14 (Kertesz). [redacted] *see also* [redacted] PX0534 at -441–442-5. (describing the Rules of Engagement between Anthem and [redacted]); [redacted]

322. TPAs that rent Cigna's network cannot use the network to compete for existing Cigna business. Novack 4/27/16 Dep. 78:14–23; [redacted] *see also* [redacted]

323. [redacted] Benedict 9/21/16 Dep. 187:5–17, 187:20–188:1. In some

instances, Cigna may even restrict a TPA's ability to bid on an account that is using another TPA, if that other TPA is using the Cigna network. *See* [redacted] If the employer is large enough, regardless of the incumbent insurer or network, Cigna reserves the right to prohibit some TPAs from quoting the account. *See* [redacted]

324. And TPAs cannot bid for an account where Aetna or another TPA administering the Aetna network is the incumbent. Espinoza (CNIC Health Solutions) 10/6/16 Dep. 90:5–9, 90:13–22, 90:25; *see also* [redacted]

(iii) National insurers and TPAs do not compete because they target different customer types.

325. TPAs do not typically target or serve national accounts. *See* Archer (HealthSmart) 10/20/16 Dep. 56:22–57:4, 74:20–22; [redacted] Rather, they generally serve smaller customers with fewer employees. *See, e.g.*, Archer (HealthSmart) 10/20/16 Dep. 32:23–33:8, 56:22–57:4 (HealthSmart Benefit Solutions, the nation's largest independent TPA, predominantly serves customers with 150 to 1,500 employees); Edwards (HealthSCOPE) 10/21/16 Dep. 104:19–21, 104:25–105:1 (HealthSCOPE's average client has between 500 and 1,000 members).

326. Cigna agrees. Through its Payer Solutions business, Cigna rents its network to TPAs, who then sell medical products to employer groups. Benedict 9/21/16 Dep. 18:17–19:16. The president of this business unit views "employer groups that prefer to buy through TPAs as

opposed to a carrier" as "a different buying group," such that Cigna "reach[es] a different customer base in general" via its Payer Solutions business. Benedict 9/21/16 Dep. 69:9–25, 70:3–9, 70:22–71:7; *see also* Benedict 9/21/16 Dep. 24:15–17, 24:20–25:11, 69:14–24 (Cigna Payer Solutions was "[d]efinitely not" merely replacing business that Cigna Direct was losing to TPAs), 71:8–11, 71:14–18 ([redacted] of Payer Solutions is new membership for Cigna).

327. The experience of other national insurers confirms that TPAs compete for unique niches of customers. [redacted] DX0026.

(iv) TPAs are generally unable to meet the needs of the typical national account.

a. TPAs do not offer a full suite of medical benefit and administrative services.

328. National accounts increasingly want a national insurer offering a full suite of medical benefit and administrative services. Over the past five to ten years, Aon's "clients have really focused on selecting carriers that can do . . . the full services . . . as opposed to having a network provider separate than [sic] an administrative provider." Sharp (Aon) 10/6/16 Dep. 91:20–25, 92:2–6.

329. TPAs are not a competitive option for a national account because they do not offer a full suite of medical benefit and administrative services. *See, e.g.*, Hayes (Aetna) 10/6/16 Dep. 272:6–20; 285:25–286:9; 287:20–288:1 (TPAs do not provide care management services); [redacted] (listing Anthem, Cigna, Aetna, and United as the primary insurers offering full-service plans to national accounts). [redacted]

[redacted]

b. TPAs cannot offer discount rates that are competitive with those of the national health insurers.

330. Because TPAs must rent provider networks from other health insurers, they are generally cost disadvantaged relative to the national insurers. *See, e.g.*, Trial Tr. 11/21/16, 117:8–25 (Abbott); Trial Tr. 11/22/16, 583:21–584:1 (Kertesz); [redacted] DX0017 at -404 (noting that United's proprietary network generally has better economics than a rental network); [redacted]

331. Employers' testimony confirms that TPAs are not competitive with the national plans because they offer weaker discounts. Steel Dynamics, for example, did not select Employee Plans LLC, a TPA, as a finalist in its insurer selection process in 2013 because the national insurers "could provide … a deeper discount and better claims processing." Record (Steel Dynamics) 10/19/16 Dep. 13:18–14:12, 14:17–19, 28:14–29:15, 29:17–18.

(v) The largest TPAs are owned by the Big Four insurers, so the benefits of any added competition from TPAs still largely accrue to the Big Four.

332. National insurer-owned TPAs are the largest in the United States. The nation's largest and second-largest TPAs, [redacted] and Meritain, are owned by [redacted] and Aetna, respectively. [redacted] DX0026 (UMR has

2.7 million members); Schmidt (Meritain) 10/20/16 Dep. 8:11–21, 8:23, 8:25–9:1, 11:20–25, 12:5–6, 81:3–9, 117:23–118:5, 118:8–10, 130:1–3; Hayes (Aetna) 10/6/16 Dep. 271:10–21; Benedict 9/21/16 Dep. 137:18–138:5. Cigna owns Allegiance, another TPA, and Qani, an insurer with a TPA business. Benedict 9/21/16 Dep. 20:10–14, 23:14–22.[2] Thus, any losses to TPAs would likely be largely recaptured by the BUCA firms through network relationships.

333. Any success of these insurer-owned TPAs cannot be generalized to other TPAs because those owned by national insurers receive a competitive boost from their preferential access to the insurers' provider networks. *See, e.g.*, Schmidt (Meritain) 10/20/16 Dep. 66:4–21 (agreeing that when United acquired a TPA, the TPA became "a more formidable competitor as against traditional insurance companies"). While independent TPAs pay national insurers an access fee to use their provider networks, UMR and Meritain use United's and Aetna's national networks, respectively, without paying a rental fee. Schmidt (Meritain) 10/20/16 Dep. 86:12–87:3, 129:19–130:8 (UMR has access to United's network "just like Meritain has access to Aetna's networks").

E. There are significant barriers to serving national accounts.

334. Defendants have failed to demonstrate that entry or expansion into the national accounts segment by other health insurers would be timely, likely, or sufficient to fill the competitive void left by the proposed merger. To the contrary, the evidence demonstrates that high barriers likely preclude any such entry or expansion.

[2] [redacted]

(i) Prerequisites to serving national accounts

335. *First*, an entrant would need to offer a provider network with a geographic scope sufficient to cover national accounts' employees throughout the country. This is because national accounts expect in-network providers where their employees live and work; out-of-network utilization results in no discounts. Trial Tr. 11/22/16, 538:2–8 (Kertesz). Anthem, for example, believes it "ha[s] an advantage when competing for very large national accounts due to the size and breadth of [its] networks." PX0125 at 51; *see also* Trial Tr. 11/28/16, 797:2–5 (Bierbower) (absent a sufficiently broad provider network, "employees would be going out of network and the costs would be higher for the employer").

336. Developing a provider network in a single market is no small task. Even for Humana—a major health insurer with 2015 revenues of about $55 billion, Trial Tr. 11/28/16, 793:17–22 (Bierbower)—developing a network in a particular geographic area may take an average of nine months to a year. Trial Tr. 11/28/16, 797:18–25 (Bierbower). [redacted]

337. *Second*, an entrant would need to offer competitive unit costs. Trial Tr. 11/28/16, 796:17–797:1, 799:22–800:4 (Bierbower). *See also* [redacted] As Beth Bierbower, president of Humana's group segment, explained, "if your discount isn't competitive comparable to the competition, then you can't win the case. The employer would be leaving too much money on the table." Trial Tr. 11/28/16, 800:2–4 (Bierbower). Indeed, Anthem believes it "ha[s] an

advantage when competing for very large national accounts due to . . . [its] ability to access the national provider networks of BCBS companies at their competitive local market rates." PX0125 at 51.

338. To obtain a competitive unit cost from providers, an insurer must have sufficient membership. Trial Tr. 11/28/16, 801:4–7 (Bierbower). In other words, an entrant must have sufficient patient volume with a particular provider to receive discounts from that provider comparable to those received by other insurers. [redacted] *See also* PX0378 at -704 ("[T]he more patients doctors and hospitals see from a carrier, the more leverage that carrier has to negotiate the best arrangements in the market."). Obtaining both membership depth and competitive discounts is a "chicken-or-egg" problem: "in order to have discounts, you need bodies, . . . but in order to have covered lives, you need to have discounts." Trial Tr. 11/28/16, 1004:17–1005:1 (Dranove). *See also* Trial Tr. 11/28/16, 800:16–801:7 (Bierbower); *cf.* Trial Tr. 11/30/16, 1721:19–22, 1733:20–1734:10 (DeVeydt) (explaining that UniCare failed to grow because it "just didn't have scale" sufficient to put programs in place and spread their costs across its membership).

339. An insurer cannot compete in the national accounts segment by simply renting provider networks from existing health insurers, such as Anthem, Cigna, Aetna, or United. According to Beth Bierbower, president of Humana's group segment, regional networks "just aren't effective at getting the deep-enough discount to have a competitive cost of goods." Trial Tr. 11/28/16, 798:4–11 (Bierbower).

340. *Third*, a new entrant would need to offer the necessary administrative services and a competitive ASO fee. *See* Trial Tr. 11/28/16, 801:12–802:3 (Bierbower). National accounts' requirements for customization and transparency tools, among other things, make such accounts

more expensive to administer than other customer types. *See* Trial Tr. 11/28/16, 803:1–11 (Bierbower). An entrant would need to spend hundreds of millions of dollars on technology. Guilmette 5/3/16 Dep. 269:12–275:11; PX0251 at -769–770.

341. *Fourth*, a new entrant could not compete for national accounts opportunities without surviving the national consultants' carrier identification and "vetting process." *See* Trial Tr. 11/21/16, 67:7–24 (Abbott). This is because consultants nearly always manage the RFP process for new national accounts opportunities, Trial Tr. 11/22/16, 549:17–21 (Kertesz), and because consultants generally work with their clients to identify which health insurers are "qualified" to compete for an opportunity. Trial Tr. 11/21/16, 67:7–24 (Abbott).

342. *Fifth*, an entrant would need to build brand awareness to compete for national accounts opportunities against well-established brands like Anthem. *See, e.g.*, Edwards (HealthSCOPE) 10/21/16 Dep. 113:18–19, 113:23–114:7 ("Members like having a name they recognize on their ID card . . . ."); Trial Tr. 11/21/16, 223:1–14 (Swedish) (stating that BCBS brands are well recognized and contribute to Anthem's "strong presence" in its 14 states); PX0494 at -295 ("[Anthem's] legacy, size and scale in each market have created a brand advantage that we enjoy today and that will play a role in fueling our growth moving forward.").

(ii) Humana tried and failed to compete in the national accounts market.

343. Humana is a large health insurance company with nearly $55 billion in annual revenues and commercial provider networks in approximately 29 markets in the United States. Trial Tr. 11/28/16, 792:21–793:1, 793:17–22 (Bierbower). Nevertheless, even Humana was unable to profitably compete for national accounts opportunities, and was forced to exit the national accounts market in 2013. Trial Tr. 11/28/16, 794:11–25, 803:13–17, 804:6–9 (Bierbower).

344. Humana was unable to compete in the national accounts segment because (a) its regional provider network was unsatisfactory to national accounts, Trial Tr. 11/28/16, 795:20–796:15 (Bierbower); (b) it lacked the necessary volume of membership to offer competitive unit costs to national accounts, Trial Tr. 11/28/16, 795:20–796:15 (Bierbower); and (c) it could not offer competitive ASO fees due to its low level of membership, Trial Tr. 11/28/16, 801:12–802:3 (Bierbower).

345. And the trend of "national accounts eliminating regional players and going with a single national carrier" made it "even less likely that Humana would have the opportunity to bid on national accounts because [its] geographic footprint isn't a national one. [It's] a regional player." Trial Tr. 11/28/16, 807:12–808:8 (Bierbower). At the time Humana decided to stop competing for national accounts, it was losing $40 million per year in its ASO business, which included national accounts. Trial Tr. 11/28/16, 803:13–804:2, 804:21–805:1 (Bierbower).

346. Humana has no reasonable basis to compete in the national accounts segment today. Trial Tr. 11/28/16, 805:5–7 (Bierbower). Even if, post-merger, the combined Anthem-Cigna were to raise prices to national account customers, Humana still would be unable to compete for national accounts opportunities. Trial Tr. 11/28/16, 805:8–14 (Bierbower).

(iii) Other local and regional insurers are unlikely to expand sufficiently to mitigate the transaction's anticompetitive effects.

347. [redacted]

348. [redacted]

[redacted]

349. [redacted]

350. [redacted]

351. [redacted]

[redacted] Many other regional insurers have no plans to expand. *See* Caldwell (Alliant) 10/17/16 Dep. 49:8–14 (stating that Alliant Health Plans does not plan to expand nationally or in any geography outside of Georgia); [redacted]

F. Multi-insurer private exchanges have not facilitated entry or increased competition in the national accounts segment.

(i) Background on private exchanges

352. Private exchanges are a distribution channel through which health plans may be offered for purchase by employees. *See* Trial Tr. 11/21/16, 115:2–11 (Abbott); *see also* Fontneau 3/31/16 Dep. 25:9–23 (describing private exchanges as a benefit administration platform sold as a package of goods and services to employers); Trial Tr. 11/28/16, 1006:19–1007:9 (Dranove) ("[P]rivate exchanges are just another form of distribution. As a result, they might make it more possible for other firms to come into the market or less possible for other firms to come into the marketplace. The evidence suggests that, if anything, the big four are more successful in the private exchanges than they are in the traditional marketplace.").

353. The national private exchanges are operated by Aon Hewitt, Willis Towers Watson, Mercer, and Buck/Xerox. Trial Tr. 11/23/16, 662:20–663:13 (Kertesz). The vast majority of national accounts that use a private exchange use one of the four national exchanges. Trial Tr. 11/23/16, 663:18–23 (Kertesz). If an employer chooses to use an exchange, its employees can

purchase health plans offered by the insurers that are enrolled in that exchange. Sharp (Aon) 10/6/16 Dep. 10:16–22.

354. Cigna and Anthem currently offer health plans on the four major private exchanges. *See* Fontneau 3/31/16 Dep. 33:20–34:10; PX0125 at 6 (Anthem). The consulting firms that operate private exchanges do not "compete" with the national insurers. Instead, the consultants and insurers partner to distribute health plans to employees. Trial Tr. 11/28/16, 1006:19–1007:9 (Dranove); Trial Tr. 11/21/16, 114:20–115:9 (Abbott); Guilmette 5/3/16 Dep. 179:2–4, 179:13–180:18; *see also* Martie 4/28/16 Dep. 115:16–19, 115:23–116:10; Fontneau 3/31/16 Dep. 121:9–122:5.

355. Aon, Mercer, Willis Towers Watson , and Buck view the other private exchanges, not the health insurers, as their competitors. *See* Trial Tr. 11/21/16, 115:2–11 (Abbott); *see also* Trial Tr. 11/21/16, 114:20–23 (Abbott) (explaining that the Willis Towers Watson exchange's primary competitors are Aon, Mercer, and Buck); Kilmartin (Mercer) 10/20/16 Dep. 186:6–14, 186:16–17, 186:19–24; Burnell (Buck) 10/11/16 Dep. 22:6–8, 22:12–13.

356. Anthem and Cigna agree. *See, e.g.*, PX0125 at 6 (stating that Anthem "participate[s] in four large national consultant-led exchanges" and "believe[s] private exchanges will provide opportunities for growth"); Guilmette 5/3/16 Dep. 180:6–18 (observing that Cigna competes against the insurers on the private exchanges, and not against the exchanges themselves).

(ii) Private exchanges have not facilitated competition from regional or local insurers.

357. The national health insurers dominate national accounts opportunities in the on-exchange environment just as they do in the off-exchange environment. The mere availability of

the private exchange channel has not facilitated competition in the national accounts segment from regional or local insurers. On-exchange market shares demonstrate this.

358. Dr. Dranove reviewed evidence from [redacted] showing that "on their exchange the market shares of the big four are actually slightly bigger" than the overall market shares. *See* Trial Tr. 11/28/16, 1006:19–1007:9, 1007:19–24 (Dranove); [redacted]

359. Swati Mathai, an Anthem National Accounts sales executive, testified that of her national accounts clients that used private exchanges for the 2015–2016 cycle, 99 percent offered their employees health plans from only the national insurers: Anthem, Cigna, Aetna, and United. Trial Tr. 11/29/16, 1287:5–1288:1 (Mathai); DX0687 at -9–10. In 2014, Anthem told investors that it was "positioned to be the dominant player in the private exchanges." PX0494 at -308.

360. Anthem may very well have been correct, because a health insurer's discount advantage in the off-exchange environment carries over to the on-exchange environment. *See, e.g.*, Trial Tr. 11/22/16, 608:8–13 (Kertesz) (agreeing that to the extent an insurer is discount disadvantaged off-exchange, there is no reason to believe that the insurer could be in a more favorable discount position on-exchange); Trial Tr. 11/28/16, 810:21–24 (Bierbower).

361. For that reason, regional or local health insurers that are discount disadvantaged relative to the national insurers find it difficult to compete on-exchange. *See* Trial Tr. 11/28/16, 810:25–811:5 (Bierbower). The president of Humana's group segment, Beth Bierbower, testified that the presence of private exchanges "certainly didn't" improve Humana's ability to enter or compete in the national accounts space. Trial Tr. 11/28/16, 810:25–811:5 (Bierbower). By contrast, Anthem looks to benefit from growth opportunities by virtue of the private exchanges, PX0125 at 6, and indeed has been a net-winner in the on-exchange channel, Trial Tr. 11/22/16, 596:13–15 (Kertesz).

362. To the extent that employers see savings after joining a private exchange, those savings are not the result of increased competition among health insurers. In 2015, Anthem and its outside consultants undertook an extensive analysis of private exchanges. DX0100 at -501–519. Part of the analysis focused on the ways in which employers could save money by moving to a private exchange. Trial Tr. 11/23/16, 672:24–673:2 (Kertesz). The analysis concluded that only one percent of an employer's savings could be attributed to any additional competition that might come from multiple insurers being offered on an exchange, with most of the savings instead coming from benefit "buy down," where employees receive fewer benefits. Trial Tr. 11/23/16, 677:9–19 (Kertesz); DX0100 at -506.

(iii) Private exchanges do not constrain the pricing of off-exchange products.

363. Anthem and Cigna agree that the existence of the private exchange platform does not impact the pricing of off-exchange medical products for national accounts.

364. Jerry Kertesz, vice president of new sales for Anthem National Accounts, explained that "however I price over here"—i.e., in the off-exchange market—"really has no impact on what's going on within the private exchange. And however I price on the private

exchange has no impact on how I'm pricing in an environment where I'm responding to an RFP and being selected as one of—more than one carrier or just one carrier." Trial Tr. 11/22/16, 598:11–22 (Kertesz). *See also* Trial Tr. 11/22/16, 597:24–598:2, 598:6–10 (Kertesz); Martie 4/28/16 Dep. 277:7–278:4 (customer's interest or lack thereof in a private exchange is "irrelevant" to Anthem's ASO pricing).

365. In addition, where Anthem is competing for a national accounts opportunity, the fact that the national account is also considering moving to a private exchange does not impact the pricing of Anthem's off-exchange medical offering. Trial Tr. 11/22/16, 602:6–10 (Kertesz). This is because Anthem participates in the national exchanges and can serve the national account in either the on- or off-exchange channel. Trial Tr. 11/22/16, 602:11–22 (Kertesz).

366. [redacted]

367. Testimony from the consulting firms that operate the private exchanges supports the proposition that the presence of the private exchange platform does not affect off-exchange pricing. Randall Abbott, of Willis Towers Watson, was not aware of a single instance in which a large employer client moved to a private exchange because fees in the off-exchange market were too high. Trial Tr. 11/21/16, 217:19–22 (Abbott). Similarly, Tucker Sharp, Aon's chief global broking officer, was not aware of any client that would adopt the private exchange model in response to an increase in ASO fees. Sharp (Aon) 10/6/16 Dep. 125:18–25, 126:2–9. *See also* Kilmartin (Mercer) 10/20/16 Dep. 186:6–14, 186:16–17, 186:19–24 (explaining that Mercer does

not view the sale of health insurance off the private exchanges as a competitor of the sale of medical insurance on the exchanges).

368. Moreover, Jerry Kertesz of Anthem admitted that the private exchange business model may not be "viable" if insurers do not make money in that channel. Trial Tr. 11/23/16, 666:6–12 (Kertesz). If, as Kertesz suggests, private exchanges will only exist if they benefit the BUCA insurers, they cannot be a meaningful constraint.

(iv) Private exchanges have underperformed expectations.

369. National accounts have been slow to adopt private exchanges, and the channel's future is uncertain.

370. According to Anthem, "adoption levels" of private exchanges by employers "have been lower than analyst predictions." PX0125 at 6; Trial Tr. 11/22/16, 596:1–8 (Kertesz); *see also* [redacted] Mascolo (Wells Fargo) 10/20/16 Dep. 148:3–6, 148:8–18.

371. [redacted] Kehaly 4/28/16 Dep. 106:11–107:13. [redacted] Kehaly 4/28/16 Dep. 105:11–107:13; 109:13–110:14. [redacted] Kehaly 4/28/16 Dep. 105:11–107:13; 109:13–110:14.

372. Cain Hayes, president of Aetna's national accounts business, testified that he had not seen a significant increase in private exchange growth, and had "no reason to believe" that more than four percent of national accounts had adopted a private exchange for 2016. Hayes (Aetna) 10/6/16 Dep. 152:14–153:4; 235:15–22.

G. Direct contracting for the full range of medical services is rare.

373. Finally, the fact that a handful of national accounts contract directly with certain providers does not constrain national accounts pricing. There is no evidence that national accounts view direct contracting as a substitute for a national health insurer. Nor is there evidence that national accounts would likely—or even could—undertake the efforts required to establish direct-contracting arrangements to defeat a post-merger price increase. *See* Trial Tr. 11/21/16, 121:25–122:9 (Abbott) (an employer must have a very large concentration of employees in one geographic area to effectively contract directly with providers); Kilmartin (Mercer) 10/20/16 Dep. 187:19–188:6, 188:9–21 (health insurers drive better provider discounts "than any individual employer could obtain on [its] own"); [redacted]

374. Those national accounts that have established such arrangements continue to offer their employees a national health plan. [redacted] In other words, direct contracting is a complement to—not a reasonable substitute for—the national insurers' medical products.

375. Willis Towers Watson's Randall Abbott has recommended direct contracting to his clients "very rarely." Trial Tr. 11/21/16, 122:23–123:2 (Abbott). Direct contracting for specified medical procedures only, on a so-called "centers of excellence" basis, is much more common than contracting directly as a complete substitute for a national insurer. Trial Tr. 11/21/16, 124:4–16 (Abbott); *see supra* ¶ 116.

VII. ANTHEM'S PURPORTED EFFICIENCIES CANNOT SAVE THIS MERGER.

376. To even be considered, efficiencies must be cognizable. That is, efficiencies need to be verifiable, merger-specific, and relate to variable costs, and they cannot result from anticompetitive reductions in output or service. Trial Tr. 11/28/16, 1008:3–21 (Dranove); Trial Tr. 12/12/16, 2512:25–2513:17 (Quintero).

A. Anthem's medical-network savings are not cognizable.

377. Anthem's primary defense to this merger is that it will enable the combined company to achieve more than $2 billion in "medical-network" cost savings from the merger, Trial Tr. 12/1/16, 1831:3–5 (Israel), and that these savings will be passed through to employers. Trial Tr. 12/1/16, 1831:10–12 (Israel); PX0299 at -554-6, -23; Trial Tr. 11/22/16, 441:15–25 (Cordani). The purported source of these savings stems from the merged firm's "best-of-best" discounts from medical providers. PX0299 at -554-6; Trial Tr. 11/22/16, 442:3–11 (Cordani). The best-of-best discount is the lower of Anthem or Cigna's reimbursement rates for common providers. Trial Tr. 11/30/16, 1482:13–1483:22 (Matheis). Anthem contends that if Anthem is currently paying a lower reimbursement rate than Cigna, post-merger both Anthem and Cigna will pay Anthem's current rate. PX0299 at -554-6; Trial Tr. 11/22/16, 442:3–11 (Cordani). Further, if Cigna is currently paying a particular provider a lower reimbursement rate than Anthem, post-merger both Anthem and Cigna will pay Cigna's current rate. PX0299 at -554-6; Trial Tr. 11/22/16, 442:3–11 (Cordani). As Dr. Dranove testified, however, these savings are not cognizable efficiencies that will outweigh the resulting harm from the merger. Trial Tr. 11/28/16, 845:18–22 (Dranove).

(i) The claimed medical-network cost savings are not verifiable.

378. Defendants' claimed medical-network cost savings are speculative and unreliable. Trial Tr. 11/28/16, 1009:22–1011:16 (Dranove). Dr. Israel assumes that the merged firm will close 100 percent of the discount gap between Anthem and Cigna for 100 percent of the overlapping providers in their networks. Trial Tr. 12/2/16, 2097:14–21 (Israel), Trial Tr. 12/2/16, 2311:2–24 (Dranove). This is not a reasonable assumption for several reasons.

379. First, Cigna itself has recognized that not all providers will agree to Anthem's plan. Alan Muney, Cigna's chief medical officer, thought the estimates represented "nirvana" and questioned their validity. PX0716 at -769 [redacted] PX0717 at -372 [redacted] PX0722 at -201 [redacted] In fact, Muney had concerns about McKinsey's overall ability to help with the integration effort: [redacted] PX0714 at -729.

380. Second, as Cigna's CEO, David Cordani, testified, cost-saving calculations based only upon medical-network discount comparisons are inaccurate because they do not account for utilization or service mix. Trial Tr. 11/22/16, 441:15–444:15 (Cordani). *See* Trial Tr. 12/1/16, 1858:9–17, 2077:7–2079:1, 2088:23–2090:8 (Israel) (noting that Dr. Israel's analysis is a claims-based unit cost analysis that does not account for utilization). The best-of-best methodology "calculates a discount where none exists," and adds these errors up. Trial Tr. 12/2/16, 2327:15–2328:1 (Dranove). They do not "cancel out," as Dr. Israel suggests. Trial Tr.

12/2/16, 2327:15–22 (Dranove); Trial Tr. 12/12/16, 2530:20–2531:8 (Quintero). For example, many asthmatic patients do not use their controlling therapies and end up in the emergency room when they have an asthmatic attack. Trial Tr. 11/22/16, 442:19–443:25 (Cordani). Cigna's utilization management initiatives seek to keep patients out of the emergency room in the first place by keeping them on controlling therapies. Trial Tr. 11/22/16, 442:19–443:25 (Cordani). In a discount calculation, if Anthem had a larger apparent discount for the emergency room service, it would appear to be a savings. Trial Tr. 11/22/16, 442:19–443:25 (Cordani). But if Cigna's clinical program keeps the patient on controlling therapies, the costs associated with the emergency room visit never materialize. Trial Tr. 11/22/16, 443:12–16 (Cordani). Yet, Dr.'s Israel's methodology includes as cost savings instances where what would be eliminated was the bonus payment an insurer made to a provider for reducing the need for additional health care procedures. Trial Tr. 12/1/16, 2111:9–2116:10 (Israel) (discussing PDX017).

381. The large majority of the claimed savings from moving Cigna customers to Anthem rates derives from providers where the calculated discount was more than 25 percentage points in Anthem's favor. Trial Tr. 12/12/16, 2529:2–6 (Quintero). It is unlikely that the true difference in their contract terms is that large in that many cases, suggesting the difference is more attributable to randomness in the claims mix or legacy contracts. Trial Tr. 12/12/16, 2529:11–18 (Quintero). The cost-savings calculations should have been a "starting point for going down to the contract level to see if Anthem's discount is really that much greater" but was never done. Trial Tr. 12/12/16, 2529:19–23 (Quintero).

382. Third, Anthem's approach for achieving these savings simply does not line up with its own business model. Anthem's CEO Joseph Swedish testified that Anthem no longer focuses solely on discounts—what is sometimes referred to as a "pure discount mentality," or "dropping

the hammer," *see* Trial Tr. 11/21/16, 287:21–23 (Swedish); PX0075 at -293–294, -301. Swedish waivered in his commitment to the best-of-best strategy, suggesting only that it "could happen over time." Trial Tr. 11/21/16, 294:10–11 (Swedish); *see also* Trial Tr. 11/21/16, 294:11–13 (Swedish) ("The fact is that we may not pay less"). If Anthem does not achieve the lower rate for every provider, Dr. Israel's calculations will "fall[] in proportion to how far [Anthem] fall[s] short [in] converting providers." Trial Tr. 12/2/16, 2312:16–21 (Dranove).

383. Indeed, Anthem has recognized that in the past it has had "two, conflicting strategies—collaborate in new models on the one hand, and 'drop the hammer' on the other." PX0075 at -294, -301. And it is "a matter of economics that if [Anthem] tr[ies] to push [Anthem's] rates on to Cigna's existing providers, it could interfere with collaborative relationships that have currently been established and ultimately reduce the quality of the product. [Dr. Israel] didn't factor that into his analysis." Trial Tr. 12/2/16, 2313:5–9 (Dranove).

384. Anthem lacks a strategy for achieving the claimed cost savings. *See* PX0089 at -894 -2, 3, 5, 7. To capture savings from moving Cigna customers to Anthem's provider rates, Anthem at times has suggested that it could: (1) apply affiliate language in Anthem contracts to Cigna customers; (2) sell products which access Anthem discounts to Cigna customers ("rebrand"); (3) recontract with providers; or a combination of the three. Trial Tr. 11/30/16, 1598:17–22 (Matheis); Trial Tr. 11/30/16, 1670:21–1671:7; 1672:3–24 (Drozdowski); PX0089 at -894-2. Anthem has not decided on a strategy, Trial Tr. 11/30/16, 1598:23–1599:6 (Matheis) ("As we sit here today, that is work that we need to complete"); Trial Tr. 11/30/16, 1671:2–24 (Drozdowski), and cannot do so without Cigna's cooperation. Trial Tr. 11/30/16, 1672:25–1673:11 (Drozdowski). Each of these strategies have unaddressed weaknesses and limitations. PX0089 at -894-3, 5. For example, Anthem does not know which providers will be selected to apply the

affiliate clause, Trial Tr. 11/30/16, 1671:8–24 (Drozdowski); and even if Anthem tries to unilaterally exercise its affiliate clause, it would face several challenges because providers have already started to reject these clauses, PX0713; Trial Tr. 11/30/16, 1679:7–19 (Drozdowski); and many provider contracts also give providers the ability to terminate their contract with Anthem, potentially forcing a renegotiation of the contract, Trial Tr. 11/30/16, 1684:8–16 (Drozdowski); *see also* PX0296 at -255, fn. 21; Trial Tr. 11/30/16, 1683:6–14 (Drozdowski). Finally, Anthem's use of the affiliate clause would not help Anthem comply with the best efforts rule. Trial Tr. 11/30/16, 1678:3–7 (Drozdowski).

385. The cost savings to be captured from moving Anthem clients to lower Cigna provider rates also "seem[] to be getting lost." PX0721 at -315. Under the Blue rules, clients with Anthem products cannot take advantage of affiliate language in Cigna contracts. PX0721 at -315; Trial Tr. 11/30/16, 1608:9–14 (Matheis). Yet, this is one of the "tranche[s] of value" contributing to the estimated cost savings put forth by Anthem. *See* Trial Tr. 11/30/16, 1483:18–22 (Matheis).

386. The best-of-best methodology is also unreliable because it does not account for why Cigna has a lower rate. Trial Tr. 12/2/16, 2313:18–2314:24 (Dranove). If Cigna's lower rate is due to it having a bigger presence in the market, Anthem may be able to achieve the lower rate. Trial Tr. 12/2/16, 2314:9–11 (Dranove). But Cigna could have a lower rate for other reasons that would be lost upon renegotiation with the merged entity. Trial Tr. 12/2/16, 2314:8–14 (Dranove). For example, "[s]ometimes providers give Cigna lower rates because they want to make sure that [Cigna] can remain competitive in the marketplace…[o]bviously they're not going to do that if Cigna is acquired by Anthem." Trial Tr. 12/2/16, 2315:9–15 (Dranove). Indeed, in many of the claimed instances where the merged firm would achieve savings based on a lower Cigna rate, Cigna in fact has lower medical billings than Anthem for that provider. Trial Tr. 12/12/16,

2531:23–2532:3, 2532:18–2532:20 (Quintero). To apply a larger discount from smaller billings to a larger amount of billings "skews the results upwards." Trial Tr. 12/12/16, 2533:9–12 (Quintero).

387. The best-of-best methodology is further flawed because calculating a "discount" based on comparing charge master prices to actual prices paid is "meaningless" because the "charge master is the most arbitrary thing in the world." Trial Tr. 12/2/16, 2320:25–2321:13 (Dranove). To get an "apples-to-apples comparison" of Anthem and Cigna's reimbursement rates, actual prices should be used. Trial Tr. 12/2/16, 2320:25–2321:13 (Dranove). Though the health insurance industry speaks of "discounts," cost comparisons for purpose of this analysis must involve actual prices paid. *See* Trial Tr. 12/2/16, 2321:25–2323:6 (Dranove).

388. Further undermining Anthem's attempt to quantify the medical-network cost savings is that small providers were grouped together within a geographic area and treated as a single provider. Trial Tr. 12/12/16, 2534:8–12 (Quintero). Additionally, their analysis calculated separate discounts for ASO and fully-insured claims at each provider, which is inappropriate because those claims are tied to the same underlying contract with the provider. Trial Tr. 12/12/16, 2535:6–10 (Quintero).

389. Nor will Anthem quickly receive the benefit of any claimed medical-network cost savings, as Dr. Israel assumes. *See* Trial Tr. 12/2/16, 2105:24–2108:6 (Israel). According to Swedish, the savings "would play out over a lengthy period of time." Trial Tr. 11/22/16, 337:21–23 (Swedish). Health insurers' contracts with providers have terms as long as five years. Trial Tr. 11/22/16, 337:23–25 (Swedish). Therefore, there would be a "long gestation period to get from day-one go-live to ultimately capturing network synergies." Trial Tr. 11/22/16, 338:14–16 (Swedish).

(ii) The claimed medical-network cost savings are not merger-specific.

390. To the extent that Anthem captures medical-network cost savings, it has not demonstrated that these savings are merger-specific. Dr. Israel testified that medical-network cost savings are merger-specific if Anthem created "a Cigna product with whatever people value about Cigna combined with an Anthem discount structure." Trial Tr. 12/1/16, 1871:13–1872:2 (Israel); *see also* Trial Tr. 11/30/16, 1429:25–1430:25 (Schlegel) (recognizing that Anthem would have to "meld" some of Cigna's value to have a "Blue-branded" product that maintains the value of Cigna's current product).

391. Dr. Israel's $2.4 billion calculation did not include any effects from rebranding. Trial Tr. 12/2/16, 2108:7–2109:1 (Israel). Dr. Israel assumes that all the Cigna customers would continue to get all the benefits they enjoy from Cigna. Trial Tr. 12/2/16, 2108:7–2109:1 (Israel). But this is a highly unreasonable assumption because "we've heard from Anthem that they're going to do the best they can to convert as many Cigna customers as they can to being Anthem customers." Trial Tr. 12/2/16, 2311:19–24 (Dranove).

392. Dr. Dranove agrees with Dr. Israel that the medical network cost savings are only merger-specific if the Cigna customers get to stay with Cigna *and* gain the benefit of Anthem's discounts. Trial Tr. 12/2/16, 2310:18–2311:1, 2311:7–11 (Dranove). Cigna customers currently have the option to buy Anthem's products to take advantage of Anthem's lower reimbursement rates; no merger is necessary for that to occur. Trial Tr. 11/28/16, 1014:11–20 (Dranove). Simply migrating Cigna clients to Anthem products by rebranding is not merger-specific. Trial Tr. 11/28/16, 1014:11–20 (Dranove).

393. Post-merger, however, it is unclear what aspects of the Cigna product, if any, will be retained. Trial Tr. 11/30/16, 1429:25–1430:25 (Schlegel). Combining "Cigna features that their customers find valuable with Anthem features" is a "vision" for "over the long haul." Trial Tr.

11/30/16, 1606:7–21 (Matheis). In the short term, Anthem is focused on migrating "a lion's share of the Cigna customers" to Anthem products to comply with the Best Efforts rule. Trial Tr. 11/30/16, 1600:17–21, 1605:18–1606:21 (Matheis). *See also* Trial Tr. 11/30/16, 1431:1–9 (Schlegel) (noting that rebranding is high on the list of options because it "represents a pretty significant opportunity…to reach compliance."). If Anthem succeeds in convincing "the lion's share" of Cigna members in the Anthem footprint to rebrand Blue, "the lion's share of [the merger-specific cost savings] disappears." Trial Tr. 12/2/16, 2311:25–2312:4 (Dranove).

394. Furthermore, because the best-of-breed methodology does not account for *why* one insurer has a better provider rate, it is not clear that the merger is necessary to capture the differences. For example, differences in the rates may be due to how long ago the provider contracts were negotiated. Trial Tr. 12/1/16, 1812:4–19 (Singhal). In fact, Anthem's M&N synergy analysis even includes instances comparing Anthem's in-network rates with Cigna's out-of-network rates. Trial Tr. 12/1/16, 1808:9–13 (Singhal). Indeed, Cigna knows how to enter into provider contracts and, particularly for those providers where it has a significant volume of business, has the ability to enter into those contracts without the merger. *See* Trial Tr. 12/1/16, 1808:18–1809:21 (Singhal). Thus, the gap could be closed upon renegotiation without the merger. Trial Tr. 12/1/16, 1812:4–19 (Singhal). But neither Mr. Matheis nor Mr. Singhal had access to the confidential clean room to assess the provider contracts, and the lead of Cigna's integration team questioned the ability of those working in the clean room. Trial Tr. 11/30/16, 1579:10–16, 1579:25–1580:1 (Matheis); Trial Tr. 12/1/16, 1798:5–7, 1815:25–1820:6 (Singhal); PX0710. Dr. Israel also did not look at the particular contracts. *See* Trial Tr. 12/2/16, 2106:24–2108:1 (Israel).

(iii) The claimed medical-network cost savings are an anticompetitive reduction in output and service, not an efficiency.

395. Anthem's claimed medical-network savings are not efficiencies because they do not represent any reduction in the amount of societal resources brought to bear in producing healthcare services. Trial Tr. 11/28/16, 1012:18–25 (Dranove). Instead, they result from a reduction in the number of competitors in the marketplace. Trial Tr. 12/2/16, 2315:16–22 (Dranove).

396. Simply bringing Cigna customers under Anthem's provider contracts results in decreased revenues for providers with "no corresponding incremental value." PX0054 at -092; Trial Tr. 11/30/16, 1680:15–1681:12 (Drozdowski); *see also* Trial Tr. 11/28/16, 1014:21–23 (Dranove) ("[P]roviders are already getting the Cigna and Anthem lives. They're not getting more lives when Cigna contracts are converted to Anthem."). Nor do providers expect new patient volume as a result of the merger. *See, e.g.,* Benton (New West Physicians) 10/20/16 Dep. 38:17–21; [redacted] Kimura (Colorado Retina Associates) 10/21/16 Dep. 66:5–8, 66:10–13. Even Defendants' expert, Dr. Willig, believes that "Anthem's already past the threshold of having enough size to do what it needs to do in terms of offering volume to providers." Trial Tr. 12/2/16, 2231:6–12 (Willig).

397. At best, providers will realize small transactional cost savings from contracting with one larger insurer instead of two. [redacted] Carley (Centura Health) 10/7/16 Dep. 85:14–17 (stating that the administrative expenses of serving commercial patients do not decrease as the insurer becomes bigger); [redacted]

[redacted]

(iv) The claimed medical-network cost savings result from an exercise of buy-side market power and could lead to an anticompetitive reduction in output and service.

a. The merger likely will increase Anthem's market power over providers.

398. The "exercise of monopsony power" involves leveraging a "bigger" market share "on the buy side of the market" to "lower the prices." Trial Tr. 12/2/16, 2230:10–14 (Willig). Dr. Israel explained that the merger will shift bargaining leverage to Anthem. Trial Tr. 12/2/16, 2101:3–7 (Israel). Anthem will be able to demand rates that providers otherwise would be able to refuse. Trial Tr. 12/2/16, 2100:2–2101:2 (Israel). But, in return, the providers get no additional patient volume. Trial Tr. 12/2/16, 2099:21–2100:4 (Israel). Providers agree, testifying that larger insurers have greater negotiating leverage over them. [redacted] Anthem, which already has a significant share of commercial lives today, will become even bigger through the merger. Anthem may be even better able to drive down rates or impose other burdensome terms on providers. [redacted] *See also* Trial Tr. 12/1/16, 2097:23–2099:2 (Israel).

b. Reduced payments to providers may lead to anticompetitive reductions in output and service.

399. "In healthcare markets, "the right measure of output . . . is quality of care, or ideally . . . the health of a population." Trial Tr. 11/28/16, 1009:12–21 (Dranove). Quantity of healthcare services is not the proper measure of output. Trial Tr. 11/28/16, 1009:1–11 (Dranove) ("Nobody goes into the healthcare marketplace . . . and say[s], 'That surgery was great. Give me another one.'"). Less competition in healthcare markets is not beneficial simply because it increases quantity. Trial Tr. 12/2/16, 2319:14–18 (Dranove). More competition in the market is beneficial because it increases quality and decreases quantity. Trial Tr. 12/2/16, 2319:3–19 (Dranove).

400. Furthermore, a premise of Dr. Israel's opinion—that the competitive rates for provider services are the government-set Medicare rates, and not what is negotiated in the open marketplace between providers and insurers, *see* Trial Tr. 12/1/16, 1968:6–1969:6 (Israel)—is wrong. The competitive rate needs to cover a supplier's costs, including its investments and other fixed costs. Trial Tr. 12/2/16, 2118:6–13 (Israel). Medicare rates are set with the "aspirational" goal of covering inpatient costs, plus a market rate of return, but it is generally recognized that Medicare rates do not cover costs. Trial Tr. 12/2/16, 2316:4–2318:7 (Dranove). *See also* McCreary (UC Health) 10/6/16 Dep. 85:22–24; [redacted] Wilhelmsen (Southern NH Health System) 10/14/16 Dep. 55:1–23; [redacted] There is also no evidence in this case that Medicare rates are designed to cover the costs of outpatient procedures. In fact, Medicare rates do not cover the costs incurred by 85 percent of hospitals. Trial Tr. 12/2/16, 2122:4–19 (Israel).

401. Ultimately, reduced payments to providers may compromise quality of care and create [redacted] When faced with revenue shortfalls, providers are forced to lay off staff, delay investments and cut services. *See, e.g.*, [redacted]

; Kimura (Colorado Retina Associates) 10/21/16 Dep. 24:11–12, 24:16–20, 40:2–4, 40:6–16 (testifying that lower reimbursement rates impact providers' "ability to provide care" and "reinvest in the technologies" and force providers to "cut[] corners," which all have "a direct bearing on patient care outcomes"); Wilhelmsen (Southern New Hampshire Health System) 10/14/16 Dep. 23:10–23 (testifying that hospital organizations need to maintain a positive operating margin to maintain its technologies and facilities, and that deficits might cause the hospital to cut its services); [redacted]

(v) The claimed medical-network savings will not necessarily pass through to consumers.

402. Anthem claims that for self-insured employers, the medical-network savings will be passed through 100 percent. But insurers, like any firm, are trying to maximize their revenue. Jay 10/12/16 Dep. 122:17–23. [redacted] Jay 10/12/16 Dep. 60:2–6, 60:9.

403. [redacted] *See, e.g.*, PX0342 at -105–

106 [redacted] In June 2016, the Anthem integration team reviewed a range of options to capture value from medical-network cost savings that would otherwise accrue to ASO customers. PX0727 at -519-2, -4–6. For example, if Anthem allowed clients to renew with Cigna, but then got the lower provider contract rate for Cigna patients, it could keep the difference in the rate for itself. Trial Tr. 11/30/16, 1617:3–9 (Matheis). Ultimately, Anthem determined that "[p]ass[ing] all savings to customers"—the key assumption underlying Anthem's defense—was "[n]ot the optimal solution to capture [the] most value from [the] deal." PX0727 at -519-6.

B. Anthem's general and administrative savings are largely not cognizable.

(i) Anthem's estimates are unreliable and speculative, and thus not verifiable.

404. Anthem and Cigna set out top-down targets for G&A efficiencies in early 2016, after comparing the two companies' financial statements. Trial Tr. 11/30/16, 1493:1–9, 1498:20–24; 1499:23–1500:10 (Matheis). In an e-mail to the Anthem CEO, Anthem's head of integration referred to these targets as "G&A ambitions." Trial Tr. 11/30/16, 1584:10–12, 1586:1–7 (Matheis). Anthem's integration team then focused on a bottoms-up effort to figure out how it will achieve those G&A targets. Trial Tr. 11/30/16, 1507:24–1508:10 (Matheis).

405. In early April, Cigna ceased to support integration efforts surrounding G&A savings, other than Day One readiness efforts such as ensuring e-mail systems would continue to operate. Trial Tr. 11/30/16, 1587:1–9 (Matheis). As a result, Cigna did not fully share important information and data with Anthem. Trial Tr. 11/30/16, 1590:4–1591:10, 1595:11–25 (Matheis); PX0084. *See also* PX0086 at -796–797; Martie 4/28/16 Dep. 158:21–159:10. This, in turn, made it difficult for members of the integration team to make decisions and build a plan for Anthem post-merger. Martie 4/28/16 Dep. 153:6–23, 154:4–19, 157:7–17.

406. Anthem's head of integration, Dennis Matheis, testified that, as of April 11, 2016, Anthem had merely set G&A targets, which was only 15 to 20 percent of the planning work on G&A synergies that needed to be done. Trial Tr. 11/30/16, 1586:1–12 (Matheis). The Anthem and Cigna integration teams needed to work together to develop plans to ensure their synergy targets could actually be achieved—but Cigna put this integration work on hold. Trial Tr. 11/30/16, 1586:13–25 (Matheis). Cigna's lack of engagement meant Anthem had to rely on broad assumptions in its value capture efficiencies work, leaving the resulting estimates as merely targets. PX0711 at -828-15. [redacted] PX0711 at -828-16.

407. Anthem proceeded to work on G&A savings without Cigna input or knowledge. Trial Tr. 11/30/16, 1595:11–1596:19 (Matheis); Trial Tr. 11/22/16, 332:4–9 (Swedish). Yet, as of June 21, 2016, Anthem had still made very limited progress on the outstanding synergy initiatives due to Cigna's lack of engagement. Trial Tr. 11/30/16, 1593:7–13 (Matheis); PX0723 at -203-12–30, -36–54 (listing open items requiring full Cigna engagement).

408. Cigna did not reengage in the G&A savings effort. Trial Tr. 11/30/16, 1594:10–21 (Matheis).

409. The integration planning teams assigned to develop the G&A savings estimates assigned confidence ratings to each savings initiative. For only seven percent of the claimed G&A savings did the planning teams assign a "high" confidence rating for achieving the savings. Trial Tr. 12/12/16, 2519:1–2519:9 (Quintero).

410. The planning teams creating the baseline from which G&A savings were measured used speculative and unreliable data. For Anthem, the baseline was created using eight months of

actual G&A expenditures in 2015 and four months of projected costs. For Cigna, only three months of 2015 actual costs were used in combination with nine months of projections. These data deficiencies undermine the reliability of the baseline, and ultimately the conclusions. Trial Tr. 12/12/16, 2520:1–2521:5 (Quintero).

411. The taxonomy created by the integration planning teams to match cost functions between the two firms was unreliable. For example, for one identical position between the two firms, the claimed salary was 70 percent higher at Cigna. Additionally, the Defendants reported a sales incentive cost per member at Cigna that was three times higher than Anthem. These reported cost differences are more likely a function of accounting for costs differently. Comparison of those costs is therefore not an apples-to-apples approach. Trial Tr. 12/12/16, 2523:6–2524:10 (Quintero).

(ii) Only a fraction of Anthem's claimed G&A savings are variable costs.

412. In merger analysis, cost savings from efficiencies should be taken into account only if they are savings in variable costs, as it is variable costs that affect pricing. Trial Tr. 11/28/16, 1008:3–13 (Dranove). Anthem's claimed variable G&A savings, even if fully credited as cognizable, are not enough to offset the static price effects of this merger. Trial Tr. 11/28/16, 1012:5–8 (Dranove).

413. Defendants have asserted that only $515 million of the $2.36 billion in claimed G&A cost savings relate to variable costs. Of that $515 million, only $361 million has been detailed through the "bottom up" analysis by the planning teams. Trial Tr. 12/12/16, 2517:20–25 (Quintero).

(iii) Anthem's claimed G&A savings are not merger specific.

414. Anthem does not need the merger to reduce its G&A costs. For example, McKinsey, who Anthem has hired in the past and who it hired to assist its integration, has been able to help a different insurer reduce its administrative expense by more than a billion dollars. Trial Tr. 12/1/16, 1777:14–21, 1820:12–14 (Singhal). Moreover, Mr. Singhal, who oversaw McKinsey's work, testified that conduct matters much more than scale for operational efficiency, that the value of scale is relatively small for operating efficiencies, and that many times those efficiencies are offset by increased complexity. Trial Tr. 12/1/16, 1825:19–1826:13, 1826:14–22 (Singhal).

415. Many of the proposed initiatives to reduce G&A costs are not dependent on the merger, but are instead representative of the typical improvements that companies typically undergo. Those improvements can be accomplished through training, use of consultants, or hiring executives from other firms. Trial Tr. 12/12/16, 2517:12–17 (Quintero).

(iv) Those G&A savings that are cognizable are overwhelmed by merger implementation costs

416. A maximum of $192 million of the claimed $2.36 billion in G&A savings are potentially cognizable. However, the implementation costs of the merger will exceed $1 billion. Therefore, on a net basis, there are no cognizable G&A savings. Trial Tr. 12/12/16, 2524:14–2525:1 (Quintero).

C. The contentious relationship between Anthem and Cigna would undermine Anthem's ability to achieve its proposed efficiencies.

(i) Cooperation between Anthem and Cigna is important to the success of integration.

417. As Anthem has recognized, effective integration planning is essential to achieving the value of a deal. Trial Tr. 11/30/16, 1707:24–1708:4 (DeVeydt). Anthem's chief risk officer told

Anthem's board of directors, "[n]o matter how well Cigna fits into Anthem's strategy, or how well the deal has been negotiated and structured, the acquisition can still fail to achieve the desired results if the two organizations aren't effectively integrated." PX0040 at -538; Trial Tr. 11/30/16, 1708:13–1709:10, 1710:24–1711:9 (DeVeydt). Wayne DeVeydt, Anthem's then-CFO, testified that it was "textbook M&A" that the deal could fail if Anthem and Cigna were not effectively integrated. Trial Tr. 11/30/16, 1711:4–12 (DeVeydt).

418. Similarly, Anthem has recognized that good internal communication at the top levels of a company is an important factor in a successful integration. Trial Tr. 11/30/16, 1711:13–22 (DeVeydt). Social issues, including the blending of corporate cultures and the companies' leaders getting along with one another, cultural fit, and corporate alignment are also important to the success of a merger. Trial Tr. 11/30/16, 1707:6–23, 1711:13–19 (DeVeydt). Anthem's head of integration agreed that some aspect of being able to successfully integrate the best-of-the-best from each company will be affected by the differing cultures and processes of Anthem and Cigna. Trial Tr. 11/30/16, 1502:8–22 (Matheis).

419. Even under the best of circumstances, the integration of Anthem and Cigna would be extraordinarily complex due to the size of the transaction, complexity of health insurance, and differences in Anthem's and Cigna's business models. Trial Tr. 11/22/16, 423:16–425:11; 454:9–456:1 (Cordani); *see* Martie 4/28/16 Dep. 154:4–155:3; [redacted] The integration was structured from the outset to include bottoms-up analysis before the deal would close. Trial Tr. 12/1/16, 1813:21–1814:5 (Singhal). Before this merger, the largest transaction in the history of the health insurance industry was the merger of Anthem and

Wellpoint, a fellow Blue company, in 2004. Trial Tr. 11/22/16, 316:8–21 (Swedish). Twelve years later, Anthem still has not finished integrating those two companies. Trial Tr. 11/22/16, 316:24–317:8 (Swedish).

420. Anthem's CEO confirmed that it would be difficult merging Anthem and Cigna under the best of circumstances. Trial Tr. 11/22/16, 317:9–16 (Swedish); *see also* PX0040 at -535 [redacted]. He agreed that how the companies work together before the merger closes will determine whether the merger succeeds. Trial Tr. 11/22/16, 317:20–318:1 (Swedish). He told his counterpart at Cigna, David Cordani, "How we integrate our companies *based on pre-close efforts* will dictate whether we capture and realize the expected value for our members and our shareholders." PX0001 at -342 (emphasis added).

421. Cigna's CEO, David Cordani, also recognized the importance of cooperation in the integration process. [redacted] PX0326 at -002. He noted, [redacted] PX0326 at -002.

(ii) Anthem and Cigna's relationship is contentious and lacks cooperation.

422. Anthem and Cigna's pre-close efforts to cooperate and integrate have not gone well. By late December 2015, Swedish wrote to Cordani that the "implementation and execution of our integration plan has been unacceptable." PX0001 at -342. Three months later, Swedish said

that the two companies were "not aligned on the timing of activities necessary to achieve a positive integration," affecting not only the top leadership but also the integration teams. PX0003 at -997; Trial Tr. 11/22/16, 324:17–325:1 (Swedish).

423. The conflicts did not relate solely to timing—they centered on how the company would be structured, the role of Cordani in the combined company, and fears that Cigna was seeking a reverse merger, attempting to take over Anthem. Trial Tr. 11/22/16, 328:13–329:4, 341:17–342:8, 346:13–348:15 (Swedish). There are significant, mission-critical disagreements between Anthem and Cigna regarding integration. Trial Tr. 11/22/16, 427:24–428:12 (Cordani). For example, integration work regarding the go-to-market strategy has been understaffed and has not received sufficient focus. Trial Tr. 11/22/16, 437:20–440:24; 454:9–456:1 (Cordani); *see* PX0010 at -597 (noting that Swedish is refusing to meet with Cordani regarding go-to-market strategy concept). Anthem's vice president of corporate development testified that he has worked on more than 100 deals since 1993, and that in his personal experience, he has never seen this level of disagreement between merging parties. Trial Tr. 11/30/16, 1454:11–1455:15 (Schlegel).

424. By April 2016, Anthem established a separate, highly confidential team to work on integration planning without Cigna's participation. PX0725 at -729; Trial Tr. 11/22/16, 332:4–9 (Swedish); *see also supra* Section VII.B.i. And Cigna's board believed that Anthem was "eroding the value of the deal." Trial Tr. 11/22/16, 340:13–18 (Swedish); PX0007 at -735.

425. As these tensions grew, Swedish continued to reassure investors that the teams were "working very, very well together," and were "incredibly well aligned." Trial Tr. 11/22/16, 355:11–25 (Swedish); *see* PX0013 at -761 (Cigna accusing Anthem of "working on a post-deal litigation case" in lieu of cooperating while also telling investors it is working well with Cigna); PX0012 at -750. Yet, in June, he warned his board that Cigna's inconsistent engagement had

impacted the integration process and cited to three prior mergers where inefficient collaboration and misalignment eroded the mergers' value—not only for shareholders, but also for consumers. Trial Tr. 11/22/16, 362:6–20; 363:11–15; 364:13–24 (Swedish).

426. By July, Anthem had accused Cigna of "an egregious breach" of the merger agreement. Trial Tr. 11/22/16, 376:13–17 (Swedish); PX0016 at -772; *see also* PX0012 at -752 (discussing Anthem's threat against Cigna of billions of dollars in liability); PX0017 at -776; PX0022 at -798. Likewise, Cigna has alleged that Anthem has "willfully violated" the agreement. Trial Tr. 11/22/16, 377:17–20 (Swedish); PX0021; *see also* PX0025 at -804.

427. This discord between Anthem and Cigna has had a real impact on their integration planning efforts. The integration work has not been completed, and work has been stopped. Trial Tr. 11/22/16, 427:14–22 (Cordani); *see also supra* Section VII.B.i. Currently, the two companies do not even agree on the claimed benefits of the merger or the purported efficiencies estimate published by Anthem in support of the merger shortly after this lawsuit was announced. Trial Tr. 11/22/16, 435:11–438:14, 441:15–442:2 (Cordani).

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on December 20, 2016, I caused a copy of the foregoing to be served upon all counsel of record via the Court's CM/ECF system.

Dated: December 20, 2016

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