No. 16-____

IN THE

Supreme Court of the United States

ANTHEM, INC.,

Petitioner,

v.

UNITED STATES OF AMERICA, *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

PETITION FOR A WRIT OF CERTIORARI

CHRISTOPHER M. CURRAN*
J. MARK GIDLEY
WHITE & CASE LLP
701 13th Street, N.W.
Washington, D.C. 20005
(202) 626-3600
ccurran@whitecase.com

Counsel for Petitioner

*Counsel of Record

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QUESTIONS PRESENTED

This Court last addressed a merger challenge under Section 7 of the Clayton Act more than four decades ago. In the interim, antitrust economics—including merger analysis—has undergone a substantial evolution. Lacking clarity on whether merger law is keeping up with modern economic thought, the circuits are split on the fundamental issue of whether consumer welfare and efficiencies should be considered in evaluating the legality of a merger. This circuit split is manifested in the decision below, and the questions presented here are:

Whether this Court's decision in *FTC v. Procter & Gamble Co.*, 386 U.S. 568 (1967), forecloses consideration of efficiencies in merger analysis. The majority below (Rogers and Millett, JJ.) opined that *P&G* does foreclose considering efficiencies, thereby siding with recent decisions by the Third and Ninth Circuits; the dissent below (Kavanaugh, J.) disagreed, concluding that *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974), requires a comprehensive consideration of relevant competitive factors, including efficiencies, thereby siding with the Eighth and Eleventh Circuits.

Assuming efficiencies should be considered, whether and how a court must weigh them as part of a determination of net competitive effect. The majority below declined to do a quantitative weighing, while other courts, such as the Eleventh Circuit, find such a weighing to be required under Section 7.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

Anthem, Inc., petitioner on review, was a defendant-appellant below and states that it has no parent corporation, and that no publicly held corporation owns, directly or indirectly, 10% or more of its stock.

Cigna Corporation was a defendant-appellant below and has no parent corporation, and no publicly held corporation owns, directly or indirectly, 10% or more of its stock.

The following parties, respondents on review, were plaintiffs-appellees below: the United States of America, the State of California, the State of Colorado, the State of Connecticut, the District of Columbia, the State of Georgia, the State of Iowa, the State of Maine, the State of Maryland, the State of New Hampshire, the State of New York, the State of Tennessee, and the Commonwealth of Virginia.

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Petitioner Anthem, Inc. respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit.

OPINIONS BELOW

The opinion of the D.C. Circuit is currently unreported but reproduced at App. 1a–76a. The court of appeals affirmed a decision by the U.S. District Court for the District of Columbia enjoining the merger. The opinion of the district court is currently unreported but reproduced at App. 91a–267a.

JURISDICTION

The D.C. Circuit entered judgment on April 28, 2017. This Court has jurisdiction under 28 U.S.C. § 1254(1).

PROVISIONS INVOLVED

The statute involved is Section 7 of the Clayton Act, codified as amended at 15 U.S.C. § 18. The statute is reproduced at App. 268a–70a.

INTRODUCTION

By a 2-1 vote, the D.C. Circuit panel below affirmed a permanent injunction of a merger that all parties agree would result in lower healthcare prices for thousands of employers and millions of their employees. The majority, echoing a similar opinion by the district court, opined that this Court's decision in *FTC v. Procter & Gamble Co.*, 386 U.S. 568 (1967)

("*P&G*"), precludes consideration of efficiencies in determining whether the effect of a merger may be substantially to lessen competition under Section 7 of the Clayton Act, 15 U.S.C. § 18. App. 15a–16a.

The majority found support for its opinion in "very recent decisions" by other circuits, specifically *FTC v. Penn State Hershey Medical Center*, 838 F.3d 327, 348 (3d Cir. 2016), and *Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke's Health System, Ltd.*, 778 F.3d 775, 790 (9th Cir. 2015). App. 18a. The majority candidly acknowledged that—"[d]espite the clear holding of *Procter & Gamble*"—at least two other circuits have ruled to the contrary, allowing consideration of efficiencies in merger analysis: *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999), and *FTC v. University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991). App. 17a. The majority also cited a third circuit that has acknowledged the availability of an efficiencies defense, *ProMedica Health System, Inc. v. FTC*, 749 F.3d 559, 571 (6th Cir. 2014). *Id.* And, finally, the majority acknowledged that a prior D.C. Circuit decision had also recognized the use of efficiencies evidence, at least in rebutting a prima facie case. *Id.* (citing *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001)).

The dissent, by Judge Kavanaugh, strongly took issue with the view of the majority (and the district court) that 1960s precedent, such as *P&G*, foreclosed consideration of efficiencies or consumer welfare. App. 63a–67a, 70a–71a. The dissent emphasized that this Court's decision in *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974), marked a major shift to modern antitrust analysis, mandating comprehensive consideration of all factors relevant to

consumer welfare in assessing the legality of a merger. App. 64a–67a.

The dissent observed that *General Dynamics*'s impact had already been recognized by the D.C. Circuit in *United States v. Baker Hughes, Inc.*, 908 F.2d 981 (D.C. Cir. 1990), where, in an opinion authored by then-Circuit Judge Thomas and joined by then-Circuit Judge Ginsburg (as well as by Circuit Judge Sentelle), efficiencies were among the considerations identified as included in *General Dynamics*'s comprehensive approach. App. 58a, 64a–67a. The dissent also noted that the comprehensive approach of *General Dynamics* (and *Baker Hughes*), including the consideration of efficiencies and consumer welfare, is the approach required by the Government's own Merger Guidelines. App. 66a.

Responding to the dissent's legal analysis, the majority dismissed the notion that *P&G* may be disregarded after *General Dynamics*, stating that *General Dynamics* "made no mention of [*P&G*]" and "did not involve efficiencies." App. 16a. The majority also disputed that the D.C. Circuit, in *Baker Hughes* or otherwise, has questioned the continuing force of *P&G*. App. 16a–17a. The majority asserted that Judge Kavanaugh, in dissent, "applies the law as he wishes it were, not as it currently is." App. 17a. The majority added that, even if this Court has not decided a Section 7 merger case since 1975, "it still is not a lower court's role to ignore on-point precedent so as to adhere to what might someday become Supreme Court precedent." App. 17a.

After the extensive back and forth between the majority and the dissent on whether efficiencies are cognizable at all under this Court's precedents, the

majority stated that it could, in any event, "assume" the availability of an efficiencies defense, because Anthem failed to show that the district court clearly erred in rejecting the merger's efficiencies. App. 19a–20a. But, despite this purported assumption that efficiencies are cognizable, neither the district court nor the majority genuinely considered Anthem's efficiencies defense. Instead, while uncritically accepting the Government's assertions of anticompetitive harm from increased concentration, both the district court and the majority imposed unreasonably high and asymmetric burdens upon Anthem, effectively nullifying the defense.

Critically, the majority questioned only certain of Anthem's claimed efficiencies, but never did any quantitative determination of the net competitive effect of the merger and did not order a remand for such a determination. The majority even chastised Anthem for "insist[ing] upon a dollar-for-dollar comparison" of anti- and pro-competitive effects (App. 39a), but that is precisely the approach mandated in other circuits. *See, e.g.*, *Univ. Health*, 938 F.2d at 1223 ("[S]uch a comparison is necessary, though, to evaluate the acquisition's total competitive effect."). The dissent seized upon the majority's failure to conduct any assessment of the merger's net competitive effect: "[T]he majority opinion does not conduct that key inquiry." App. 73a.

As the dissent recognized, the majority's failure to consider or weigh Anthem's claimed efficiencies was a particular affront to modern economic analysis, because those efficiencies would redound

directly to the benefit of consumers. App. 56a–57a, 62a–63a. This direct consumer benefit is a consequence of the commercial insurance market, in which insurers act as "purchasing agents" for their employer-customers and ultimately for rank-and-file employees. App. 56a–57a, 62a–63a.

All told, the majority's ruling departs from other circuits in both (i) its legal conclusion that an efficiencies defense is foreclosed by this Court's precedent from the 1960s and (ii) its failure to assess the net competitive effects of the proposed merger. As the dissent put it: "for the majority opinion, there are no cognizable efficiencies to consider in the first place and no need to assess whether the cost savings for employers are greater than the increased fees paid by employers." App. 73a.

This Court's guidance is needed, after half of a century, to resolve an intolerable circuit split on these important aspects of Section 7 merger analysis. The thousands of mergers proposed each year are too important to the national economy to be reviewed under such divergent standards or subjected to consequent forum shopping by government and private antitrust plaintiffs. Furthermore, because many mergers are abandoned for practical business reasons if the merger is enjoined by a district court, this case presents an important opportunity for this Court to settle this entrenched debate among the lower courts.

STATEMENT OF THE CASE

On July 23, 2015, Anthem and Cigna, two publicly traded health insurance companies,

executed a $54 billion merger agreement under which Anthem would be the surviving company, Anthem's current shareholders would retain a majority interest, and Anthem's current board of directors would constitute a majority of the merged company's board. App. 9a; App. 107a–08a. Anthem's and Cigna's shareholders voted overwhelmingly in support of the merger (although Cigna's incumbent senior management has since not supported the transaction). App. 107a–09a.

The Antitrust Division of the United States Department of Justice investigated the merger for almost a year. Then, on July 21, 2016, the Division, joined by Attorneys General from eleven states and the District of Columbia (collectively the "Government"), commenced this action in the district court seeking a permanent injunction under Section 7 of the Clayton Act. App. 9a–10a.

Although Anthem and Cigna have several lines of business, the Government pursued claims relating only to the companies' commercial health insurance, i.e., insurance purchased by employers for their employees. App. 9a–10a.

The Complaint alleged that the merger likely would substantially lessen competition in three alleged markets: (i) the sale of health insurance to "national accounts," the largest employers in the United States (App. 275a–76a); (ii) the sale of health insurance to "large-group" employers in 35 metropolitan areas (App. 276a); and (iii) the purchase of healthcare services by commercial health insurers in the same 35 metropolitan areas (App. 277a). (The Complaint included a fourth claim based on the sale of health insurance on the public

exchanges established by the Affordable Care Act, but the Government voluntarily dismissed that claim prior to trial.)

The Complaint expressly acknowledged that the proposed merger is likely to *reduce* healthcare costs for millions of U.S. employees, alleging that the proposed merger is likely to reduce "reimbursement rates" paid to healthcare providers. *See*, *e.g.*, App. 302a (merger will "likely lead to lower reimbursement rates"); 305a (merger would "enhance Anthem's leverage" during negotiations with providers and "likely would reduce the rates"); 306a ("Anthem plans to lower reimbursement rates by applying its generally lower rates to the Cigna membership it acquires"); 309a (merger will likely have the effect of "causing reimbursements to drop").

The Complaint also acknowledged that these lower "reimbursement rates" would be passed directly to employers because the overwhelming majority of large employers—such as the alleged "national accounts"—contract to bear the healthcare costs of their employees: "Most large employers buy self-insured plans (also known as administrative-services-only or 'ASO' contracts), under which the employer retains most of the risk of its employees' healthcare costs and pays the insurer an administrative fee for access to the insurer's network of doctors and hospitals and for processing medical claims." App. 280a.

A. District Court Proceedings

The district court expedited the proceedings before it. App. 110a. Extensive discovery and other

pretrial proceedings were conducted in a compressed timeframe. *Id.* A bench trial was held from November 21, 2016 until January 4, 2017. *Id.* The Division led the Government's case, while Anthem led the defense.

At trial, Anthem's principal defense was that the merger would generate substantial savings in medical costs and that consumers (i.e., employers and their employees) would be the beneficiaries, given the automatic pass-through of healthcare costs under the ubiquitous ASO contracting. App. 96a, 141a. The savings would come from applying Anthem's lower reimbursement rates to Cigna customers (and, in those limited geographies where Cigna had negotiated lower reimbursement rates, applying Cigna's lower rates to Anthem customers). App. 96a, 206a–08a.

Anthem's economist Mark Israel, Ph.D. quantified the medical cost savings that the combined firm would achieve post-merger, using a "best-of-best" methodology based on the economic theory that the combined firm, with its greater volume, would be able to obtain discount rates that are no worse than either of the firms could obtain separately. App. 210a–12a. By analyzing claims data from Anthem and Cigna, Dr. Israel calculated that the merger would generate $2.4 billion in medical cost savings through improved discount rates, and that 98% of the lower rates would be passed through to self-insured ASO customers (after accounting for modest increases in administrative fees). App. 210a–11a, 250a. Using merger simulation models, Dr. Israel balanced these substantial customer savings against potential

anticompetitive effects from the loss of the rivalry between the two companies, and found that the cost savings would swamp any potential harm by such a large margin that the merger would remain procompetitive even if only one-third of the medical cost savings were realized. App. 164a–65a. Dr. Israel also analyzed whether the merger would cause anticompetitive (or "monopsonistic") harm to providers. He found that the cost savings would in fact be procompetitive because provider prices would not fall below the competitive level, output would not be reduced, and cost savings would be passed through to customers.

The Government's economist, Dr. Dranove, acknowledged that the merger would in fact lead to lower reimbursement rates and that those lower rates should be considered, but he never computed a final medical cost savings number, and never included any medical cost savings in the merger simulation he used to assess the competitive effects of the merger. *See* App. 60a–61a (Kavanaugh, J., dissenting). At trial, several provider witnesses, called by the Government, testified that the merger would cause them to lose millions of dollars in revenue through lower reimbursement rates (i.e., the savings enjoyed by consumers). App. 62a (Kavanaugh, J., dissenting).

On February 8, 2017, the district court issued its opinion permanently enjoining the merger. App. 91a–267a. In enjoining the merger, the district court categorically rejected Anthem's defense that the merger would enable employers (and their employees) to save at least $2.4 billion annually in medical expenses through lower reimbursement

rates, i.e., discounts. App. 82a–83a. The district court held that the medical cost savings were not "merger-specific" or "verifiable" and added that "it is questionable whether they are 'efficiencies' at all." *Id.*

Drawing a distinction between "competition" and "consumer welfare," the district court even chastised Anthem for arguing that consumer welfare was a relevant consideration: "no court has held that a potential general benefit to consumers at the end of the day can negate competitive harm." App. 251a (relying upon *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 371 (1963) ("*PNB*")); *see also* App. 219a ("there is no support for Anthem's contention that the Court should consider claimed benefits to consumers or society in general").

B. The D.C. Circuit's Decision

On expedited appeal, Anthem argued that the district court clearly erred in rejecting the evidence that medical costs savings for customers far outweighed any potential adverse competitive effects of the merger. Anthem argued that the district court's failure to consider efficiencies, and its rejection of a consumer-welfare standard, defied modern antitrust law.

On April 28, 2017, after full briefing and oral argument, the D.C. Circuit issued a 2-1 decision affirming the district court's decision. Judge Judith W. Rogers authored the majority opinion; Judge Patricia A. Millett joined the majority opinion and authored a separate concurring opinion; Judge Brett M. Kavanaugh dissented.

In its own consideration of Anthem's efficiencies defense, the majority acknowledged that Anthem's economist, Dr. Israel, had quantified the medical cost savings resulting from the merger and conducted a net weighing of competitive effects: "Using merger simulation models, he balanced these projected savings against potential anticompetitive effects from the loss of the rivalry between the two companies and found the savings easily outweighed any potential harm." App. 15a. The majority added that "the government offered its own evidence and experts to challenge these conclusions" (*id.*), but the majority could not state that the Government's economist used a merger simulation, or any other tool, to weigh any estimated medical cost savings against potential anticompetitive effects, because the Government's economist never did, either as to the alleged "national accounts" market or as to any of the alleged 35 local markets (including Richmond, Virginia).

The majority then embarked upon an extended analysis of whether efficiencies "offer a viable legal defense to illegality under Section 7." App. 15a–19a. The majority viewed as binding *P&G*'s statement "that '[p]ossible economies cannot be used as a defense to illegality.'" App. 15a–16a (quoting *P&G*, 386 U.S. at 580) (alteration in original). The majority observed that, "[d]espite the clear holding of *Procter & Gamble*," the Eighth, Eleventh, and Sixth Circuits (and the D.C. Circuit itself) have recognized the use of efficiencies, while "[o]ther circuits," including at least the Third and Ninth Circuits, have recently recognized the continued viability of *P&G*. App. 17a–18a. Despite expressing a firm view that

P&G continues to control ("no party points to any subsequent step back by the Court" (App. 16a)), the majority stated that it could nonetheless assume the availability of an efficiencies defense because Anthem had failed to show that the district court clearly erred in rejecting its defense. App. 19a–20a.

Addressing "[o]ne further preliminary analytical point," the majority addressed a concern, expressed by amici supporting Anthem, that the district court "place[d] an asymmetric burden" on Anthem to show claimed medical cost savings, which was higher than the burden on the Government to show its claimed anticompetitive effect on price. App. 20a–21a. (Contrary to the majority's suggestion (App. 21a), Anthem itself raised essentially the same argument. Anthem App. Br. at 15–16, 38; Reply Br. for Def.-Appellant Anthem, Inc. at 7, *United States v. Anthem, Inc.*, No. 17-5024 (D.C. Cir. Mar. 20, 2017).) The majority defended the asymmetrical burdens on the stated basis that medical cost savings were "indirect" effects of the merger, while increased prices from greater concentration were "direct" effects. App. 21a.

The majority proceeded to consider Anthem's claimed efficiencies, but, like the district court, never did so in the meaningful, quantitative manner required to determine the net competitive effect of the merger. Addressing merger specificity, the majority noted testimony that Anthem would require a short-term transition period in which to create its new hybrid Anthem-Cigna project (combining Anthem's favorable rates with Cigna's attractive customer-facing features). App. 23a–24a. And the majority noted that, while the evidence showed that

Anthem had tried and failed to replicate Cigna's attractive features, the district court could have found that Anthem's failure was due to the firm's possible reluctance "to devote the resources needed." App. 25a. The majority thus concluded that "certain of Anthem's claimed efficiencies fall away" (App. 23a), even though the majority also concluded that the district court clearly erred in finding *none* of the medical cost savings to be merger specific. App. 26a–27a. The majority never quantified or even estimated the "certain" efficiencies that it considered not to be merger specific.

As to whether Anthem's claimed medical cost savings were sufficiently verified, the majority concluded that the district court did not clearly err in finding that "practical business realities" would undermine Anthem's plans. App. 27a. Most prominently, the majority relied upon the prospect that imposing Anthem rates on healthcare providers serving Cigna customers would cause "abrasion." App. 28a–32a. The majority never acknowledged that the Government's own complaint alleges that, notwithstanding any such "abrasion," the merger is likely to lead to lower reimbursement rates for Cigna customers (App. 302a, 305a, 306a, 309a), that Anthem intends merely to have Cigna customers enjoy the same rates the provider has already agreed to charge Anthem, or that multiple healthcare-provider witnesses testified at trial that the merger would cause them to charge Anthem rates to Cigna customers. *See* App. 61a–62a (Kavanaugh, J., dissenting).

As to whether medical cost savings would be passed on to Anthem's customers, the majority

acknowledged: "Because ASO customers pay their employees' medical costs directly, any reduction in medical rates would result in savings that automatically pass through to the customer, absent some corresponding ASO price increase by Anthem." App. 34a. The majority concluded that the district court had not clearly erred in relying upon internal Anthem documents exploring ways that Anthem might be able to capture some of the savings. App. 34a–35a. The majority did not consider that ASO fees are a small fraction of an employer's total medical costs—usually less than 10%—such that it is wholly unrealistic that an increase in ASO fees could offset a material reduction in medical claims costs.

Thus, the majority, like the district court, concluded that Anthem's claimed medical cost savings were overstated. But the majority, again like the district court, did not calculate or estimate the medical cost savings that were likely to be realized. Nor did the majority remand so that a calculation or estimate could be done, or so that a proper figure could be included in a merger simulation.

In dissent, Judge Kavanaugh found that "the record decisively demonstrates that this merger would be *beneficial* to the employer-customers who obtain insurance services from Anthem and Cigna." App. 57a (emphasis in original). And he criticized the majority's reliance upon outdated 1960s antitrust law. App. 70a–71a.

Judge Kavanaugh emphasized the Government's concessions that "*this merger would allow Anthem-Cigna to obtain lower provider rates*" and that "Anthem-Cigna would be able to negotiate lower

provider rates that employers would pay for their employees' health care." App. 59a (emphasis in original). And he found that the consumer benefits flowing from the merger were merger specific "by definition," given that the medical cost savings concededly result from the merger. App. 61a. As for verifiability, he found that the claimed savings were sufficiently verified by Dr. Israel, the merger integration planning team working with independent consultant McKinsey & Company, and by provider testimony at trial. App. 62a. Finally, Judge Kavanaugh found that even if there were a question of how much of these cost savings would be passed through to customers, even the low-end estimate of $1.7 billion would result in employers spending "significantly less on healthcare costs." App. 60a, 62a–63a.

For these reasons, Judge Kavanaugh concluded that the "District Court clearly erred . . . in concluding that the merger would substantially lessen competition in the market in which insurance services are sold to large employers." *Id.*

REASONS FOR GRANTING THE PETITION

I. THE CIRCUITS ARE SPLIT ON WHETHER EFFICIENCIES SHOULD BE CONSIDERED IN MERGER ANALYSIS UNDER SECTION 7 OF THE CLAYTON ACT

As the majority below lays plain, the circuits are sharply divided over whether Supreme Court precedent permits consideration of efficiencies in merger analysis. App. 15a–20a. Indeed, confusion permeates across the lower courts.

At least two circuits—and now the majority below—recently have cast doubt on whether any consideration of efficiencies is reconcilable with this Court's statement in *P&G* that "[p]ossible economies cannot be used as a defense to illegality." 386 U.S. at 580. The Third Circuit in *Penn State Hershey*, after quoting from both *PNB* and *P&G*, concluded: "Based on this language and on the Clayton Act's silence on the issue, we are skeptical that such an efficiencies defense even exists." 838 F.3d at 348. Similarly, in *Saint Alphonsus*, the Ninth Circuit invoked *P&G* when concluding that "[t]he Supreme Court has never expressly approved an efficiencies defense to a § 7 claim" and that "[w]e remain skeptical about the efficiencies defense in general and about its scope in particular. It is difficult enough in § 7 cases to predict whether a merger will have future anticompetitive effects without also adding to the judicial balance a prediction of future efficiencies." 778 F.3d at 788–90.

In contrast, at least three circuits have accepted this Court's direction in *General Dynamics* to employ a comprehensive, totality-of-the-circumstances approach as including efficiencies among the factors appropriately considered in modern merger analysis.

Most notably, in *University Health*, the Eleventh Circuit considered both *P&G* and *PNB*, and nonetheless *endorsed* considering efficiencies: "It is clear that whether an acquisition would yield significant efficiencies in the relevant market is an important consideration in predicting whether the acquisition would substantially lessen competition." 938 F.2d at 1222. The court continued: "evidence that a proposed acquisition would create significant

efficiencies benefiting consumers *is useful in evaluating the ultimate issue*—the acquisition's overall effect on competition." *Id.* (emphasis added).

The Eleventh Circuit "recognize[d] . . . that it is difficult to measure the efficiencies a proposed transaction would yield and the extent to which these efficiencies would be passed on to consumers." *Id.* at 1223. It also acknowledged that "it is difficult to calculate the anticompetitive costs of an acquisition against which to compare the gains realized through greater efficiency." *Id.* These difficulties notwithstanding, the Eleventh Circuit concluded that such a comparison is *mandated*: "such a comparison is necessary, though, to evaluate the acquisition's *total competitive effect*." *Id.* (emphasis added).

The efficiencies-consideration rule, stated and applied in the Eleventh Circuit, is irreconcilable with the decision below and, notably, tracks the basis upon which Justice Harlan wrote his separate concurring opinion in *P&G*. 386 U.S. at 597 (Harlan, J., concurring) ("Congress' use of the word 'competition' was a shorthand for the invocation of the benefits of a competitive market, one of which is a price close to average cost. Such an approach leads also to the conclusion that economic *efficiencies produced by the merger must be weighed against anticompetitive consequences in the final determination whether the net effect on competition is substantially adverse*.") (citing Robert H. Bork & Ward S. Bowman, Jr., *The Crisis in Antitrust: A Dialogue on Policy*, 65 Colum. L. Rev. 363 (1965) (emphasis added)).

As *University Health* recognizes, the statutory language of Section 7—calling for a determination of whether the merger is likely "substantially to lessen competition"—seems to compel consideration of efficiencies. 938 F.2d at 1222 (finding that presence of efficiencies in the relevant market is an "important consideration in predicting whether the acquisition would substantially lessen competition"). After all, a court cannot reasonably assess whether there is likely to be a substantial lessening of competition without considering the net result of pro- and anti-competitive effects together.

And the Eleventh Circuit does not stand alone. Consistent with Section 7's language, other courts have weighed efficiencies (along with other factors) in a totality-of-circumstances competitive effects analysis. In *Tenet Health*, the Eighth Circuit held that "although Tenet's efficiencies defense may have been properly rejected by the district court, the district court should nonetheless have considered evidence of enhanced efficiency *in the context of the competitive effects of the merger*." 186 F.3d at 1054 (emphasis added); *see also United States v. Country Lake Foods, Inc.*, 754 F. Supp. 669, 680 (D. Minn. 1990) (accepting defendants' efficiencies although "the government disputes the extent and uniqueness of [those] efficiencies"). The Eighth Circuit reversed the district court's injunction and remanded for further proceedings. *Tenet Health*, 186 F.3d at 1055.

The Sixth Circuit and prior decisions of the D.C. Circuit likewise have considered efficiencies an appropriate factor in merger analysis. *See ProMedica*, 749 F.3d at 571–72 (suggesting that courts may consider "*downward* pricing pressure

that may outweigh the upward pricing pressure," before proceeding to fault ProMedica for its "failure to cite any efficiencies that would result from this merger") (quotations omitted); *FTC v. Butterworth Health Corp.*, No. 96-2440, 1997 U.S. App. LEXIS 17422, at *8–9 (6th Cir. July 8, 1997) (rejecting argument that it was legal error to allow "the hospitals to rebut the FTC's *prima facie* case with evidence that the merger would give rise to consumer savings" and finding that a "direct examination of consumer welfare is an appropriate form of § 7 analysis"); *Heinz*, 246 F.3d at 720 ("[T]he trend among lower courts is to recognize the [efficiency] defense."); *Baker Hughes*, 908 F.2d at 985–86 (including efficiencies among the "variety of factors other than ease of entry [that] can rebut a prima facie case"); *see also FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 151 (D.D.C. 2004) ("However, even where evidence of efficiencies in the relevant market will not support an outright defense to an anticompetitive merger, such evidence is relevant to the competitive effects analysis of the market required to determine whether the proposed transaction will substantially lessen competition.") (citing *Tenet Health*, 186 F.3d at 1054; *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1088 (D.D.C. 1997)).

The majority here did not feel bound to follow *Heinz* (or *Baker Hughes*) because *Heinz* considered efficiencies merely to rebut a prima facie case. App. 17a–20a. The majority and concurrence purported to find support for that distinction in footnote 29 of *University Health*. App. 18a, App. 54a–55a n.5 (citing *Univ. Health*, 938 F.2d at 1222 n.29). But that footnote does not limit consideration of

efficiencies to the prima facie case: it merely states that once a merger is found to have net anticompetitive effect *after* the requisite full weighing (with consideration of efficiencies), the existence of efficiencies—no matter how great and whether in the relevant market or otherwise—cannot reverse that result.

The aggregate result of the judicial confusion on efficiencies is that, in some circuits, courts are not conducting a comprehensive Section 7 inquiry, and instead are at most grudgingly considering efficiencies without quantifying them or otherwise fully exploring their impact on the transaction's competitive effects under the totality of circumstances.

The harm from this distinct and growing circuit split is pronounced. First, the split enables forum shopping by both government and private antitrust plaintiffs. Second, as a result of the split, there currently is no uniform judicial standard on which to base corporate planning and growth strategies. Third, the national economy is not best served in the absence of a single, pro-competitive, pro-consumer rule to be applied to merger analysis.

II. THIS CASE DIRECTLY IMPLICATES THE CIRCUIT SPLIT BECAUSE THE MAJORITY DID NOT PROPERLY CONSIDER EFFICIENCIES

After acknowledging the circuit split on efficiencies, the majority disclaimed that it was picking sides in that debate. App. 15a–20a. But even a cursory review of the majority's opinion shows

that its expressed skepticism about the very existence of an efficiencies defense colored its consideration of the issue.

Because Anthem had successfully rebutted the Government's prima facie case (App. 11a–12a), the burden of producing additional evidence shifted to the Government and merged with its ultimate burden of proving likely anticompetitive effects, "which remains with the [plaintiff] at all times." App. 7a (citing *Baker Hughes*, 908 F.2d at 983) (alteration in original). After acknowledging this shifting of the burden, the majority purported to consider Anthem's claimed efficiencies under *Baker Hughes*'s "totality of the circumstances approach." App. 20a.

The majority, however, did not properly consider Anthem's claimed medical cost savings, did not attempt to balance the likely medical cost savings against the Government's alleged harm, and did not order remand for further proceedings to do so.

This refusal to quantify the likely harm and to compare it to the likely savings is at the crux of Judge Kavanaugh's dissent:

> [T]he record evidence overwhelmingly indicates that the savings to employers from lower provider rates would greatly exceed the increased fees they would pay to Anthem-Cigna for the insurance services. But the majority opinion does not conduct that key inquiry. That is because the majority opinion does not fully accept the fact, undisputed by the parties, that provider

> rates would actually be lower as a result of this merger.

App. 73a.

As Judge Kavanaugh further concluded, the totality-of-the-circumstances approach adopted by *General Dynamics* and *Baker Hughes*, and promoted by the Government in its Horizontal Merger Guidelines, "establish[es] that [courts] must consider the efficiencies and consumer benefits of a merger together with its anti-competitive effects." App. 58a. This is precisely the approach demanded by the Eleventh Circuit: "[I]t is difficult to calculate the anticompetitive costs of an acquisition against which to compare the gains realized through greater efficiency; such a comparison is necessary, though, to evaluate the acquisition's total competitive effect." *Univ. Health*, 938 F.2d at 1223.

Consistent with *University Health*, Anthem put forward extensive evidence of $2.4 billion in efficiencies, and showed that "these efficiencies would be passed on to consumers." 938 F.2d at 1223. Even the majority could not dispute that "rates would be lower for some existing Cigna . . . customers post-merger" (App. 40a), and that they "would access lower rates through renegotiation or exercise of the affiliate clause." App. 31a.

Although the majority contends that Dr. Israel *assumed* and then applied a 98% pass-through rate for all customers (App. 35a–36a), Dr. Israel actually performed an econometric analysis of actual claims data, which showed 98% pass-through for ASO customers and 86% pass-through for fully-insured customers. Then, in order to be conservative, his

simulations of the merger's likely effects set pass-through at just 50%: the rate at which even a monopolist will pass through cost changes. *See* George Kosicki & Miles B. Cahill, *Economics of Cost Pass Through and Damages in Indirect Purchaser Antitrust Cases*, 51 Antitrust Bull. 599, 612 (2006).

The evidence of massive benefits to consumers put forward by Anthem—$2.4 billion—far exceeded even the worst-case harm scenario posited by the Government: $930 million. App. 59a, 62a–63a (Kavanaugh, J., dissenting). Rather than quantifying the likely efficiencies to determine if the Government met its burden of persuasion, however, the majority summarily concluded that the savings "would be insufficient to offset the likely harm to competition." App. 20a. In effect, the majority paid mere lip service to the Government's burden and to the decisive issue of whether the merger was likely anticompetitive in totality.

For example, the majority repeatedly pointed to *possible* difficulties in achieving the savings, such as the "potential" for some providers to push back against lower rates (App. 27a–28a), while ignoring that the Government's own provider witnesses confirmed that they would in fact be paid millions of dollars less post-merger, yet they did not plan to cancel their contracts with Anthem. The majority even suggests that healthcare quality will decrease post-merger (App. 43a–44a), but the district court noted there was not "sufficient evidence in the record" to find that the "merger would result in a reduction in the availability or quality" of healthcare. App. 253a. As Judge Kavanaugh put it, when looking at Anthem's efficiencies, the majority seemed

to accept "the worst-case possibility rather than determining what is likely." App. 73a–74a.

Of course, Section 7 "deals in 'probabilities, not certainties.'" *Gen. Dynamics*, 415 U.S. at 505 (quoting *Brown Shoe v. United States*, 370 U.S. 294, 323 (1962)). Thus, for courts to consider efficiencies "they need not be certain. They merely must be probable." App. 62a (Kavanaugh, J., dissenting) (citations omitted). That is why the lower courts should have genuinely considered and quantified all likely efficiencies, rather than rejecting them en masse because of theoretical concerns that some unspecified portion of them may not be achieved. Anything less precludes a true determination of net competitive effect. *See Univ. Health*, 938 F.2d at 1223.

In essence, the majority imposed upon Anthem the insurmountable burden of proving that it would achieve all of the claimed efficiencies with *certainty*, before the majority would even entertain weighing the merger's potential harm against its benefits: "Perhaps Anthem *is certain* to take those actions [to achieve the savings], and *there will be no impediments* to the savings' realization, but that showing is still *necessary* for a court to conclude that the merger's [harm] is likely to be offset by [the savings]." App. 21a (emphasis added).

Neither of the lower courts imposed a similarly insurmountable burden on the Government to prove its claimed competitive harm, even though the majority acknowledged that the Government has the burden of proving that the merger is likely "substantially to lessen competition." App. 6a–7a (quoting 15 U.S.C. § 18). As then-Circuit Judge

Thomas wrote for the D.C. Circuit in *Baker Hughes*, imposing such a high burden on defendants—forcing them to "rebut a prima facie case only by a *clear* showing"—"in effect shifts the government's ultimate burden of persuasion to the defendant." 908 F.2d at 983; *but see St. Alphonsus*, 778 F.3d at 790–91 (merging parties "must clearly demonstrate that the proposed merger enhances rather than hinders competition because of the increased efficiencies" (quotations omitted)).

Nor did the district court or majority require the Government to completely negate Anthem's efficiencies or otherwise account for them when attempting to prove whether the merger was likely to have net anticompetitive effects. While both sides' experts used merger simulations to estimate the merger's likely effects, the Government's economist never incorporated any medical cost savings into his models assessing the merger's effects on "national account" customers or on customers in the 35 metropolitan areas, including Richmond. Instead, he "built an assumption into all of his models that there would be *zero* medical cost savings." App. 60a (Kavanaugh, J., dissenting). Such a one-sided model proves nothing.

Only Anthem's expert accounted for *both* harms and benefits in his merger simulation, and he found that the merger will provide $1.5 billion in net annual savings to ASO customers within the 14 Anthem states. Furthermore, he found that if only one third of the expected medical cost savings were achieved, that would make the merger procompetitive even using the Government economist's simulation model.

Nevertheless, the majority held that the district court "reasonably determined" that Anthem failed to prove sufficient efficiencies to offset the merger's likely harm. App. 38a. But how can that be when the district court never calculated either cognizable efficiencies or the likely harms? Although the majority excused the district court and the Government from conducting any net weighing of effects—and did not undertake any net weighing itself—it seemed to fault Anthem for not anticipating and quantifying the cost savings that would be questioned by the courts. App. 39a. But Anthem could not reasonably be expected to have such foresight and, in any event, the district court's (and majority's) breezy chiseling away at Anthem's claimed cost savings was far too imprecise to permit an adjusted calculation.

Ostensibly to give comfort that a net weighing would not have changed things, the majority asserts that "this is not a close case." *Id.* But this naked assertion has no basis, quantitative or otherwise. Without a true net weighing, one cannot know how "close" this case is or, indeed, what the outcome should be.

The majority also suggests that courts are ill-equipped to consider harm and benefits on a "dollar-for-dollar" basis (*id.*), but that purported concern is no reason to relieve the Government of the burden of proving a Section 7 violation based on the totality of the circumstances. *University Health* requires as much. Indeed, courts in antitrust cases routinely must make complex economic determinations. *See*, *e.g.*, *Comcast Corp. v. Behrend*, 133 S. Ct. 1426, 1433 (2013) (requiring rigorous analysis of complex

econometric damages model); *Arch Coal*, 329 F. Supp. 2d at 153 (considering $35–50 million in efficiencies "likely" to be realized, even though the efficiencies were not precisely quantifiable and not "as great as defendants have claimed").

Relying again heavily on a structural, market-share-is-high approach (App. 44a–45a, 47a), the majority failed to confront (much less weigh) even the medical cost savings in Richmond admitted by Government provider witnesses. The majority (and the district court) is silent about the Government's own provider witnesses from the Richmond area, who testified that Anthem had negotiated for medical rates significantly lower than Cigna and who had made internal real-world calculations of the specific additional network cost savings that the merger would uniquely yield. But, again, the Government's economist Dr. Dranove never plugged these medical network cost savings—or any medical cost savings—into his own merger simulation models. App. 60a (Kavanaugh, J., dissenting). And thus, the lower courts had no basis for comparing ASO fees with the substantial medical cost savings the merger would yield.

The district court and majority's refusal to quantify and account for the efficiencies is particularly inappropriate where, as here, the efficiencies are consumer-benefiting reductions in the price of the relevant product. The Government's quantified harm is the dollar amount that it projects health insurance costs will increase post-merger, expressed in terms of the ASO fee paid by "national account" customers. But lower provider rates reduce the cost of health insurance: they "result in savings

that automatically pass through to the [ASO] customer, absent some corresponding ASO price increase by Anthem." App. 34a. Thus, to carry its burden of persuasion, the Government was required to show that a likely increase in ASO fees exceeds the likely medical cost savings by an amount substantial enough to constitute a Section 7 violation. Because the court did not quantify or require the Government to account for likely efficiencies—which in this case are part of the price of the relevant product—it had no basis to find that the Government met its burden of proving net anticompetitive harm.

III. THIS CASE PRESENTS A RARE OPPORTUNITY TO CLARIFY AND MODERNIZE MERGER LAW

In declining to credit efficiencies in its merger analysis, the majority here plainly considered itself bound by this Court's 1967 *P&G* statement "that '[p]ossible economies cannot be used as a defense to illegality.'" App. 15a (quoting *P&G*, 386 U.S. at 580) (alteration in original). Likewise, the district court plainly considered itself bound by similar statements from this Court's 1963 decision in *PNB*. *See*, *e.g.*, App. 251a ("[A] merger that may substantially lessen competition is not saved because 'on some ultimate reckoning of social or economic debits and credits, it may be deemed beneficial.'" (quoting *PNB*, 374 U.S. at 371)). As shown in Section I above, various courts across the country similarly have considered themselves bound by such 1960s antitrust jurisprudence. Those courts were unconvinced that *General Dynamics* had overridden such 1960s case

law and moved antitrust law into a new, more modern age. Lower courts plainly need guidance from this Court, lest some of them continue to follow antitrust jurisprudence from a prior, discredited era.

The Supreme Court has offered no guidance to lower courts on Section 7 merger law since 1975. The 1903 Expediting Act previously provided that antitrust merger cases brought by the government and decided by a district court could be appealed as of right directly to the Supreme Court. The Expediting Act, ch. 544, 32 Stat. 823 (1903). Even though mergers are more common than ever and more important than ever to the national economy, this Court's steady diet of merger cases ended when the Expediting Act was repealed by the Tunney Act in 1974. Antitrust Procedures & Penalties Act § 5 (Tunney Act), Pub. L. No. 93-528, 88 Stat. 1708-09 (repealing The Expediting Act, (codified at 15 U.S.C. § 29)); *see also* 15 U.S.C. § 29 (current version); Lawrence Sullivan et al., *The Law of Antitrust, An Integrated Handbook* 178, n.98 (3d ed. 2015) ("It has been common to attribute the lack of Supreme Court merger cases, in part, to repeal of the Expediting Act."). Today, a government merger case may come before this Court only after winding its way through the ordinary layers of courts below. Few mergers survive long enough in gestation to face review by this Court. Warren S. Grimes, *Transparency in Federal Antitrust Enforcement*, 51 Buff. L. Rev. 937, 946 (2003) ("[W]e have yet to see a single substantive Supreme Court case generated through the premerger clearance procedure.").

As Judge Kavanaugh and numerous scholars have noted, this Court's ruling in *General Dynamics*

"remains the last relevant word from the Supreme Court" regarding how courts should assess the lawfulness of horizontal mergers under Section 7. App. 65a; Douglas H. Ginsburg & Joshua D. Wright, *Philadelphia National Bank: Bad Economics, Bad Law, Good Riddance*, 80 Antitrust L.J. 377, 379 (2015); Herbert Hovenkamp, *The Antitrust Enterprise: Principle and Execution* 208 (2005). The majority opinion here confirms that *General Dynamics* was not emphatic enough in its rejection of cases such as *P&G* and *PNB*.

As the dissent below warned (App. 70a–71a) lower courts, such as the district court and majority here, remain haunted by Supreme Court precedents from a bygone era of *per se* rules and structural presumptions. Jamie Henikoff Moffitt, *Merging in the Shadow of the Law: The Case for Consistent Judicial Efficiency Analysis*, 63 Vand. L. Rev. 1697, 1702–03, 1708–18 (2010) ("Courts facing Section 7 efficiency claims today are caught between historic—and outdated—Supreme Court cases and contemporary Agency antitrust policy" resulting in courts failing to "engag[e] in any true balancing of the pro-competitive effects of efficiencies versus other anticompetitive aspects of a proposed deal" and letting their "determination regarding market concentration levels . . . color their assessment of the associated efficiencies.").

"In the mid-1960s, the Supreme Court construed section 7 to prohibit virtually any horizontal merger or acquisition." *Baker Hughes*, 908 F.2d at 989. The "sole consistency" of 1960s merger jurisprudence was that "the government always wins." *United States v.*

Von's Grocery Co., 384 U.S. 270, 301 (1966) (Stewart, J., dissenting).

Following this Court's decision in *General Dynamics*, the "big is bad" mentality of the 1960s cases such as *P&G* and *PNB* has been resoundingly rejected by the evolution of sound antitrust economics. *See* D. Daniel Sokol, *Tensions Between Antitrust and Industrial Policy*, 22 Geo. Mason L. Rev. 1247, 1251–52 (2015) ("Much of US antitrust enforcement from the 1950s and 1960s is an embarrassment by today's standards. Back then, big was bad, merger efficiencies were ignored . . . . Such economically misguided and aggressive enforcement hurt American competitiveness and contributed to America's economic malaise.") (citations omitted); *see also* Ginsburg & Wright, *supra*, at 380, 383–86 (noting that the underlying logic of *PNB* relies on a "semicentenary standard" that modern economic theory cannot justify). In what now must be seen as hyperbole, one prominent antitrust scholar observes that "[w]hile antitrust casebooks continue to print 1960s-vintage merger decisions that have never been overruled, no one, not even federal judges . . . pay much attention to them." Hovenkamp, *Antitrust Enterprise*, *supra*, at 208.

For nearly 40 years, this Court has emphasized in non-merger cases that the ultimate purpose of the antitrust laws is to protect consumer welfare, not competitors. *NCAA v. Bd. of Regents of Univ. of Okla.*, 468 U.S. 85, 107 (1984) ("Congress designed the Sherman Act as a 'consumer welfare prescription'" (quoting *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979))); *see also Weyerhaeuser Co. v. Ross-Simmons Hardwood Lumber Co.*, 549 U.S. 312,

319 (2007) (reversing trial court where legal standard did not account for benefit to the consumer); *Brooke Grp. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 221 (1993) (noting "the antitrust laws' traditional concern for consumer welfare and price competition"). Judge Kavanaugh underscored this understanding in his dissenting opinion. App. 64a (stating that in *General Dynamics* and other landmark decisions "the Supreme Court indicated that modern antitrust analysis focuses on the effects on the consumers of the product or service, not the effects on competitors").

This Court's non-merger antitrust cases teach that low prices benefit consumers and increase competition. *See, e.g.*, *Brooke Grp.,* 509 U.S. at 223 ("'Low prices benefit consumers regardless of how those prices are set . . . .'" (quoting *Atl. Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 340 (1990))); *Matsushita Elec. Indus. v. Zenith Radio Corp.*, 475 U.S. 574, 594 (1986) ("[C]utting prices in order to increase business often is the very essence of competition."); *see also Kartell v. Blue Shield*, 749 F.2d 922, 926–28 (1st Cir. 1984) (Breyer, J.) (Congress "enacted the Sherman Act . . . as a way of protecting consumers against prices that were too *high*, not too low."). Unfortunately, this Court's decisive focus on low prices and consumer welfare has not yet extended to merger cases.

In *P&G*, this Court evaluated the acquisition of Clorox by Procter & Gamble. *P&G*, 386 U.S. at 569–70. Rather than viewing enhanced output as a societal positive, the Court saw this "an offense," and another barrier to new entrants and competition. *See* William Kolasky & Andrew Dick, *The Merger*

Guidelines And The Integration of Efficiencies Into Antitrust Review of Horizontal Mergers, 71 Antitrust L.J. 207, 211 (2003). With structural concerns predominating, the Court demonized Clorox's enhanced scale. *See P&G*, 386 U.S. at 579. It was in this context that the Court stated that "[p]ossible economies cannot be used as a defense to illegality." *Id.* at 580; *see*, *e.g.*, App. 15a–16a.

Even in the 1960s and 1970s, antitrust enforcers and scholars found *P&G* inconsistent with law and logic. *E.g.*, U.S. Dep't of Justice, Merger Guidelines § 10 (1968) (recognizing efficiencies may justify a merger under "exceptional circumstances"); Moffitt, *supra,* at 1705 n.34 ("[A]s things stand now, we observe the regrettable condition in which a company proposing a merger, an apparent effect of which is to realize economies, consciously suppresses the economies aspect lest it be used affirmatively by the government to attack the merger." (quoting Oliver E. Williamson, *Allocative Efficiency and the Limits of Antitrust*, 59 Am. Econ. Rev. 105, 113 (1969))); Robert H. Bork, *The Antitrust Paradox* 204 (1978) ("[*P&G*'s] statement that efficiency is not relevant means that consumer welfare is not important, and that in turn means that the primary reason for preserving competition is to be disregarded.").

Lower courts today struggle with a *P&G* opinion that does not reflect modern understanding of economics and commercial realities. *Compare* App. 16a (majority opinion: "No matter that Justice Harlan's view [in his *P&G* concurrence] may be the more accepted today, the Supreme Court held otherwise, and no party points to any subsequent step back by the Court.") (citations omitted), *with*

Phillip Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 970c2 ("The Court's brief and unelaborated language [in *P&G*] cannot reasonably be taken as a definitive disposition of so important and complex an issue as the proper role of economies in analyzing the legality of a merger."); *see also* U.S. Dep't of Justice, Antitrust Div. Submission for OECD Roundtable on Portfolio Effects in Conglomerate Mergers (Oct. 12, 2001) (advocating that theories of competitive harm "found in *Procter & Gamble* . . . should be rejected for the same reason they were in the United States a generation ago. Challenging a merger because it will create a more efficient firm through economies of scale and scope is at odds with the fundamental objectives of the antitrust laws. And there is no empirical support for the notion that size alone conveys any significant competitive advantage that is not efficiency-related.").

Since *P&G*, six sets of Merger Guidelines have recognized merger efficiencies. *See* Kolasky & Dick, *supra*, at 212–22, 224–31 (describing approaches to crediting efficiencies in 1968, 1982, 1984, 1992, and 1997); *see also* App. 318a (2010 Guidelines: "[A] primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products."). Not only does the successive promulgation of these guidelines show that efficiencies have been recognized as important for over five decades, but it also illustrates vividly the continued evolution of merger antitrust thought and policy.

Also since *P&G*, merger analysis has benefited from an "improved economic toolkit available." Carl Shapiro, *The 2010 Horizontal Merger Guidelines: From Hedgehog to Fox in Forty Years*, 77 Antitrust L.J. 49, 51–52 (2010). Notably, the current Merger Guidelines endorse "merger simulation methods," which "can incorporate merger-specific efficiencies" "to quantify the unilateral price effects resulting from the merger." U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines (Aug. 19, 2010) § 6.1.

An evaluation of the net competitive effect of a merger must evaluate *both* upward and downward pressures on pricing. *See* Joseph Farrell & Carl Shapiro, *Antitrust Evaluation of Horizontal Mergers: An Economic Alternative to Market Definition*, B.E. J. Theoretical Econ., Jan. 2010, at 2 (2010) (explaining "the underlying economics of pricing" requires merger analysis to balance the two opposing forces). To conduct such analysis, courts must "consider the efficiencies and consumer benefits of a merger together with its anti-competitive effects." App. 58a (Kavanaugh, J., dissenting) (citing *Gen. Dynamics*, 415 U.S. at 498–500, and App. 318a–22a).

Consideration of a merger's net downward effect on price is especially important in the healthcare industry. Health insurers are an employer's (and its employees') only line of defense against skyrocketing healthcare costs. Since 1999, U.S. healthcare spending has more than doubled, growing 5.8% in 2015 alone and reaching $3.2 trillion or 17.8% of the overall share of the U.S. economy. U.S. Dep't of Health and Human Servs., NHE Fact Sheet, CMS.gov (last modified Mar. 21, 2017). These

skyrocketing costs are estimated to include over $765 billion a year in waste and inefficiency. *See* Inst. of Med. of the Nat'l Acads., *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* 13 (Mark Smith et al. eds., 2012).

Skyrocketing healthcare costs mean fewer jobs and lower wages. *See generally* Neeraj Sood, et al., *Employer-Sponsored Insurance, Health Care Cost Growth, and the Economic Performance of U.S. Industries*, 44 Health Res. Servs. 1449, 1457, 1460 (2009) ("The findings of our study indicate that 'excess' growth in health care costs has adverse effects on economic outcomes in the United States, and that these effects are greater for industries where high percentages of workers have [employer-sponsored health insurance]."). Growing healthcare costs also mean increased out-of-pocket expenses for employees. *See* David I. Auerbach & Arthur L. Kellermann, *A Decade Of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average US Family*, 30 Health Affairs, 1630, 1630–64 (2011). Conversely, cost savings redound to the benefit of employees. App. 63a (Kavanaugh, J., dissenting) ("Some of the ultimate beneficiaries of this merger would be the rank-and-file workers who are employed by the businesses that obtain insurance services from Anthem and Cigna.").

Given that many lower courts have felt bound by an interpretation of this Court's precedent that is inconsistent with modern economics, guidance is sorely needed from this Court to ensure that mergers are analyzed in a way that will protect consumers, including consumers of healthcare. Without

clarification, mergers benefiting consumers may never be pursued, let alone cleared in the courts.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

CHRISTOPHER M. CURRAN
Counsel of Record
J. MARK GIDLEY
ERIC GRANNON
MATTHEW S. LEDDICOTTE
WHITE & CASE LLP
701 13th Street, N.W.
Washington, D.C. 20005
(202) 626-3600
ccurran@whitecase.com

HEATHER M. BURKE
WHITE & CASE LLP
3000 El Camino Real
5 Palo Alto Square, 9th Floor
Palo Alto, California 94306
(650) 213-0300

MICHAEL E. HAMBURGER
WHITE & CASE LLP
1221 Avenue of the Americas
New York, New York 10020
(212) 819-8200

Counsel for Petitioner

May 5, 2017

APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

[Filed 04/28/2017]

Argued March 24, 2017 Decided April 28, 2017

No. 17-5024

UNITED STATES OF AMERICA, ET. AL.,
APPELLEES

v.

ANTHEM, INC.,
APPELLANT

CIGNA CORPORATION,
APPELLANT

Consolidated with 17-5028

Appeals from the United States District Court for the District of Columbia
(No. 1:16-cv-01493)

Christopher M. Curran argued the cause for appellant Anthem, Inc. With him on the briefs was *J. Mark Gidley*. *Noah A. Brumfield*, *Matthew S. Leddicotte*, and *George L. Paul* entered appearances.

Charles F. Rule was on the brief for appellant Cigna Corporation. *Craig A. Benson* entered an appearance.

Paul T. Denis and *Steven G. Bradbury* were on the brief for amici curiae Antitrust Economists and Business Professors in support of appellant.

Scott A. Westrich, Attorney, U.S. Department of Justice, argued the cause for appellees. With him on the brief were *Kristen C. Limarzi*, *James J. Fredricks*, *Mary Helen Wimberly*, and *Daniel E. Haar*, Attorneys, *Rachel O. Davis*, Assistant Attorney General, Office of the Attorney General for the State of Connecticut, and *Paula Lauren Gibson*, Deputy Attorney General, Office of the Attorney General for the State of California. *Loren L. AliKhan*, Deputy Solicitor General, Office of the Attorney General for the District of Columbia, *Sarah O. Allen* and *Tyler T. Henry*, Assistant Attorneys General, Office of the Attorney General for the Commonwealth of Virginia, *Ellen S. Cooper*, Assistant Attorney General, Office of the Attorney General for the State of Maryland, *Victor J. Domen Jr.*, Senior Counsel, *Cynthia E. Kinser*, Deputy Attorney General, and *Erin Merrick*, Assistant Attorney General, Office of the Attorney General for the State of Tennessee, *Jennifer L. Foley*, Assistant Attorney General, Office of the Attorney General for the State of New Hampshire, *Devin Laiho*, Senior Assistant Attorney General, Office of the Attorney General for the State of Colorado, *Layne M. Lindebak*, Assistant Attorney General, Office of the Attorney General for the State of Iowa, *Christina M. Moylan*, Assistant Attorney General, Office of the Attorney General for the State of Maine, *Irina C. Rodriguez*, Assistant Attorney General,

Office of the Attorney General for the State of New York, and *Daniel S. Walsh*, Assistant Attorney General, Office of the Attorney General for the State of Georgia, entered appearances.

David A. Balto was on the brief for amici curiae American Antitrust Institute, et al. in support of plaintiffs-appellees.

Edith M. Kallas, *Joe R. Whatley, Jr.*, and *Henry C. Quillen* were on the brief for amici curiae The American Medical Association and The Medical Society of the District of Columbia in support of appellees.

Douglas C. Ross, *David A. Maas*, and *Melinda Reid Hatton* were on the brief for amicus curiae American Hospital Association in support of appellees.

Richard P. Rouco was on the brief for amici curiae Professors in support of appellees.

Before: ROGERS and MILLET and KAVANAUGH, *Circuit Judges*.

Opinion for the Court filed by *Circuit Judge* ROGERS.

Concurring opinion filed by *Circuit Judge* MILLETT.

Dissenting opinion filed by *Circuit Judge* KAVANAUGH.

ROGERS, *Circuit Judge*: This expedited appeal arises from the government's successful challenge to "the largest proposed merger in the history of the health insurance industry, between two of the four national carriers," Anthem, Inc. and Cigna

Corporation. Appellees Br. 1. In July 2015, Anthem, which is licensed to operate under the Blue Cross Blue Shield brand in fourteen states, reached an agreement to merge with Cigna, with which Anthem competes largely in those fourteen states. The U.S. Department of Justice, along with eleven States and the District of Columbia (together, the "government"), filed suit to permanently enjoin the merger on the ground it was likely to substantially lessen competition in at least two markets in violation of Section 7 of the Clayton Act. Following a bench trial, the district court enjoined the merger, rejecting the factual basis of the centerpiece of Anthem's defense, and focus of its current appeal, that the merger's anticompetitive effects would be outweighed by its efficiencies because the merger would yield a superior Cigna product at Anthem's lower rates. The district court found that Anthem had failed to demonstrate that its plan is achievable and that the merger will benefit consumers as claimed in the market for the sale of medical health insurance to national accounts in the fourteen Anthem states, as well as to large group employers in Richmond, Virginia.

Anthem and Cigna (hereinafter, Anthem) challenge the district court's decision and order permanently enjoining the merger on the principal ground that the court improperly declined to consider the claimed billions of dollars in medical savings. *See* Appellant Br. 10.[1] Specifically, Anthem

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[1] Cigna has become a reluctant supporter of the merger, stating in its appellate brief that "[i]n accordance with the merger agreement, Cigna has appealed and defers to Anthem." Cigna Br. 3. Indeed, the district court noted the "elephant in the courtroom," for at trial Cigna executives

maintains the district court improperly rejected a consumer welfare standard — what it calls "the benchmark of modern antitrust law," *id.* — and generally abdicated its responsibility to balance likely benefits against any potential harm. According to Anthem, the mergers efficiencies would benefit customers directly by reducing the costs of customer medical claims through lower provider rates, without harm to the providers. The government has not challenged Anthem's reliance on an efficiencies defense *per se*. Rather, it points out that Anthem neither disputes that the merger would be anticompetitive but for the claimed medical cost savings, nor challenges the district court's findings on the relevant market definition, ease of entry, the effect of sophisticated buyers, or innovation. Instead, Anthem's appeal focuses principally on factual disputes concerning the claimed medical cost savings, which the government maintains were not verified, not specific to the merger, and not even real efficiencies.

For the following reasons, we hold that the district court did not abuse its discretion in enjoining the merger based on Anthem's failure to show the kind of extraordinary efficiencies necessary to offset the conceded anticompetitive effect of the merger in

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dismissed various of Anthem's claims of savings, cross-examined the merging parties' expert witness, and refused to sign Anthem's proposed findings of fact and conclusions of law. *United States v. Anthem, Inc.*, No. CV 16-1493 (ABJ), 2017 WL 685563, at *4 (D.D.C. Feb. 21, 2017). Anthem suggested this is a "'side issue,' a mere 'rift between CEOs.'" *Id.* That their relationship may have deteriorated has little to do with the anticompetitive effects of the proposed merger.

the fourteen Anthem states: the loss of Cigna, an innovative competitor in a highly concentrated market. Additionally, we hold that the district court did not abuse its discretion in enjoining the merger based on its separate and independent determination that the merger would have a substantial anticompetitive effect in the Richmond, Virginia large group employer market. Accordingly, we affirm the issuance of the permanent injunction on alternative and independent grounds.

I.

Under Section 7 of the Clayton Act, a merger between two companies may not proceed if "in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such [merger] may be substantially to lessen competition." 15 U.S.C. § 18.

A burden-shifting analysis applies to consider the merger's effect on competition. *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982 (D.C. Cir. 1990). First, the plaintiff must establish a presumption of anticompetitive effect by showing that the "transaction will lead to undue concentration in the market for a particular product in a particular geographic area." *Id.* The most common way to make this showing is through a formula called the Herfindahl-Hirschman Index ("HHI"), which compares a market's concentration before and after the proposed merger. *See id.* at 983 n.3. By squaring the market share percentage of each market participant and adding them together, a market's HHI can range from >0 to 10,000 (*i.e.*, a pure monopoly, or 100^2). Dept. of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines § 5.3

& n.9 (Aug. 19, 2010) (the "Guidelines"). Under the Guidelines, a market will be considered highly concentrated if it has an HHI above 2500, and if the merger increases HHI by more than 200 points and results in a highly concentrated market, it "will be presumed to be likely to enhance market power." *Id.* § 5.3. Although, as the Justice Department acknowledges, the court is not bound by, and owes no particular deference to, the Guidelines, this court considers them a helpful tool, in view of the many years of thoughtful analysis they represent, for analyzing proposed mergers. *See Baker Hughes*, 908 F.2d at 985–86.

The burden shifts, once the prima facie case is made, to the defendant to rebut the presumption. *Id.* at 982. To do so, it must provide sufficient evidence that the prima facie case "inaccurately predicts the relevant transaction's probable effect on future competition," or it must sufficiently discredit the evidence underlying the initial presumption. *Id.* at 991. "The more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully," but because the burden of persuasion ultimately lies with the plaintiff, the burden to rebut must not be "unduly onerous." *Id.*

Upon rebuttal by the defendant, "the burden of producing additional evidence of anticompetitive effect shifts to the [plaintiff], and merges with the ultimate burden of persuasion, which remains with the [plaintiff] at all times." *Id.* at 983.

II.

Anthem is the second-largest seller of medical health insurance to large companies in the United States, and it serves approximately 38.6 million medical members. It is a member of the Blue Cross Blue Shield Association, a group of thirty-six health insurance companies licensed to do business under the Blue Cross and/or Blue Shield brands. Anthem holds an exclusive license to the Blue brands in all or part of fourteen states (the "Anthem states"), and it may also compete for business outside those states if it receives permission from the Blue licensee in the relevant area. Anthem also owns non-Blue subsidiaries through which it may operate both in and outside of the Anthem states, subject to Anthem's "Best Efforts" obligations in its licensing agreement with the Blue Cross Association. Under these "Best Efforts" provisions, at least 80% of Anthem's revenue within the Anthem states must come from Blue-branded products, as must at least 66.67% of its revenue nationwide. Failure to comply could result in termination of Anthem's license, which would trigger a $2.9 billion fee to the Association.

Cigna, the third-largest seller of health insurance to large companies in the United States, serves approximately 13 million medical members nationwide and in more than 30 countries, in addition to offering other specialty products such as dental and vision insurance. Unlike Anthem, which has historically been able to leverage its size to negotiate steep discounts from providers, Cigna's provider discounts have generally not been as good, so Cigna has developed a different and innovative value proposition in order to compete for customers.

Under its more collaborative arrangements with providers, and through the integrated, customized wellness programs it offers its customers' employees, Cigna's focus is on reducing employees' utilization of expensive medical procedures and promoting wellness through behavioral supports and lifestyle changes. This offers customers a different means of lowering health care costs than the traditional model relying heavily on provider discounts.

On July 23, 2015, Anthem reached an agreement to merge with Cigna. The merger would leave Anthem as the surviving company, with a controlling share of the merged company's stock and a majority of seats on the merged company's board of directors. Within the Anthem states, Cigna customers would be permitted to remain with Cigna, at least for the time being, but Anthem and Cigna would otherwise no longer compete with one another in those states. Outside the Anthem states, Cigna's existing business would allow Anthem a bigger foothold to compete, subject to Anthem's "Best Efforts" obligations. The merger agreement extends until April 30, 2017.

On July 21, 2016, the United States, along with California, Colorado, Connecticut, Georgia, Iowa, Maine, Maryland, New Hampshire, New York, Tennessee, Virginia, and the District of Columbia, sued to enjoin the merger. Relying on Section 7 of the Clayton Act, 15 U.S.C. § 18, plaintiffs alleged that the merger would substantially lessen competition in the market for the sale of health insurance to national accounts in both the Anthem states and the United States as a whole, as well as in the market for the sale of health insurance to large group employers in 35 local markets. Plaintiffs also alleged that the merger would substantially lessen

competition for the purchase of services from healthcare providers in the 35 local markets by giving the combined company anticompetitive buying power.

Following a six-week bench trial, the district court permanently enjoined the merger on the basis of its likely substantial anticompetitive effect in the market for the sale of health insurance to national accounts in the Anthem states, as well as in the market for the sale of health insurance to large group employers in Richmond, Virginia. *United States v. Anthem, Inc.*, No. CV 16-1493 (ABJ), 2017 WL 685563, at *68 (D.D.C. Feb. 21, 2017). It first defined the relevant national accounts market, accepting the government's proposed definition of "national account" as an employer purchasing health insurance for more than 5,000 employees across more than one state. It also found that the market properly included both fully insured and "administrative services only" ("ASO") plans. Under a fully-insured plan, the employer pays for claims adjudication, access to the insurer's provider network (including whatever discounted rates the insurer has negotiated), and coverage of the employees' medical costs. Under an ASO plan, the employer pays for claims adjudication and network access, but the employer self-insures and thus takes on the risk of its employees' medical costs. Finally, the district court found that the relevant geographic market for national accounts was the fourteen Anthem states, because that is where Anthem and Cigna currently compete most prominently, given the geographical restrictions imposed on Anthem under its Blue Cross license.

With the national accounts market so defined, the district court then found a presumption of anticompetitive effect based on the combined company's market share. It determined that the merger would increase HHI by 537 to 3000, while the Guidelines threshold is an increase of 200 to 2500, resulting in a highly concentrated market. Guidelines § 10. It also noted that under any variation performed by plaintiffs' expert the resulting numbers were still well over the presumptive Guidelines limits: considering only national accounts where 5% of employees reside in another state, HHI would increase 641 to 3124; considering only ASO customers with 5% out-of-state employees, HHI would increase 880 to 3675; and considering all ASO national accounts, HHI would increase 771 to 3663. Anthem objected that these calculations overstated Anthem's market share by including all Blue customers even if they were not Anthem's, but the district court found that this was appropriate. Anthem's own internal calculations include these customers, and a key part of Anthem's value proposition to customers is that they can access all non-Anthem Blue networks nationwide.

Next, the district court found that Anthem had provided sufficient evidence to rebut the government's prima facie case. It relied on evidence that Anthem's primary competitor for national accounts is United Healthcare, not Cigna; that national accounts tend to be sophisticated, well-informed customers and thus better able to thwart an attempted price increase; that new entrants to the market will constrain pricing; and that the combined company would have incentives to

innovate in its collaborative care arrangements with healthcare providers.

Finally, the district court found that the merger's overall effect in the Anthem states would be anticompetitive by reducing the number of national health insurance carriers from four to three. It rejected Anthem's efficiencies defense, which posited the combined company would realize $2.4 billion in medical cost savings through its ability to (1) "rebrand" Cigna customers as Anthem in order for them to access Anthem's existing lower rates; (2) exercise an affiliate clause in some of its provider agreements to allow Cigna customers access to Anthem rates; and (3) renegotiate lower rates with providers. First, it found that the claimed savings were not merger-specific because they were based on the application of rates that either company was already able to attain, and thus presumably each company could attain the other's superior rates on its own. It also found that for Cigna customers that would be rebranded to Anthem, any related savings would not be merger-specific because Cigna customers could simply purchase the Anthem product today. It rejected the notion that the merger was necessary to allow Anthem customers access to Cigna's popular product offerings because Anthem had failed to show that it could not develop and offer these products on its own. Second, the district court found that the claimed savings also failed because they were not sufficiently verifiable. It found that Anthem's plan to exercise the affiliate clause in its provider contracts was unlikely to work as Anthem suggested. That is, exercise of the affiliate clause would likely give rise to provider resistance because the providers were unlikely to accept lower rates and

provide more services without getting anything in return. The district court also found, as a matter of fact, that attempts to achieve the claimed savings through renegotiation of provider contracts would run into similar problems. It found that any savings would take time to be realized, and that Anthem's expert failed to account for utilization, *i.e.*, the amount of medical services that would be consumed by a given customer. In sum, it found the claimed savings were aspirational inasmuch as every proffered strategy either floundered in the face of business reality or was achievable without the merger, or both. The district court also expressed doubt as to whether the type of efficiencies claimed by Anthem, which merely redistribute wealth from providers to Anthem and its customers rather than creating new value, are even cognizable under Section 7.

Additionally, with regard to the Richmond market for large group employers, the district court found a presumption of anticompetitive effect based on the fact that Anthem and Cigna were the city's first-and second-largest competitors, with a combined market share of between 64% and 78%. It found that Anthem rebutted the presumption by challenging the government's calculations, pointing to additional competitors outside the Richmond area and claiming that Anthem customers in the Federal Employee Program skewed its Richmond market share. Overall, however, the district court credited the testimony of the government's expert that even accepting all of Anthem's claimed efficiencies, the merger would still have a net anticompetitive effect. Because Anthem had not shown that the remaining competition (or potential market entrants) could

likely constrain a price increase by the combined company, it found that the merger should be enjoined on that additional basis as well.

III.

Our review of the district court's decision whether to issue a permanent injunction under the *Clayton Act* is limited to determining whether there was an abuse of discretion. *United States v. Borden Co.,* 347 U.S. 514, 518 (1954); *see FTC v. H.J. Heinz Co.,* 246 F.3d 708, 713 (D.C. Cir. 2001) ("*Heinz*"). The district court's conclusions of law are reviewed *de novo*, and its findings of fact must be affirmed unless clearly erroneous. *Heinz,* 246 F.3d at 713. If a finding of fact rests on an erroneous legal premise, then the court "must examine the decision in light of the legal principles [it] believe[s] proper and sound." *Id.* (quoting *Ambach v. Bell,* 686 F.2d 974, 979 (D.C. Cir. 1982)).

A.

It is undisputed that the government met its burden to demonstrate a highly concentrated post-merger market, which would be reduced from four to just three competing companies. Anthem also does not dispute the definition of the national accounts market, nor that such a market will be even more highly concentrated post-merger. Anthem's appeal instead hinges on the district court's treatment of its efficiencies defense. The premise of its defense was explained by its expert, Mark Israel, Ph.D. According to Anthem, Dr. Israel quantified the medical cost savings that the combined company could achieve post-merger using a "best of best" methodology, based on the economic theory that the combined company, with its greater volume, would be able to

obtain discount rates that are no worse than either of the companies could achieve separately. Using claims data from Anthem and Cigna, he calculated that the merger would generate $2.4 billion in medical cost savings through improved discount rates, 98% of which he predicted would be passed through to customers, the large national employers with which Anthem and Cigna contract. Of the $2.4 billion in claimed savings, Dr. Israel projected that $1.517 billion would result from Cigna customers accessing Anthem's lower rates, while $874.6 million would result from Anthem customers accessing Cigna's lower rates; when viewed in terms of self-insured versus fully-insured customers, the former would purportedly see $1.772 billion of the claimed $2.4 billion, while the latter would see $619.8 million. Using merger simulation models, he balanced these projected savings against potential anticompetitive effects from the loss of the rivalry between the two companies and found the savings easily outweighed any potential harm. *See* Appellant Br. 5–6. But, as Anthem tends to ignore, the government offered its own evidence and experts to challenge these conclusions, as we discuss below.

Despite, however, widespread acceptance of the potential benefit of efficiencies as an economic matter, *see, e.g.*, Guidelines § 10, it is not at all clear that they offer a viable legal defense to illegality under Section 7. In *FTC v. Procter & Gamble Co.*, 386 U.S. 568 (1967), the Supreme Court enjoined a merger without any consideration of evidence that the combined company could purchase advertising at a lower rate. It held that "[p]ossible economies cannot be used as a defense to illegality. Congress was aware that some mergers which lessen

competition may also result in economies but it struck the balance in favor of protecting competition." *Id.* at 580. In his concurrence, Justice Harlan criticized this attempt to "brush the question aside," and he "accept[ed] the idea that economies could be used to defend a merger." *Id.* at 597, 603 (Harlan, J., concurring). No matter that Justice Harlan's view may be the more accepted today, the Supreme Court held otherwise, *id.* at 580, and no party points to any subsequent step back by the Court.

Nor does our dissenting colleague, despite his wishful assertion that *Procter & Gamble* can be disregarded by this court because it preceded the "modern approach" adopted in cases like *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974), and *Continental T. V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36 (1977). *See* Dis. Op. 9–11, 14–15. The Supreme Court made no mention of *Procter & Gamble* in *General Dynamics*, 415 U.S. 486, and it cannot be read to have implicitly overruled the earlier decision because it did not involve efficiencies. *See id.* at 494–504; *see also* 4A PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 976c2, at 115 (2016) ("AREEDA & HOVENKAMP") (distinguishing between an efficiencies defense and *General Dynamics*' "competitive significance" defense). And whatever significance *Continental T. V.* may have in the area of vertical restraints on trade, 433 U.S. at 54–59, it did not do the yeoman's work that the dissent apparently ascribes to it here, for it did not involve efficiencies, mergers, or Section 7 of the Clayton Act. Even stranger is the dissent's suggestion that our decision in *Baker Hughes*, 908 F.2d at 986, blessed an efficiencies defense, *see* Dis.

Op. 10–11, because *Baker Hughes* did not concern efficiencies and, like *Heinz*, 246 F.3d at 720, it could not overrule Supreme Court precedent. Nor has this court even hinted, as the dissent proclaims, that *General Dynamics* overruled *Procter & Gamble*'s efficiencies holding. *See Baker Hughes*, 908 F.2d at 988 (citing *Procter & Gamble* favorably); *Heinz*, 246 F.3d at 720 & n.18 (interpreting *Procter & Gamble*'s efficiencies holding). Put differently, our dissenting colleague applies the law as he wishes it were, not as it currently is. Even if "the Supreme Court has not decided a case assessing the lawfulness of a horizontal merger under Section 7 of the Clayton Act" since 1975, Dis. Op. 10, it still is not a lower court's role to ignore on-point precedent so as to adhere to what might someday become Supreme Court precedent.

Despite the clear holding of *Procter & Gamble*, 386 U.S. at 580, two circuit courts, and our own, have subsequently recognized the use of efficiencies evidence in rebutting a prima facie case. *Heinz*, 246 F.3d at 720 (citing, inter alia, *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991)); *see also ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 571 (6th Cir. 2014). The Eighth Circuit, in holding that the government had produced insufficient evidence of a well-defined market, acknowledged that the district court may have properly rejected the efficiencies defense, while observing evidence of enhanced efficiencies should be considered in the context of the competitive effects of the merger. *Tenet Health Care Corp.*, 186 F.3d at 1053–55. The Eleventh Circuit similarly concluded that whether an acquisition would yield significant

efficiencies in the relevant market is "an important consideration in predicting whether the acquisition would substantially lessen competition," *University Health, Inc.*, 938 F.2d at 1222, while noting both that "[i]t is unnecessary . . . to define the parameters of this defense now," and that "it may further the goals of antitrust law to limit the availability of an efficiency defense," *id.* at 1222 n.30. Other circuits have remained skeptical and simply assumed efficiencies can rebut a prima facie case, before finding that the merging parties had not clearly shown the merger would enhance rather than hinder competition. *See*, *e.g.*, *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 348 (3d Cir. 2016); *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 790 (9th Cir. 2015). These very recent decisions put to rest the dissent's notion that "no modern court" recognizes the continued viability of *Procter & Gamble*, *see Penn State Hershey Med. Ctr.,* 838 F.3d at 348; *Saint Alphonsus Med. Ctr.*, 778 F.3d at 789, while even a cursory reading of the court's opinion today puts to rest any suggestion that it "espouses the old . . . position that efficiencies might be reason to condemn a merger." Dis. Op. 15 (emphasis added) (quoting ERNEST GELLHORN ET AL., ANTITRUST LAW AND ECONOMICS IN A NUTSHELL 463 (5th ed. 2004)).

"Of course, once it is determined that a merger would substantially lessen competition, expected economies, however great, will not insulate the merger from a [S]ection 7 challenge." *Univ. Health*, 938 F.2d at 1222 n.29. Notably, Professors Areeda and Hovenkamp have observed that "Congress may not have wanted anything to do with an efficiencies

defense asserted by a firm that was already large or low cost within the market and to whom the efficiencies would give an even greater advantage over rivals." AREEDA & HOVENKAMP, *supra*, ¶ 950f, at 42; *id.* ¶ 970c, at 31. As our subsequent analysis shows, this court, like our sister circuits, can simply assume the availability of an efficiencies defense to Section 7 illegality because Anthem fails to show that the district court clearly erred in rejecting Anthem's efficiencies defense.

This court was satisfied in *Heinz*, in view of the trend among lower courts and secondary authority, that the Supreme Court can be understood only to have rejected "possible" efficiencies, while efficiencies that are verifiable can be credited. 246 F.3d at 720 & n.18 (discussing 4 PHILLIP AREEDA & DONALD TURNER, ANTITRUST LAW ¶ 941b, at 154 (1980)). The issue in *Heinz* was whether under Section 13(b) of the Federal Trade Commission Act, 15 U.S.C. § 53(b), preliminary injunctive relief would be in the public interest. 246 F.3d at 727. The court held that the district court "failed to make the kind of factual findings required to render that defense sufficiently concrete to rebut the government's prima facie showing," *id.* at 725, and, upon weighing the equities, remanded for entry of a preliminary injunction. *Id.* at 726–27. The court expressly stated however: "It is important to emphasize the posture of this case. We do not decide whether . . . the defendants' claimed efficiencies will carry the day." *Id.* at 727. These are not the issues in Anthem's appeal from the grant of a permanent injunction. *See LaShawn A. v. Barry*, 87 F.3d 1389, 1393 (D.C. Cir. 1996) (en banc).

Consequently, the circuit precedent that binds us allowed that evidence of efficiencies could rebut a prima facie showing, *Heinz*, 246 F.3d at 720–22, which is not invariably the same as an ultimate defense to Section 7 illegality. *Cf.* generally *Saint Alphonsus Med. Ctr.*, 778 F.3d at 789–90 (and authorities cited therein). In this expedited appeal, prudence counsels that the court should leave for another day whether efficiencies can be an ultimate defense to Section 7 illegality. We will proceed on the assumption that efficiencies as presented by Anthem could be such a defense under a totality of the circumstances approach, *see Baker Hughes*, 908 F.2d at 984–85 (citing *General Dynamics*, 415 U.S. at 498), because Anthem has failed to show the district court clearly erred in rejecting Anthem's purported medical cost savings as an offsetting efficiency. Guidelines § 10; *cf. Heinz*, 246 F.3d at 720–22. Additionally, because the district court could permissibly conclude that the efficiencies defense failed, because the amount of cost saving that is both merger-specific and verifiable would be insufficient to offset the likely harm to competition, this court has no occasion to decide whether the type of redistributional savings claimed here are cognizable at all under Section 7. It bears noting, though, that all of those other issues pose potentially substantial additional obstacles to this merger.

One further preliminary analytical point. Amici supporting Anthem invite the court to disregard the merger-specificity and verifiability requirements on the ground they place an asymmetric burden on merging parties that could doom beneficial mergers. *See* Br. for Antitrust Economists and Business Professors as Amicus Curiae in Support of Appellant

and Reversal ("Amici Economists") at 5–7. Anthem itself has not adopted this argument. *See Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2776 (2014); *Eldred v. Reno*, 239 F.3d 372, 378 (D.C. Cir. 2001). We note, however, that Amici Economists misapprehend the nature of Anthem's claimed efficiencies as "direct price reductions," *id.* at 6–7, rather than as potential price reductions subject to a number of uncertainties. For customers to realize any price reduction, Anthem would first have to succeed in reducing providers' rates, and to that extent the purported reductions would not be a direct effect of the merger. By contrast, the merger would immediately give rise to upward pricing pressure by eliminating a competitor, *see*, *e.g.*, Tr. 960:12–18, and Anthem could unilaterally raise its prices in response. Further, Amici Economists ignore that fully-insured customers, and potentially self-insured customers depending on the terms of their contracts with Anthem, will not see any savings until Anthem takes a second action, renegotiating the customers' contracts to pass through the savings. This illustrates the reason for the verifiability requirement: Perhaps Anthem is certain to take those actions, and there will be no impediments to the savings' realization, but that showing is still necessary for a court to conclude that the merger's direct effect (upward pricing pressure) is likely to be offset by an indirect effect (potential downward pricing pressure). *See* Guidelines § 10. As for merger-specificity, Amici Economists point to no logical flaw in the policy that consumers should not bear the loss of a competitor if the offsetting benefit could be achieved without a merger. *See Heinz*, 246 F.3d at 722.

B.

Any claimed efficiency must be shown to be merger-specific, meaning that it "cannot be achieved by either company alone because, if [it] can, the merger's asserted benefits can be achieved without the concomitant loss of a competitor." *Heinz*, 246 F.3d at 722. The Guidelines frame the issue slightly differently: an efficiency is said to be merger-specific if it is "likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects." Guidelines § 10. Anthem faults the district court for considering whether the efficiencies "could" be achieved absent the merger, without regard to likelihood, Appellant Br. 24, even though in *Heinz*, 246 F.3d at 722, this court spoke repeatedly in terms of possibility ("can" or "could").

Heinz, 246 F.3d at 721–22, cited the Guidelines with approval in describing the standard for merger-specificity. Both the current and then-current Guidelines refer to "practical" alternatives to achieving the efficiency short of merger, alternatives that are more than "merely theoretical." Guidelines § 10 (2010); Guidelines § 4 (1997). Similarly, in *Heinz*, 246 F.3d at 722, the court considered whether it was practical for the company to obtain better baby food recipes by investing more money in product development, or whether that would cost more money than the merger itself. The real question is whether the alternatives to merger are practical and more than merely theoretical, *see id.*; Guidelines § 10. Even assuming there is any difference between the two standards, it would not affect the outcome here on this factual record. Viewed under either

articulation, certain of Anthem's claimed efficiencies fall away.

The crux of Anthem's argument regarding merger-specificity is the theory that the combined company will allow Anthem to create a "new product" that is "unavailable on the market today": a product that features both "Cigna's customer-facing programs" and Anthem's "generally lower . . . rates." Appellant Br. 26. One way Anthem maintains the merger will result in this new product is through rebranding. According to Anthem, "rebranding means [the combined company] retain[s] the Cigna product but brand[s] it under the Anthem name with Anthem's negotiated provider rates." Appellant Br. 34. The record, however, refutes rather than substantiates Anthem's proposed rebranding approach. In fact, the record evidence Anthem cites for its rebranding plan is the testimony of Anthem Senior Vice President Dennis Matheis. But in that testimony, Matheis confirmed that, at least "[i]n the short term," rebranding would simply involve Anthem "offer[ing] Cigna customers Anthem products," in a manner that is "no different" than Anthem "selling new business in the market." Tr. 1599:20–25. In other words, when a Cigna customer rebrands, the immediate effect is that the customer gives up a Cigna contract and Cigna product in favor of an Anthem contract and Anthem product. Indeed, it is only "[o]ver the long haul," Matheis testified, that Anthem could actualize its "vision . . . [to] combine Cigna features . . . with Anthem features," Tr. 1606:17–21, and then rebranding might result in a former Cigna customer obtaining some semblance of the former Cigna product at the new Anthem rate. But rebranding in the immediate aftermath of the

merger would involve a Cigna customer switching to the extant Anthem product, and that is not a merger-specific outcome; that is just more successful marketing of the existing Anthem product. And Anthem expressly "does not contend that . . . a customer simply switching from a Cigna product to an existing Anthem product[] results in merger-specific efficiencies." Appellant Reply Br. 21.

Instead, Anthem claims only that rebranding over the long haul, once it has successfully rolled out an improved, Cigna-like product, will result in a merger-specific benefit, and maintains that the district court clearly erred in finding Anthem could simply develop and offer an improved product on its own. Just as in *Heinz*, 246 F.3d at 722, the evidence offered by Anthem is woefully insufficient to show that it cannot develop better customer-facing programs. Anthem points to testimony from two witnesses that Anthem has failed to replicate Cigna's products, for reasons unknown. In particular, Anthem's President of Specialty Business Pam Kehaly testified that Cigna offers a "packaged integrated wellness approach where [Anthem offers] disparate pieces that employers kind of have to piece together on their own." Kehaly Depo. Tr. 87:12–15 (Apr. 28, 2016). According to Kehaly, Anthem has been trying to solve the problem for "probably a decade" but for whatever reason it just has "not been able to crack this nut." *Id.* at 88:3–13. She did not indicate how intensive the effort has been, how many hours were devoted to it, or how much money Anthem has allocated toward it. Anthem's Regional Vice President of Sales Brian Fetherston also testified that Cigna has "done a really good job of building wellness programs" and that Anthem has

tried but failed to catch up. Fetherston Depo. Tr. 170:14–19 (May 6, 2016). The district court could properly find that failure likely results more from Anthem's own no-frills culture or flawed marketing strategies than from any inherent difficulties in pulling together an integrated wellness program. For instance, Fetherston testified that Cigna is "significantly better at marketing" its wellness program, while by contrast Anthem "just [was not] actively promoting" its own, and indeed, Anthem recently decided to "dial back some of [its] disease management programs," which Fetherston believed was a mistake. *Id.* 169:1–170:6, 323:1–23. To the extent Anthem has failed to devote the resources needed to improve its product, it is in no position to claim that consumers will benefit from it swallowing up Cigna's superior product.

Put differently, rebranding does not create a merger-specific benefit in either the short-or long-term. Perhaps Anthem could create some brief, interim benefit in the mid-term by integrating Cigna's product faster than it could develop a comparable product of its own. Guidelines § 10 n.13 ("If a merger affects not whether but only when an efficiency would be achieved, only the timing advantage is a merger-specific efficiency."). But Anthem made no sufficient factual showing in the district court on this point. It has offered no evidence to show how long it would take, once the necessary resources were allocated, to develop an improved product. Nor has it shown how long it would take to roll out a hybrid Anthem-Cigna product. At oral argument, Anthem claimed that it could do so in six months, but at trial, Anthem's Senior Vice President

Matheis allowed that it might not be able to do so within two-and-a-half years.

To the extent Anthem also maintains that none of Dr. Israel's claimed savings are dependent on rebranding, it ignores the reality of his economic model. Without one of its mechanisms to get current Cigna customers access to Anthem rates, none of the $1.517 billion in claimed Cigna savings could be realized. Although Dr. Israel may have been agnostic as to which mechanism is used to achieve those savings, he acknowledged that rebranding would achieve a portion of them: "If there was rebranding as a way to get the discounts . . . that would just be another way to get them faster." Tr. 2108:9–11. Given that rebranding is the linchpin of Anthem's post-merger strategy, because it is the only option that helps Anthem comply with its "Best Efforts" obligations, the inability to credit rebranding savings seriously undermines Anthem's efficiencies defense.

The district court further found that none of the medical cost savings are merger-specific because they are based on an application of rates that each of the companies has already achieved on its own. Anthem, quite reasonably, challenges this finding with regard to Cigna's rates on the ground that "there is no dispute that [Cigna] has generally secured less favorable provider rates than Anthem for years and has been unable to close that gap despite its best efforts." Appellant Br. 27. The record shows that, by its own account, Cigna has been unable to match Anthem's volume-based discounts and instead has had to compete on quality and innovation. Even the government's expert, Dr. David Dranove, agreed that a true Cigna product at Anthem rates would not be achievable absent the

merger. That the district court clearly erred in finding that the application of Anthem rates to customers that choose to remain with Cigna is not merger-specific, however, is immaterial to the district court's ultimate conclusion that the merger would be unlawful because these claimed efficiencies are not sufficiently verifiable.

C.

Under the Guidelines, projected efficiencies will not be credited "if they are vague, speculative, or otherwise cannot be verified by reasonable means." Guidelines § 10. Anthem maintains that the district court clearly erred because the $2.4 billion in projected post-merger savings was verified by two independent sources (Dr. Israel and an integration planning team from McKinsey & Company, which had access to each company's internal files). In Anthem's view, the district court also erred as a matter of law by imposing a "virtually insurmountable burden" of persuasion, Appellant Br. 38, when all that is required is to show "*probabilities*, not certainties," *Baker Hughes*, 908 F.2d at 984.

As discussed, Anthem plans to achieve the claimed savings through a combination of three mechanisms: rebranding, renegotiating provider contracts, and exercising Anthem's affiliate clause. The district court found that practical business realities would undermine the execution of that plan, making achievement of the savings speculative, and therefore unverifiable. With regard to the affiliate clause, the district court focused on evidence of the potential for provider discontent if the lower Anthem rates are forced on providers that must expend extra effort and resources to deliver the Cigna product,

without any corresponding increase in value for providers. This evidence included testimony by both Anthem and Cigna witnesses as well as documents from Anthem and Cigna that acknowledged the likely "abrasi[on]." *E.g.*, Pls.' Ex. 89. The record indicates that physician contracts can be terminated by either party with only 90 days' notice, so the affiliate clause would accomplish little if the contract is terminated or renegotiated soon after the clause is exercised. Hospital contracts tend to involve three-year commitments, so the affiliate clause may bind them to offer lower rates for a longer period. Still, when those hospital contracts expire, large delivery systems with greater leverage "could push back hard" in renegotiation. Pls.' Ex. 717. In either event, it is probable, as Cigna CEO David Cordani testified, that some providers will eventually "react [by] renegotiating . . . and putting upward pressure on rates, which has been a market force to date." Tr. 443:17–23. That "very few" Anthem providers have preemptively sought to renegotiate proves little, *see* Tr. 1686:15–25, because the feared abrasion would not occur until Anthem invokes the affiliate clause, assuming it ever does so.

This raises another practical difficulty with the affiliate clause: although it is theoretically useful to Anthem, in reality it is unlikely to be widely exercised because it works counter to Anthem's contractual obligations. Under the "Best Efforts" clause in Anthem's licensing agreement with the Blue Cross Blue Shield Association, 80% of Anthem's revenue within the Anthem states must be Blue-branded, as must 66.67% of its revenue nationwide. The merger would immediately throw Anthem out of compliance and so Anthem intends to rebrand a

"lion's share" of current Cigna customers in order to count that revenue as Blue-branded. Tr. 1600:17–21 (Anthem Sr. VP Matheis). By contrast, widespread exercise of the affiliate clause would remove any incentive for Cigna customers to convert to Anthem because those customers would then be receiving the Cigna product at Anthem prices, Dr. Israel's much-touted "best of both worlds" scenario. Anthem fails to address this reality when it maintains that 80% of the savings to Cigna customers could be achieved rapidly using the affiliate clause. *See* Appellant Br. 40. Because doing so would work contrary to Anthem's own contractual obligations, its witnesses conceded that it will instead rely heavily on rebranding, which, as discussed, gives rise to no merger-specific benefits.

As for renegotiation, the short answer is that if Anthem cannot persuade providers to extend lower rates to Cigna under its affiliate clauses — where it has apparent contractual recourse to do so — then it is speculative that Anthem could get them to agree to do the same thing through negotiations absent compulsion. Anthem assumes, as did Dr. Israel's model, that in all instances renegotiation would result in providers accepting the lower Anthem rates. That assumption appears questionable in the case of a provider that has just terminated a contract because Anthem mandated, through an affiliate clause, the acceptance of *those very rates*. Instead, Cigna's CEO Cordani predicted such renegotiation would put upward pressure on the Anthem rate, and to the extent Anthem were to adopt a take-it-or-leave-it approach, the provider could simply choose to walk away. *See* Br. for Amici Am. Med. Ass'n. & Med. Soc'y of D.C. ("AMA Br.") 11–12. This is

especially true for large hospital networks with significant bargaining power.

To the extent that some medical savings would be achieved for Cigna customers at the bargaining table due to the combined company's volume, the district court expressed concern over how long such savings would take to be realized. Anthem's CEO Swedish testified that capturing medical savings requires a "long gestation period," in part because existing hospital contracts span three to five years and would not be subject to renegotiation "for a considerable period of time." Tr. 337:21–338:16. He also rejected the idea that Anthem would simply "drop[] the hammer" on providers by insisting on maximum discounts across-the-board because Anthem instead relies upon "customized relationship-driven contract[s]" that seek to optimize performance on a case-by-case basis, rather than focusing solely on discounts. Tr. 294:20–295:11. Anthem's expert agreed that renegotiations in the ordinary course of business will take place over time. The longer it takes for an efficiency to materialize, the more speculative it can be, *see* Guidelines § 10 & n.15, so the district court was on solid ground to give less weight to the claimed renegotiation savings.

In sum, although renegotiation will lead to a decrease in Cigna's rates, the assumption that it will in every instance lead to the Anthem rate is farfetched. *See Tenet Health Care Corp.*, 186 F.3d at 1054. Indeed, as the district court observed, "the Department of Justice is not the only party raising questions about Anthem's characterization of the outcome of the merger" because Cigna itself had "provided compelling testimony undermining the

projections of future savings." *Anthem, Inc.*, 2017 WL 685563, at *4; *see also* Pls.' Ex. 722.

Whatever mechanism is employed to achieve the savings, the district court had "reason to question . . . whether the quality of the Cigna offering will in fact degrade" as a result of the merger, *Anthem*, 2017 WL 685563, at *61, which further undermines the purported efficiency claims. Guidelines § 10. For those that choose to stay with Cigna post-merger — and thus would access lower rates through renegotiation or exercise of the affiliate clause — the abrasion problem arises because providers would be asked to continue offering the high-touch, collaborative Cigna service, with its added behavioral, wellness, and lifestyle programs, for less money. *See* AMA Br. 10–11. It was perfectly reasonable for the district court to find that some providers, even if they are willing to accept less money, will simply respond by offering customers less in the way of Cigna high-touch service. Furthermore, according to Cigna's CEO Cordani, the value of the Cigna offering will be diminished because Anthem's rebranding strategy will siphon business away from Cigna, leaving behind an atrophied Cigna customer base that is less attractive to providers. This will in turn diminish Cigna's capacity for further innovation with its collaborative model. And for Cigna customers that agree to migrate to Anthem (or are pushed into doing so because the company refuses to extend their expiring Cigna contracts), provider abrasion again rears its head, this time with providers being asked to offer Anthem customers better, and more resource-intensive, collaborative service for the same rates they have historically received. Anthem does not

respond meaningfully to these concerns, simply labeling them "speculation." Appellant Reply Br. 10. In light of the numerous Anthem witnesses who acknowledged the abrasion problem, the district court did not err in finding it "dubious" that Anthem would be able to offer a true Cigna-like product, or that legacy Cigna would be able to maintain the quality of its own product. *Anthem*, 2017 WL 685563, at *59, *61.

The fact is, it is widely accepted that customers value the existing Cigna product, and that Cigna is a leading innovator in collaborative patient care. That threat to innovation is anticompetitive in its own right. *Cf. United States v. Cont'l Can Co.*, 378 U.S. 441, 465 (1964). And the problem is neither answered by Anthem's evidence nor offset by its purported efficiency of offering a degraded Cigna product at a lower rate.

In addition to claimed savings to current Cigna customers, Dr. Israel also projected that $874.6 million in savings would be realized if Anthem's customers were able to access superior rates that Cigna has already negotiated. In focusing almost entirely on the other side of the ledger, Anthem offers little reason to think that the district court clearly erred in rejecting the claimed savings to existing Anthem customers. *See* Appellant Br. 41–42. To the extent Anthem argues on appeal that Anthem customers could access Cigna's superior rates through rebranding or exercise of an affiliate clause, the only witness it cites was actually discussing the affiliate clause in *Anthem*'s contracts that would apply to *Cigna*'s customers. And even assuming that Cigna's contracts contain an affiliate clause, Blue Cross Association rules would prohibit Anthem from

exercising it. Further, rebranding Anthem customers to Cigna would only exacerbate Anthem's "Best Efforts" problem, which indicates why Anthem Senior VP Matheis testified that Anthem would rebrand a lion's share of Cigna customers to Anthem, not the other way around. Renegotiation would be the only viable option for realizing the projected savings to Anthem customers.

Moreover, Anthem has not explained why these projected savings would even exist. The record is clear that Anthem, unlike Cigna, has already achieved whatever economies of scale are available. According to *Anthem*'s expert Dr. Robert Willig, in the 35 local markets identified in the government's complaint, the data did not show that Anthem's size correlated with its provider discounts. To the contrary, Dr. Willig testified that Anthem is "already past the threshold of having enough size to do what it needs to do in terms of offering volume to providers." Tr. 2231:9–12. Similarly, Anthem's CEO Joseph Swedish denied that Anthem would seek to negotiate even greater volume-based discounts after the merger because post-merger Anthem would "certainly not [pay] less than what [it is] now paying as Anthem." Tr. 294:10–19. The evidence indicates that where Cigna has better discounts than Anthem, that is a result of factors other than volume, and the district court reasonably questioned whether those atypical discounts would remain available post-merger. In the absence of an additional volume-based discount, then, Anthem makes no effort to show how its current customers would see lower prices as a result of the merger, and certainly not to the tune of $874.6 million. Consequently, the district

court did not clearly err in rejecting these alleged medical cost savings as unverifiable.

Next, the claimed medical cost savings only improve consumer welfare to the extent that they are actually passed through to consumers, rather than simply bolstering Anthem's profit margin. *See Univ. Health, Inc.*, 938 F.2d at 1223. After all, the merger potentially harms consumers by creating upward pricing pressure due to the loss of a competitor, and so only efficiencies that create an equivalent downward pricing pressure can be viewed as "sufficient to reverse the merger's potential to harm consumers . . . , *e.g.*, by preventing price increases." Guidelines § 10; *see also* AREEDA & HOVENKAMP, *supra*, ¶ 971a, at 48 ("[A] sufficient amount of any efficiencies [must] be passed on that the post-merger price is no higher than the pre-merger price."). Dr. Israel testified that absent monopsony (*i.e.*, the exercise of market power to gain subcompetitive prices from providers), *any* cost savings will create downward pricing pressure, and while this is unobjectionable, the amount passed through to consumers indicates the strength of that pressure. *See* Br. of Professors as Amici Curiae in Support of Appellee and for Affirmance 7–8 ("Amici Professors"). The district court rightly cast doubt on Dr. Israel's estimated pass-through rate of 98%, which was unsupported by the evidence and treated self-insured and fully-insured customers identically.

Because ASO customers pay their employees' medical costs directly, any reduction in medical rates would result in savings that automatically pass through to the customer, absent some corresponding ASO price increase by Anthem. This would improve the quality of one aspect of the ASO product (*i.e.*,

access to more deeply discounted network rates), and it could thus be procompetitive even if it did not immediately result in an ASO price decrease. *See* Guidelines § 10. Dr. Israel's analysis rested on the assumption that rather than raising ASO prices to capture the medical cost savings, Anthem would attempt to increase its market share by providing a much superior product at only a slightly higher price, thereby maximizing its profits through increased sales. The district court highlighted internal Anthem documents that discussed ways to keep those savings for itself, in particular where Anthem listed seven alternatives with 100% pass-through to ASO customers considered last. Contrary to Dr. Israel's assumption, then, Anthem apparently concluded that total pass-through was not the profit-maximizing, "optimal solution to capture the most value from [the] deal," and that it could actually lose business if customers initially saw savings that were not sustained over the long term. Pls.' Ex. 727. Amici Professors offer another reason why Anthem might have come to this conclusion: in highly concentrated markets, already-large insurers are less constrained by competition and thus tend to find it more profitable to capture medical savings and increase premiums. Amici Professors Br. 6–9; *see also* AREEDA & HOVENKAMP, *supra*, ¶ 971f, at 56 (in highly concentrated markets "there is less competition present to ensure that the benefit of efficiencies will flow to consumers"). That corroborates rather than remediates anticompetitive concerns.

As for fully insured customers, which comprise $619.8 million of the projected savings, the estimated pass-through is even less likely given that the

savings would automatically inure to Anthem's benefit absent some corresponding price decrease to its customers. Dr. Israel recognized this dynamic at trial, and yet his model takes no account of it, applying a pass-through rate of 98% to both ASO and fully insured accounts. The record indicates that ASO customers, which pay medical costs directly to providers, are keenly attuned to fee transparency, but it is unclear fully-insured customers are afforded the same transparency. That is, if Anthem negotiates provider rates and pays providers directly, how would a customer be aware that Anthem had achieved medical savings, in order to be able to seek a pass-through in the form of a lower negotiated price? Further, when would fully-insured customers realize that renegotiated price, given that their existing contracts would not pass though any savings? *See* Tr. 2107:17–21 (Dr. Israel: ordinary-course renegotiation of employers' contracts "will take place over time"). Neither Anthem nor Dr. Israel answers (or addresses) these problems.

Finally, the district court did not clearly err when it criticized Anthem's failure to account in its projected savings for utilization, which is a signature aspect of the Cigna product. Dr. Israel's model was based on discounts that either company was able to achieve on its own multiplied by the total claims value, but as Anthem's CEO Swedish testified, "We don't live in a discount world any longer." Tr. 295:11. Cigna's CEO Cordani agreed: "If you're looking [only at] a discount calculation, if [Anthem] has a 2 percent lower discount for the emergency room service, you would assume that that's a savings," unless Cigna's wellness program helps the patient avoid that emergency room visit altogether. Tr.

443:10–16. Anthem maintains that Dr. Israel and the McKinsey & Co. team did account for utilization, because Dr. Israel testified that lower utilization would result in a lower total claims value, a value that factored into both his and the McKinsey & Co. models. But this ignores that on cross-examination, Dr. Israel conceded that he did not control for the different risks and features of each company's population at a particular provider, which would be necessary to compare utilization, and so his model did not account for whether one company's utilization was better than the other's. And although Anthem nevertheless maintains that no evidence shows accounting for utilization would materially reduce the claimed savings, Dr. Dranove testified that any error or incorrect assumption would have a significant effect on the overall projected savings. *See* Tr. 2327:15–2329:11. Thus, the problem is less that the failure to account for utilization would necessarily reduce the projected savings, and more that it undermined the district court's confidence in the reliability and factual credibility of those savings calculations.

Both sets of projections suffered from additional, basic analytic flaws. For instance, Dr. Israel did not agree with the district court's national accounts market definition (employers with 5,000+ employees), so his savings projection was based on the broader market definition that he believed appropriate (large-group employers with either 50+ or 100+ employees). In other words, Dr. Israel's claimed $2.4 billion in savings is unmoored from the actual market at issue, and there is no indication of what portion is properly derived from the national accounts market. Similarly, the McKinsey & Co.

analysts based some of their savings on a comparison of Cigna and Anthem rates where only one of the companies had negotiated a discount with that particular provider. This apples-to-oranges comparison of in-network versus out-of-network rates overstated the true disparity between the companies' existing discounts and thus necessarily inflated McKinsey & Co.'s projected savings. Even Dr. Israel acknowledged as much: his model only compared in-network rates because he concluded that "that's what the economics tells you you need to do to get the answer right." Tr. 1855:2–22. This could help to explain why Dr. Israel's otherwise similar methodology resulted in a projection that was almost *a billion dollars* less than McKinsey & Co.'s.

The savings projected by McKinsey & Co. and Dr. Israel — uncritically relied on by the dissent, *e.g.*, Dis. Op. 4–8, 18 — were without a doubt enormous. The problem is, those projections fall to pieces in a stiff breeze. If merging companies could defeat a Clayton Act challenge merely by offering expert testimony of fantastical cost savings, Section 7 would be dead letter.

D.

Having considered the totality of circumstances, *see Baker Hughes*, 908 F.2d at 984, we hold that the district court reasonably determined Anthem failed to show the kind of "extraordinary efficiencies" that would be needed to constrain likely price increases in this highly concentrated market, and to mitigate the threatened loss of innovation. *Cf. Heinz*, 246 F.3d at 720. Given the record evidence, Anthem's objection that the district court "abdicated its responsibility" to balance the merger's likely benefits against its

potential harm, Appellant Br. 46, rings hollow. Anthem seems to insist upon a dollar-for-dollar comparison after discounting whatever claimed efficiencies were properly rejected, in responding that "so long as at least one-third of the $2.4 billion of savings are likely to be achieved, the merger is procompetitive." Appellant Reply Br. 10. This would apparently require the court to calculate, for instance, a more realistic pass-through rate than the rejected 98% figure, or to estimate what percentage of the claimed $2.4 billion was attributable to customers with fewer than 5,000 employees and thus outside of the relevant market. Anthem has pointed to no relevant expert economic evidence on which to base such an imprecise calculation, and Anthem, not the district court, has the burden of showing what portion of the claimed efficiencies will result from the merger itself. Even assuming it were possible on this record, *see University Health*, 938 F.2d at 1223, "[e]conomies cannot be premised solely on dollar figures, lest accounting controversies dominate § 7 proceedings," *Procter & Gamble*, 386 U.S. at 604 (Harlan, J., concurring). Because "the state of the science does not permit such refined showings," commentators have recommended simply giving the government the benefit of the doubt in a close case. *See* AREEDA & HOVENKAMP, *supra*, ¶ 971f, at 56. In any event, this is not a close case.

The dissent's critique of the court's opinion is not well founded. Its fundamental flaw is the failure to engage with the facts shown in the record as they pertain to merger-specificity and verifiability. Repeated references to unspecified evidence, *see*, *e.g.*, Dis. Op. 3, 12, 14, 17, on which the dissent bases sweeping conclusions, speak volumes. Rather than

engage with the record, much less adhere to our standard for reviewing findings of fact by the district court, the dissent offers a series of bald conclusions and mischaracterizes the court's opinion. For instance, the dissent repeatedly claims that the court "does not fully accept the fact . . . that providers rates would actually be lower," Dis. Op. 17; *id.* at 15, when in fact the court accepts that rates would be lower for some existing Cigna (but not Anthem) customers post-merger. Those who rebrand with Anthem, however, will see no merger-specific savings, Op. 20–21, and the few that Anthem fails to rebrand will see far fewer savings than Anthem claims, due in large part to provider abrasion and big hospital systems that will stand their ground in renegotiation, Op. 24–27. The dissent baldly asserts that the efficiencies "are merger-specific by definition," Dis. Op. 6–7, without addressing the paucity of evidence that Anthem would be unable to develop a Cigna-like product without merging. So too, it baldly asserts that the savings were "sufficiently verified," while admitting that it is not clear "just how much the employers would benefit from this merger." *Id.* at 7 (emphasis omitted). In other words, Anthem estimated an astronomical amount of savings, so even if that amount were wildly overstated, the dissent expects the court to trust that, as an unknown fraction of a large number, the result "would be large." *Id.*

To the extent the dissent notes any of the major factual problems with Anthem's depiction of the merger, it brushes them aside. It dismisses as "highly speculative" the provider abrasion problem that was *conceded by both Anthem and Cigna witnesses*, Dis. Op. 17, a problem that undermines

Anthem's plans for realizing the savings through the affiliate clause and renegotiation. It characterizes record evidence that squarely contradicts Anthem's pass-through estimates — Anthem's own internal PowerPoint presentation — as "secret Anthem plans to dramatically raise [its] fees," *id.*, which is precisely what the evidence reflects. It attacks straw men like supposed reliance on "friction between the Anthem and Cigna CEOs," *id.*, when the court does not so rely, noting indeed the limited probative value of that evidence. Op. 4 n.1. It fails entirely to address Anthem's "Best Efforts" obligations, which make it likely that Anthem will rely predominantly on rebranding, a strategy that gives rise to no merger-specific benefit. Op. 24–25. The "Best Efforts" clause also creates a verifiability problem with regard to Anthem's other savings strategies, for instance undercutting Anthem's assertion that 80% of the savings to Cigna customers "could be achieved simply [and rapidly] by invoking the affiliate clause." Appellant Br. 40. Again, pulling at any one loose thread quickly unravels Anthem's narrative, but the dissent is simply unwilling to do so.

Ultimately, the dissent concludes that "[o]n this record, there is little basis to doubt that the cost savings for employers as a result of the merger would be large," without evincing any real awareness of the record beyond the testimony of Anthem's expert and consultants. *See* Dis. Op. 7. To wit, the dissent suggests that Anthem's savings estimates went unrebutted at trial, Dis. Op. 6, when the record shows Dr. Dranove not only offered his own estimate of $100 million to $500 million but explained why those savings were unlikely to be realized, essentially for the reasons discussed in this opinion.

See, *e.g.*, Tr. 3802:25–3803:11. Similarly, it recognizes no distinction between savings to existing Cigna customers (some of which the government concedes will materialize) and savings to existing Anthem customers (the existence of which even Anthem cannot explain in light of the testimony of both its CEO and expert, *see supra* Part III.C). Likewise, in concluding that the quality of the Cigna product (its wellness programs and the high-touch service that providers offer in support of the programs) will not degrade post-merger, the dissent does not go so far as to say there is no evidence to support the district court's contrary finding, *Anthem*, 2017 WL 685563, at *59, *61; rather, it asserts it does not consider this evidence "persuasive" or "convincing." Dis. Op. 18. Such *de novo* analysis throughout the dissent betrays no meaningful effort to engage with the district court's factual findings, which are subject only to review for clear error.

Furthermore, the dissent's assumption that the prices paid by consumers (regardless of the quality of the resulting product) are the sole focus of antitrust law is flawed. "The principal objective of antitrust policy is to maximize consumer welfare *by encouraging firms to behave competitively*." *Kirtsaeng v. John Wiley & Sons, Inc.*, 133 S. Ct. 1351, 1363 (2013) (emphasis added) (quoting 1 P. AREEDA & H. HOVENKAMP, ANTITRUST LAW ¶ 100, at 4 (2006)). This single-minded focus on price ignores that in highly concentrated markets like this one, lower prices, if they occur at all, may be transitory. Owing to the lower level of competition in highly concentrated markets, when presented with lower supply input prices, companies have a greater ability to retain for themselves the input savings rather

than pass them on to consumers. The Clayton Act, as the Supreme Court "ha[s] observed many times, [is] a prophylactic measure, intended primarily to arrest apprehended consequences of intercorporate relationships before those relationships could work their evil." *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 485 (1977) (internal quotation marks and citation omitted). The ability of a firm to obtain lower prices for inputs for its product (here, provider services) should, especially in light of the prophylactic nature of the Clayton Act, be viewed skeptically when high market concentrations may have the future effect of permitting capture of those savings. The dissent uncritically accepts Dr. Israel's rosy testimony to the effect that ASO savings "will be passed through to employers," Dis. Op. 15, but fails to address contrary Anthem documents and the historical tendencies of large companies in highly concentrated markets to capture savings. *E.g.*, AREEDA & HOVENKAMP, *supra*, ¶ 971f, at 56. The dissent also ignores the district court's numerous and not clearly erroneous findings, as previously discussed, that total or nearly total pass-through is unlikely. *See*, *e.g.*, *Anthem*, 2017 WL 685563, at *4, *62. Even if ASO savings would pass through in the short term, that does not "practically guarantee[]" that Anthem would not then raise its prices correspondingly. *But see* Dis. Op. 16.

Additionally, the dissent fails to recognize that lower prices may arise due to, or ultimately lead to, a decrease in product quality. Everyone would agree that rock-bottom provider rates seem beneficial to consumers, but when those rock-bottom prices lead to inferior medical services, any benefit to the consumers' wallets is diminished by the harm to

their health. As the Guidelines state, if merging firms "would withdraw a product that a significant number of customers strongly prefer to those products that would remain available, this can constitute a harm to customers over and above any effects on the price or quality of any given product." Guidelines § 6.4; *see also id.* § 10 ("[P]urported efficiency claims based on lower prices can be undermined if they rest on reductions in product quality or variety that customers value."). And a decrease in product quality is not merely speculative here — every dollar of medical cost savings realized by consumers will come at the expense of providers. It thus is quite plausible that paid less, the medical providers will provide less. These inconvenient facts do not jibe with the dissent's superficial, thirty-thousand-foot view of this case, and it is thus unsurprising that they are addressed in passing, if at all.

IV.

Anthem fares no better in its challenge to the district court's independent and alternative determination that the merger should be enjoined on the basis of its anticompetitive effect in the Richmond, Virginia market for the sale of health insurance to "large group" employers with more than fifty employees. There, the government's prima facie case was even stronger than in the market for national accounts in the fourteen Anthem states. Depending on how market share was calculated (*i.e.*, including all Blue customers as Anthem or not, including fully insured customers or just ASO), the companies' combined market share ranged from 64% to 78%. Even under the calculation most favorable to Anthem (ASO-only, disregarding non-Anthem Blue

customers), the merger would raise an overwhelming presumption of anticompetitive effect: HHI would rise 1511 to a post-merger total of 4350, where the Guidelines presumption threshold is an increase of 200 to a post-merger total of 2500. As the President of Anthem Virginia acknowledged, Anthem has the biggest share of the large group employer market across all of Virginia, and in Richmond, Cigna is its strongest competitor.

Anthem principally challenges the district court's reliance on a chart prepared by Dr. Dranove, the government's expert witness, showing the merger would have an anticompetitive effect in Richmond even crediting all of Dr. Israel's claimed efficiencies. The chart included an asterisk next to the Richmond entry signifying that "no amount of cost savings could offset employer harm due to decreased competition." Pls.' Ex. 760. On cross examination, Dr. Dranove was asked whether that meant even a savings of $10 billion or $20 billion would not offset the merger's harm, and he acknowledged that he could not recall the foundation for his statement. Given this inability to address that extreme hypothetical, Anthem maintains that the district court should not have relied on the statement or even on the chart as a whole.

The record shows that the district court did not rely on the "asterisk" statement and explained at trial that it would not do so because it was unnecessary to finding a substantial anticompetitive effect. As to the broader question whether Dr. Dranove's inability to explain the asterisk meant that the district court should have disregarded his chart (and related testimony) altogether, the district court did not abuse its discretion. *See Heller v.*

District of Columbia, 801 F.3d 264, 272 (D.C. Cir. 2015). Leaving the asterisk statement aside, Anthem raises no real objection to the substance of the chart, only urging that Dr. Dranove's inability to explain the asterisk was so damaging that it called into doubt the reliability of his overall analysis. The district court, which heard extensive testimony from Dr. Dranove about the anticompetitive effects revealed by his economic models and relied on it heavily throughout its opinion, clearly concluded otherwise. The district court had "considerable leeway" to do so in determining that all other aspects of the chart and his testimony were reliable. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152 (1999); *cf. Snyder v. Louisiana*, 552 U.S. 472, 477 (2008).

Anthem's remaining challenges amount to an ineffectual attack on the district court's weighing of rebuttal evidence. It incorrectly states that the district court relied solely on Dr. Dranove's chart to find anticompetitive harm while ignoring evidence of "enormous" medical savings, Appellant Br. 53, when in fact Dr. Dranove testified that his chart credited 100% of Anthem's claimed savings and still found a net anticompetitive effect. Anthem posits that there would still be five or more competitive insurers in Richmond post-merger, but even assuming that is true (one of the two witnesses it cites identified only four, including the combined company), the mere existence of competitors may not be sufficient to constrain a larger Anthem that would control 64% to 78% of the market. *See* Guidelines § 5. Indeed, one of those competitors, Optima, was said to have struggled in the Richmond market, and Anthem shows no clear error in the district court's finding that Optima "does not appear able to compete on the

same field as the merged company." *Anthem*, 2017 WL 685563, at *68. Nor does Anthem show clear error in the finding that other companies do not appear interested in entering the Richmond market, or that even if they did, their entry would be insufficient to constrain the combined company. The evidence cited by Anthem shows only that other companies may intend to enter Richmond (Innovation), or may have the ability to enter Richmond (Piedmont, VCU), or may have a marginal or embryonic presence in Richmond (Kaiser, Bon Secours), not that entry by these companies would offset the merger's anticompetitive potential.

Tellingly, our dissenting colleague offers a single mention of the district court's Richmond holding (in a parenthetical, no less), which itself is a sufficient basis for enjoining the merger. Any suggestion that the claimed savings would make the merger procompetitive in Richmond ignores the record evidence, namely that even crediting all of the claimed savings, the merger of Richmond's two biggest large-group insurers would give the combined company such a vast market share that the overall effect of the merger would still be anticompetitive. As Dr. Dranove testified at trial, his analysis "still predicts a price increase" in the Richmond market "even [after] crediting every penny of th[e] efficiencies" estimated by Dr. Israel. That is, even ignoring Anthem's failure to show that the savings were merger-specific and sufficiently verifiable, *see supra* Part III.B—C, the proposed merger would cause an already highly concentrated market to become overwhelmingly so, with Anthem controlling as much as 78% of the market and two or three other companies fighting to maintain

relevance. Although the dissent recognizes this appeal raises "fact-intensive question[s]," Dis. Op. 13, it has persistently failed to engage with the facts.

In conclusion, the district court did not clearly err in its factual findings that the merger would have anticompetitive effects in the Richmond market, and importantly, Anthem does not allege any error of law with respect to that determination. Thus, the district court did not abuse its discretion in enjoining the merger on the basis of the merger's anticompetitive effects in the Richmond market. And, as previously noted, this holding provides an independent basis for the injunction, even absent a finding of anticompetitive harm in the fourteen-state national accounts market.

Accordingly, we affirm the issuance of the permanent injunction on alternative and independent grounds.

MILLETT, *Circuit Judge*, concurring: I join the opinion of the court in full, including its two separate and independent holdings that the proposed merger would substantially reduce competition in (i) the national-accounts market and (ii) the large-group-employer market in Richmond. Indeed, as to the latter holding, all of Anthem's and the dissenting opinion's *Sturm und Drang* over efficiencies is beside the point because the district court held that, even accepting all of Anthem's claimed cost savings, the merger would still have substantial anticompetitive effects. *United States v. Anthem*, Civil Action No. 16-1493 (ABJ), 2017 WL 685563, at *68 (D.D.C. Feb. 21, 2017).

With respect to the holding regarding the national-accounts market, I write separately only to underscore the foundational problems that pervade Anthem's and the dissenting opinion's insistence that any reduction in provider rates, standing alone, excuses an anticompetitive merger.

First, there is no dispute that, to have any legal relevance, a proffered efficiency cannot arise from anticompetitive effects. Dissenting Op. 13 ("Cognizable efficiencies * * * do not arise from anticompetitive reductions in output or service.") (quoting DEPARTMENT OF JUSTICE & FEDERAL TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 10, at 30 (Aug. 19, 2010)). Rather, the proffered efficiencies, even if verifiable, must at least neutralize if not outweigh the harm caused by the loss of competition and innovation. HORIZONTAL MERGER GUIDELINES § 10, at 30 ("cognizable efficiencies" must "reverse the merger's potential to harm customers in the relevant market"); *see also* 4A PHILLIP E. AREEDA &

HERBERT HOVENKAMP, ANTITRUST LAW ¶ 270e, at 36–40 (4th ed. 2016).

That means that once a court has found a Section 7 violation, a generic statement that prices will go down proves nothing by itself. Yet the dissenting opinion repeatedly hangs its hat on the government's statement that the proposed merger will "lower" provider rates. *See* Dissenting Op. 4, 7, 15, 18–19. The government, however, never agreed with Anthem or the dissenting opinion's assigned dollar amounts. Nor did it ever concede that (i) the reduction would be sufficiently large to offset the merger's anticompetitive effects, (ii) the savings were obtainable only through merger, or (iii) the savings were verifiable.

In fact, all that the government stated was that any decrease in provider rates would come about through an exercise of unlawful market power. *See* J.A. 545. That would be an antitrust violation, not an efficiency. And that statement by the government hardly seems to merit "[l]inger[ing]" over, Dissenting Op. 4.

Second, what the dissenting opinion (at 15) labels as an "undeniable" predicate assumption—that any cost savings will necessarily be passed through to customers—not only is very much denied, Appellees' Br. 58, but actually flies in the face of the factual record. As the district court found, a number of damaging internal Anthem documents detailed the company's efforts and specific business options for actively *preventing* those savings from being passed through to customers and instead capturing the money for itself. *Compare* Dissenting Op. 5–6, 12, 15–16, *with*, *e.g.*, *Anthem*, 2017 WL 685563, at

*62 ("Anthem's internal documents reflect that the company has been actively considering multiple scenarios for capturing any medical cost savings for itself[.]"); J.A. 2159 (Anthem presentation, entitled "Overview of potential ASO value capture models," states that "[p]ass[ing] all savings through to customers" is "not * * * optimal" because it fails to "capture most value from [the] deal"); Suppl. App'x 1863–1865, 1858, 1419, 463, 472 (sealed materials). It is right there in black and white.[1]

So the reason the opinion of the court does not "fully accept[]" the dissenting opinion's "key fact[]," Dissenting Op. 15, is because the district court found it to be untrue. And given the content of the internal Anthem documents, that factual determination was not clearly erroneous.[2]

Third, context matters. Lower rates cannot be trumpeted without first asking what those lower rates will buy. The second half of the government's statements about decreased provider rates was that they would lead to an inferior health care product, including reduced access to medical care and fewer doctors. Compl. ¶ 72; *see also* J.A. 545. The district court found as a matter of fact, and the opinion of the court rightly affirms, that customers would be paying less because they would be getting less in the form of

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[1] In addition, the dissenting opinion's rosy forecast (at 8) that Anthem's employer-customers would then automatically use those (unproven) savings to raise their employees' pay is cut out of whole cloth. Not even Anthem offered up that Panglossian prediction.

[2] Curiously, none of the large employers who, according to Anthem, stand to gain billions of dollars in savings have filed any brief in support of this merger.

a degraded Cigna product. Op. 27–28; *Anthem*, 2017 WL 685563, at *59 (crediting testimony that "imposing lower fee structures would unravel [Cigna's] collaborative relationships with providers"); *id.* at *61; *id.* at *63 ("[T]here is ample evidence in the record that the merger would harm consumers by reducing or weakening the Cigna value based offerings which aim to reduce medical costs by reducing utilization and by engaging with, rather than simply reducing the fees paid to, providers.").

Paying less to get less is not an efficiency; it is evidence of the anticompetitive consequences of reducing competition and eliminating an innovative competitor in a highly concentrated market.

Fourth, while the dissenting opinion repeatedly declares the record evidence "overwhelming[]" that the post-merger firm will deliver health care for less, *e.g.*, Dissenting Op. 8, it bears emphasizing that one half of this merger disagrees. "In this case, the Department of Justice is not the only party raising questions about Anthem's characterization of the outcome of the merger: one of the two merging parties"—Cigna—"is also actively warning against it." *Anthem*, 2017 WL 685563, at *4. Importantly, "Cigna officials provided compelling testimony undermining the projections of *future savings*" that Anthem proffered and the dissenting opinion embraces. *Id.* (emphasis added).

Finally, the assumption that the prices paid by Anthem's customers—whatever the quality of the resulting product—are the sole focus of antitrust law sits at the center of Anthem's and the dissenting opinion's contentions. But antitrust law is not so monocular. Rather, product variety, quality,

innovation, and efficient market allocation—all increased through competition—are equally protected forms of consumer welfare. *See* HORIZONTAL MERGER GUIDELINES § 6.4, at 24.[3] Indeed, "withdraw[al of] a product that a significant number of customers strongly prefer to those products that would remain available * * * can constitute a harm to customers over and above any effects on the price or quality of any given product." *Id.* That is why, under antitrust law, anticompetitive conduct that lowers prices can be illegal. *See United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940) ("Under the Sherman Act a combination formed for the purpose and with the effect of raising, *depressing*, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal per se.") (emphasis added).[4]

The dissenting opinion also founders on the mistaken belief that any exercise of increased bargaining power short of monopsony is procompetitive. But securing a product at a lower cost due to increased bargaining power is not a

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[3] *See also Rebel Oil Co. v. Atlantic Richfield Co.*, 51 F.3d 1421, 1433 (9th Cir. 1995) ("Consumer welfare is maximized when economic resources are allocated to their best use, and when consumers are assured competitive price and quality.") (citing, *inter alia*, *National Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross of Kansas City*, 452 U.S. 378, 387–388 & n.13 (1981)).

[4] *See also Knevelbaard Dairies v. Kraft Foods, Inc.*, 232 F.3d 979, 988 (9th Cir. 2000) ("[T]he central purpose of the antitrust laws, state and federal, is to preserve competition. It is competition—not the collusive fixing of prices at levels either low or high—that these statutes recognize as vital to the public interest.").

procompetitive efficiency when doing so "simply transfers income from supplier to purchaser without any resource savings." AREEDA & HOVENKAMP, *supra*, ¶ 975i, at 106. Plus, as Professors Areeda and Hovenkamp explain in language that speaks directly to Anthem's proposed merger: "Congress may not have wanted anything to do with an efficiencies defense asserted by a firm that was already large or low cost within the market and to whom the efficiencies would give an even greater advantage over rivals." *Id.* ¶ 970c, at 31.

Ultimately, the judicial task here is not to favor cost redistribution or any other economic agenda for its own sake. Congress has decided that any merger that "substantially * * * lessen[s] competition" is forbidden. 15 U.S.C. § 18. Our task is to enforce that legislative judgment. To allow a merger that has already been proven to "substantially * * * lessen competition," *id.*, to proceed anyhow because of some unverifiable and non-merger-specific amount of price decreases accruing to one segment of the health care market would rewrite rather than enforce the Clayton Act.[5]

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[5] Thus far the courts of appeals—including *United States v. Baker Hughes*, 908 F.2d 981 (D.C. Cir. 1990), and all of the cases on which the dissenting opinion relies—have only held that efficiencies may be used as part of an *evidentiary burden-shifting* scheme to *rebut* the government's *prima facie* showing of an anticompetitive merger. No court of appeals has gone as far as Anthem and held that a reduction in costs *standing alone* greenlights a substantially anticompetitive merger that would otherwise be barred by the Clayton Act. *See Federal Trade Comm'n v. University Health, Inc.*, 938 F.2d 1206, 1222 n.29 (11th Cir. 1991) ("Of course, once it is determined that a merger *would* substantially lessen competition, expected

KAVANAUGH, *Circuit Judge*, dissenting: This important antitrust case involves a multi-billion dollar merger between two health insurers, Anthem and Cigna. As relevant to this case, those two insurers sell insurance services to large national businesses. There are four national insurers in that market: Anthem, Cigna, United, and Aetna. Anthem and United are the two major insurers in this market, whereas Cigna is a fairly small player. In the 14 States where Anthem and Cigna sell insurance services to large national businesses, Anthem has a 41% share of the market, and Cigna has a 6% share.

The U.S. Government sued under Section 7 of the Clayton Act to block the Anthem-Cigna merger. *See* 15 U.S.C. §§ 18, 25. The Government alleged that the merger would unlawfully lessen competition in the market for insurance services sold to large national businesses. The District Court agreed with the Government and enjoined the merger. The majority opinion affirms. I respectfully dissent.

At the outset, it is important to stress that this is an unusual horizontal merger case because of the nature of this particular slice of the insurance industry. To properly analyze this case, it is essential to understand precisely how these markets work.

There are three main players: (i) large employers, (ii) insurers, and (iii) healthcare providers, namely hospitals and doctors. Under the standard contracts that apply in this particular segment of the insurance industry, the employers do

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economies, however great, will not insulate the merger from a section 7 challenge."); AREEDA & HOVENKAMP, *supra*, ¶ 970f, at 42.

not pay premiums to the insurers. And the insurers do not pay the hospitals and doctors for healthcare services provided to the employers' employees. Instead, the employers pay insurers a fee for obtaining access to the insurers' provider network. Insurers in turn contract with healthcare providers — hospitals and doctors — to develop that provider network. In that upstream market, the insurers negotiate rates in advance with the hospitals and doctors.

As a result, when the employers' employees need health care, the employers pay those negotiated rates to the healthcare providers. Importantly, therefore, employers in this market are self-insured. They pay the insurers a fee simply to obtain access to the provider networks arranged by the insurers, as well as for certain administrative services performed by the insurers.

To summarize in simple terms: The employers pay the insurers a fee, and the insurers then act as the employers' purchasing agents for healthcare services. In that upstream market, the insurers negotiate in advance with hospitals and doctors over the rates that will be charged to employers for their employees' health care. When insurers negotiate lower provider rates, employers save money on health care.

Here, two insurers (Anthem and Cigna) want to merge. The majority opinion sees this as a classic horizontal merger case where the high concentration of this market and the merged insurer's high market share would mean increased prices for the employer-customers. But that understanding misses what I believe is the critical feature of this case. Here, these

insurance companies act as purchasing agents *on behalf of their employer-customers* in the upstream market where the insurers negotiate provider rates for the employer-customers. When the insurers negotiate lower provider rates, those savings go directly to the employer-customers. The merged Anthem Cigna would be a more powerful purchasing agent than Anthem and Cigna operating independently. The merged Anthem-Cigna would therefore be able to negotiate *lower* provider rates on behalf of its employer-customers. Those lower provider rates would mean cost savings that would be passed through directly to the employer-customers. To be sure, the merged company may charge its employer-customers an increased fee for obtaining those savings. But the record overwhelmingly demonstrates that the cost savings to employers would far exceed any increased fees paid by employers.

In short, the record decisively demonstrates that this merger would be *beneficial* to the employer-customers who obtain insurance services from Anthem and Cigna. That is the core of my respectful disagreement with the majority opinion. (As I will explain in Part I-C below, if there is a problem with this merger, the problem lies in the merger's effects on hospitals and doctors in the upstream market, not in the merger's effects on employers in the downstream market.)

In Part I of this dissent, I will outline my approach to this case. In Part II, I will briefly summarize some of my concerns about the majority opinion and the concurrence.

I

A

The Government contends that this merger between Anthem and Cigna would cause undue market concentration in the market for the sale of insurance services to large employers, and would increase the merged company's market share to an anti-competitive level. The Government argues that, as a result, the merged Anthem-Cigna would be able to use its market power to raise the fees it charges to large employers for those insurance services. How much? The evidence in the record suggests that large employers would pay Anthem-Cigna increased fees of about $48 million annually by one estimate, up to $220 million annually by another estimate, and up to $930 million annually by yet another estimate.

But that is not the end of the antitrust analysis under the law governing horizontal mergers. The case law of the Supreme Court and this Court, as well as the Government's own Merger Guidelines, establish that we must consider the efficiencies and consumer benefits of a merger together with its anti-competitive effects. *See United States v. General Dynamics Corp.*, 415 U.S. 486, 498–500 (1974); *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001); *United States v. Baker Hughes Inc.*, 908 F.2d 981, 990–91 (D.C. Cir. 1990); U.S. Department of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* § 10, at 29–31 (2010).

Here, as I will explain, the analysis of the overall effects of this merger shows that the merger would not substantially lessen competition in the market for the sale of insurance services to large employers. The record demonstrates that those large employers

would *save* an amount ranging from $1.7 to $3.3 billion annually due to reduced rates charged by healthcare providers. For large employers, therefore, the savings from the merger would far exceed the increased fees they would pay to Anthem-Cigna as a result of the merger.

To begin with, the record evidence overwhelmingly demonstrates that the merged Anthem-Cigna, with its additional market strength and negotiating power in the upstream market, would be able to negotiate lower provider rates from hospitals and doctors for healthcare services. *Indeed, the Government itself agrees that this merger would allow Anthem-Cigna to obtain lower provider rates.* Linger on that point for a moment: The Government concedes that Anthem-Cigna would be able to negotiate lower provider rates that employers would pay for their employees' health care. On top of that, in light of the "affiliate clause" in many of Anthem's existing contracts, the merger would allow at least some of the businesses that currently purchase insurance services from Cigna to obtain lower rates that Anthem has previously negotiated with providers.

How much would provider rates be reduced? Anthem-Cigna's integration planning team, working in consultation with McKinsey, an independent consulting firm, calculated $2.6 to $3.3 billion in projected annual savings for AnthemCigna's employer-customers as a result of the merger. Anthem-Cigna's expert, Dr. Israel, worked independently of the integration team, but he came to a similar conclusion. He determined that the merger would yield $2.4 billion in annual medical cost savings.

The record evidence also overwhelmingly demonstrates that the medical cost savings from the lower provider rates negotiated by Anthem-Cigna would be largely if not entirely passed through to the large employers that contract with Anthem-Cigna. The savings are passed through to employers because, under the contractual arrangements that apply in that market, the employers pay healthcare providers for the healthcare services provided to employees. So if the price of healthcare services is lower, the employers would directly benefit because the employers would then pay those lower prices.

The Government critiques those estimates in part by noting that the estimates include cost savings that will accrue to the fully insured employers. It is true that a slice of this large employer market is fully insured, not self-insured. For those large employers, there would not necessarily be automatic pass-through. Even taking the fully insured employers out of the equation, however, the annual savings to self-insured employers would still be at least $1.7 billion annually.

By contrast, the Government's expert, Dr. Dranove, never did a merger simulation that calculated the amount of the savings that would result from the lower provider rates and be passed through to employers. Even though the Government admitted that the merger would lead to a reduction in provider reimbursement rates, Dr. Dranove built an assumption into all of his models that there would be *zero* medical cost savings. *See* Trial Tr. 1159, 1867. So we are left with Anthem-Cigna's evidence

showing $1.7 to $3.3 billion annually in passed-through savings for employers.[1]

Under the law, those efficiencies and consumer benefits identified by Anthem-Cigna must be both merger-specific and verified. *See* U.S. Department of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* § 10, at 30. Both requirements are satisfied here.

The efficiencies and consumer benefits in this case are merger-specific by definition. As even the Government admits, Anthem-Cigna's enhanced bargaining power would come from the merger. And that enhanced bargaining power is a large part of what would enable Anthem-Cigna to negotiate the lower provider rates that in turn would lead to cost savings for employers. So, too, Anthem's ability to rely on its existing contracts to offer lower rates to

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[1] To be sure, if a price decrease were accompanied by a substantial reduction in quality, that fact would raise a separate concern about this merger. But here, the record does not contain sufficient evidence, beyond some speculation and guesswork by the Government, that the merger would cause an actual decrease in the quality of medical service provided to employers by hospitals and doctors, or in the quality of customer service provided to employers by insurers.

Relatedly, the Government suggests that the current Cigna employer-customers, once switched over to Anthem after the merger, would utilize healthcare services more often. The Government argues that the higher utilization would cancel out some of the cost savings that the employer-customers would otherwise achieve. That suggestion is likewise highly speculative and does not square with the record, which shows that current Anthem employer-customers have *lower* utilization rates than the current Cigna employer-customers. *See* J.A. 480.

Cigna customers is a direct result of the merger. There is little if any evidence to support the made-up notion that Anthem and Cigna could obtain lower provider rates even absent the merger. The claimed savings are merger-specific.

Moreover, the efficiencies and benefits were sufficiently verified (i) by Anthem-Cigna's expert witness Dr. Israel, (ii) by the merger integration planning team, working with McKinsey, the independent consulting firm, and (iii) by various healthcare providers who testified at trial. To be verified, the efficiencies and consumer benefits must be "more than mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 721. But they need not be certain. They merely must be probable. *See Baker Hughes*, 908 F.2d at 984 ("Section 7 involves *probabilities*, not certainties or possibilities."). Here, that bar is cleared because there is no doubt that the merger would reduce provider rates (as the Government concedes) and no doubt that the savings from those lower provider rates would be largely passed through to employers (as the contracts and basic structure of this self-insured market require). To be sure, one can debate just *how much* the employers would benefit from this merger. But Anthem-Cigna's expert and integration planning team calculated savings of $1.7 to $3.3 billion annually. On this record, there is little basis to doubt that the cost savings for employers as a result of the merger would be large — and far larger than the increased fees charged by insurers to employers as a result of the merger.

In short, the record overwhelmingly establishes that the merger would generate significant medical cost savings for employers in all of the geographic

markets at issue here — overall, approximately $1.7 to $3.3 *billion* annually — and employers would therefore spend significantly less on healthcare costs. (As noted, the increased fees for employers, on the other hand, would amount to $48 to $930 *million*.) And because the employers would spend less on health care for employees, they would have more to spend on employees' salaries, thereby benefitting their employees. Some of the ultimate beneficiaries of this merger would be the rank-and-file workers who are employed by the businesses that obtain insurance services from Anthem and Cigna.

I of course recognize that the District Court's factual findings are reviewed only for clear error. But we are not a rubber stamp. And here, the record convincingly demonstrates that this merger would significantly reduce healthcare costs for the large employers that purchase insurance services from Anthem and Cigna. That is true across the 14 states in which Anthem and Cigna both operate, including Virginia (and the Richmond market). The District Court clearly erred, therefore, in concluding that the merger would substantially lessen competition in the market in which insurance services are sold to large employers.

B

In a separate discussion, however, the District Court also relied on 1960s Supreme Court cases and suggested that antitrust law may not allow consideration of the efficiencies and consumer benefits in the first place. If that were true, this would be an easy case for the Government given the concentration of the market and the market share of

the merged company. But that description of the law is not correct.

In landmark decisions in the 1970s — including *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974), and *Continental T. V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36 (1977) — the Supreme Court indicated that modern antitrust analysis focuses on the effects on the consumers of the product or service, not the effects on competitors. In the horizontal merger context, the Supreme Court in the 1970s therefore shifted away from the strict anti-merger approach that the Court had employed in the 1960s in cases such as *Brown Shoe Co. v. United States*, 370 U.S. 294 (1962), and *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963).

As this Court has previously noted, in "the mid-1960s, the Supreme Court construed section 7 to prohibit virtually any horizontal merger or acquisition," but the Supreme Court subsequently "cut" those precedents "back sharply," beginning with its 1974 decision in *General Dynamics*. *Baker Hughes*, 908 F.2d at 989–90. In *General Dynamics*, the Supreme Court made clear that the merger analysis must take account not just of market concentration and market shares, but also of the "structure, history and probable future" of the market. 415 U.S. at 498 (quoting *Brown Shoe*, 370 U.S. at 322 n.38); *see also* E. THOMAS SULLIVAN & JEFFREY L. HARRISON, UNDERSTANDING ANTITRUST AND ITS ECONOMIC IMPLICATIONS 369 (6th ed. 2014) ("*General Dynamics* signaled a major shift in § 7 interpretation."); Note, *Horizontal Mergers After* United States v. General Dynamics Corp., 92 HARV. L. REV. 491, 499, 502 (1978) (The *General Dynamics*

case "signaled a new judicial approach to section 7 cases. . . . By endorsing an inquiry into such factors — the structure, history and probable future of the relevant market — *General Dynamics* brought antitrust analysis back into line with current economic thought.") (internal quotation marks omitted); *cf*. ROBERT H. BORK, THE ANTITRUST PARADOX 210 (1978) ("It would be overhasty to say that the *Brown Shoe* opinion is the worst antitrust essay ever written. . . . Still, all things considered, *Brown Shoe* has considerable claim to the title.").

Applying that broader analysis, the *General Dynamics* Court rejected the Government's assertion in that case that a proposed merger between two leading coal producers would violate Section 7 of the Clayton Act. In subsequent cases, the Supreme Court has adhered to *General Dynamics*. *See*, *e.g.*, *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 631 (1974); *United States v. Citizens & Southern National Bank*, 422 U.S. 86, 120 (1975). Notably, since 1975, the Supreme Court has not decided a case assessing the lawfulness of a horizontal merger under Section 7 of the Clayton Act. So *General Dynamics* remains the last relevant word from the Supreme Court.

This Court has already concluded that we are bound by *General Dynamics*, not by the earlier 1960s Supreme Court cases. In *Baker Hughes*, we explained that "*General Dynamics* began a line of decisions differing markedly in emphasis from the Court's antitrust cases of the 1960s. Instead of accepting a firm's market share as virtually conclusive proof of its market power, the Court carefully analyzed defendants' rebuttal evidence."

Baker Hughes, 908 F.2d at 990.[2] In *Baker Hughes*, we thus cited *General Dynamics* for the proposition that the Section 7 analysis is "comprehensive" and focuses on a "variety of factors," including "efficiencies." *Id.* at 984, 986. As *Baker Hughes* recognized, and as this Court reaffirmed in its later decision in *Heinz*, modern merger analysis must consider the efficiencies and consumer benefits of the merger. *See Baker Hughes*, 908 F.2d at 984–86; *Heinz*, 246 F.3d at 720 ("[E]fficiencies can enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, or new products.") (internal quotation marks omitted). Importantly, even the Government's own Merger Guidelines now recognize that the merger analysis must consider the efficiencies and consumer benefits of the merger. *See* U.S. Department of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* § 10, at 29–31; *see* a*lso Baker Hughes*, 908 F.2d at 985–86 ("It is not surprising" that "the Department of Justice's own Merger Guidelines contain a detailed discussion of non-entry factors that can overcome a presumption of illegality established by market share statistics." Those "factors include . . . efficiencies.").

We are bound by the modern approach taken by the Supreme Court and by this Court. *See generally* BRYAN A. GARNER ET AL., THE LAW OF JUDICIAL PRECEDENT 31 (2016) ("[W]hen the Supreme Court overturns the standard that it had previously used to resolve a particular class of cases,"

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[2] *Baker Hughes* was authored by Judge Clarence Thomas and joined by Judge Ruth Bader Ginsburg and Judge David Sentelle.

federal courts "must apply the new standard and reach the result dictated under that new standard." The "results reached under the old standard" are no longer "binding precedent."). Under the modern approach reflected in cases such as *General Dynamics*, *Baker Hughes*, and *Heinz*, the fact that a merger such as this one would produce heightened market concentration and increased market shares (and thereby potentially harm other insurers that are competitors of Anthem and Cigna) is not the end of the legal analysis. Under current antitrust law, we must take account of the efficiencies and consumer benefits that would result from this merger. Any suggestion to the contrary is not the law.

C

That said, on my view of the case, the Government could still ultimately block this merger based on the merger's effects on hospitals and doctors in the *upstream* provider market. At trial, the Government asserted an alternative ground for blocking the merger: The Government claimed that the merger between Anthem and Cigna would give Anthem-Cigna monopsony power in the upstream market where Anthem-Cigna negotiates provider rates with hospitals and doctors. The District Court did not decide that separate claim. I would remand for the District Court to decide it in the first instance.

Monopsony power describes a scenario in which Anthem-Cigna would be able to wield its enhanced negotiating power to unlawfully push healthcare providers to accept rates that are below competitive levels. That may be an antitrust problem in and of itself. Moreover, the exercise of monopsony power to

temporarily reduce consumer prices does not qualify as an efficiency that can justify an otherwise anti-competitive merger. The consumer welfare implications (and consequently, the antitrust law implications) of monopsony power and ordinary bargaining power are very different. Although both monopsony and bargaining power result in lower input prices, ordinary bargaining power usually results in lower prices for consumers, whereas monopsony power usually does not, at least over the long term. *See* 4A PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 980, at 108 (3d ed. 2009); HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY § 1.2b, at 15 (4th ed. 2011). Therefore, the exercise of *bargaining power* by Anthem-Cigna is *pro-competitive* because it usually results in lower prices for Anthem-Cigna's employer-customers. By contrast, the exercise of *monopsony power* by Anthem-Cigna may be *anticompetitive* because it may result in higher prices for Anthem-Cigna's employer-customers. *Cf.* U.S. Department of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* § 10, at 30 ("Cognizable efficiencies . . . do not arise from anticompetitive reductions in output or service.").

Notably, even Anthem-Cigna concedes that the merger would be unlawful if the merger would give Anthem-Cigna monopsony power in the upstream market. *See* Tr. of Oral Arg. at 85 (Defense Counsel: "If it was an exercise of market power on the buy-side, monopsony, we are not claiming that it's a cognizable efficiency. We're accepting the rule in the merger guidelines that if it really is the exercise of market power, which means a constraint in output,

bringing the price away from the competitive level, yes, we're not claiming that that's a cognizable efficiency.").

To be clear, if Anthem-Cigna would obtain lower provider rates merely because of its enhanced ability to negotiate lower prices with providers, that alone would not necessarily be an antitrust problem. But if Anthem-Cigna would obtain provider rates that are below competitive levels because of its exercise of unlawful monopsony power against providers, that could be a problem, and perhaps a fatal one for this merger. In other words, if the lower provider rates from this merger turn out to be the fruit of a poisonous tree — namely, the fruit of Anthem-Cigna's exercise of unlawful monopsony power against hospitals and doctors in the upstream market — then the merger may be unlawful. *See* U.S. Department of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* § 10, at 30.

As a result, the legality of the merger should turn on the answer to the following fact-intensive question: Would Anthem-Cigna obtain lower provider rates from hospitals and doctors because of its exercise of unlawful monopsony power in the upstream market where it negotiates rates with healthcare providers? Given the way it resolved the case, the District Court never reached that critical question. Therefore, I would remand for the District Court to expeditiously decide that question in the first instance.

II

The majority opinion portrays this as an easy case for blocking the merger. If the law and the facts

were as described by the majority opinion, I would agree with it. But in my view, the law and the facts are not as described by the majority opinion. Indeed, the majority opinion outflanks even the Government's position on the law and the facts.

First, the Government accepts as a given that a defendant in a Section 7 case may rely on a merger's efficiencies to show that a merger would not be anti-competitive despite the increased market concentration and market shares that would result from the merger. But the majority opinion — echoing the District Court — does not accept that legal principle as a given. On the contrary, the majority opinion casts doubt on this Court's opinions in *Baker Hughes* and *Heinz*, and on whether Section 7 analysis allows a court to take account of a merger's efficiencies as a defense in a merger case. The majority opinion says that the Supreme Court's 1967 decision in *FTC v. Procter & Gamble Co.*, 386 U.S. 568 (1967), is the essential precedent on this question. For the majority opinion, we are apparently stuck in 1967. The antitrust clock has stopped. No *General Dynamics*. No *Continental T. V. v. GTE Sylvania*. No *Baker Hughes*. No *Heinz*. No updated *Merger Guidelines*.[3] To reiterate, not even the Government makes that far-reaching argument. For good reason. As one hornbook aptly puts it, the "truly important point is that no modern observer, and no modern court, espouses the old *FTC v. Procter & Gamble Co.* (1967) position that efficiencies might be reason to condemn a merger." ERNEST

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[3] The concurrence goes so far as to say that even if "prices will go down," that "proves nothing by itself." Concurring Op. at 1.

GELLHORN, WILLIAM E. KOVACIC & STEPHEN CALKINS, ANTITRUST LAW AND ECONOMICS IN A NUTSHELL 463 (5th ed. 2004); *see also Baker Hughes*, 908 F.2d at 985 ("Indeed, that a variety of factors other than ease of entry can rebut a prima facie case has become hornbook law. . . . [O]ther factors include industry structure, weakness of data underlying prima facie case, elasticity of industry demand, inter-industry cross-elasticities of demand and supply, product differentiation, *and efficiency*.") (emphasis added).

Fortunately, the majority opinion in the end does not actually *hold* that there is no efficiencies defense available in Section 7 cases. The majority opinion merely suggests as much in dicta — perhaps portending a return to 1960s antitrust law in some future merger case. For purposes of this case, however, the majority opinion simply says that even assuming such a defense exists under the law, the defense would not be satisfied here. The majority opinion's lack of a square holding on the role of efficiencies in merger cases is some measure of good news because it means that future district courts and future panels of this Court still must follow *General Dynamics*, *Baker Hughes*, and *Heinz*, not the ahistorical drive-by dicta in today's majority opinion.

Second, on the facts, the majority opinion never fully accepts the two key facts in this case: First, provider rates will be lower; and second, the savings from those lower rates will be passed through to employers. The first fact is conceded by the Government, and the second fact is undeniable given the nature of this market and the contractual relationships between employers and insurers.

As mentioned above, the key difference between this horizontal merger and some horizontal mergers is that the increased savings obtained by the merged company in the upstream supply market in this case would be passed through *directly* to consumers. That one fact makes this merger unusual. In the ordinary case of a merger where the merged firm would have market power, it can be difficult for the merged firm to demonstrate that a substantial portion of the efficiencies resulting from the merger would actually be passed through to consumers instead of being retained by the merging companies. *See*, *e.g.*, *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1090 (D.D.C. 1997) ("Staples and Office Depot have a proven track record of achieving cost savings through efficiencies, and then passing those savings to customers in the form of lower prices. However, in this case the defendants have projected a pass through rate of two-thirds of the savings while the evidence shows that, historically, Staples has passed through only 15–17%."); *see also* U.S. Department of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* § 10, at 31 ("The greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to customers."). However, in this case, a high pass-through rate is practically guaranteed because, under the contractual arrangements that apply in the relevant market, the employers pay healthcare providers for the healthcare services provided to employees. So if the price of healthcare services is lower, the employers directly benefit because Anthem-Cigna's employer-customers pay those lower prices.

The only real factual question concerning the effects of the merger on large employers should be whether the savings to employers from lower provider rates would exceed the increased fees employers would pay to Anthem-Cigna for the insurance services. As I have explained, the record evidence overwhelmingly indicates that the savings to employers from lower provider rates would greatly exceed the increased fees they would pay to Anthem-Cigna for the insurance services.

But the majority opinion does not conduct that key inquiry. That is because the majority opinion does not fully accept the fact, undisputed by the parties, that provider rates would actually be lower as a result of this merger. And the majority opinion likewise does not accept that any possible cost savings would actually be passed through. So for the majority opinion, there are no cognizable efficiencies to consider in the first place and no need to assess whether the cost savings for employers are greater than the increased fees paid by employers.

The majority opinion offers up a smorgasbord of reasons to think that provider rates would not be lower or would not really be passed through, ranging from provider "abrasion," to secret Anthem plans to dramatically raise the fees it charges employers, to Anthem's supposed inability to force or negotiate with providers to obtain Anthem rates for Cigna customers, to friction between the Anthem and Cigna CEOs. All of that seems at best highly speculative. The plural of anecdote is not data. Of course, lots of bad things *could* happen after the merger. But the courts have to assess what is *likely*. *See Baker Hughes*, 908 F.2d at 984 ("Section 7 involves *probabilities*, not certainties or possibilities."). The

majority opinion seems to be accepting the worst-case possibility rather than determining what is likely. And the overwhelming evidence of what is likely is that provider rates would go down, that the savings would be passed through to employers, and that the savings to employers would greatly exceed any increase in fees paid by employers.

To the extent the majority opinion acknowledges even obliquely that prices possibly could go down after the merger, the majority opinion retorts that quality will also go down after the merger. But quality of what? As noted earlier, there is no persuasive evidence that the quality of medical care provided by hospitals and doctors would decrease. Nor is there any convincing evidence that the quality of services provided to employers by insurers would meaningfully decrease. Not to mention, does any supposed decrease in quality really rise to the level of $1.7 to $3.3 billion annually? The record discloses no meaningful effort to quantify or calculate the supposed decrease in quality.

The majority opinion also says that Cigna provides programs that help reduce utilization and that those could be jettisoned after the merger. But there is no good reason to think that those programs would be jettisoned rather than adopted by the merged company. Moreover, this speculation does not account for the fact that Anthem already has lower utilization rates than Cigna. So is it not likely that Cigna customers would utilize health care *more* after the merger than they do now.

* * *

The analysis of a merger's effects necessarily entails a predictive judgment. Courts are often ill-

equipped to render those predictive judgments in cases of this sort. But here, we have a far clearer picture of what will unfold than we often do. We know that Anthem-Cigna would be able to negotiate lower provider rates; indeed, *even the Government admits as much*. And we know that those savings will be largely passed through to employers because that is the way the market and contracts are structured. After all, the whole point of the provider rates negotiated by insurers is to establish the prices that the *employers* will pay. If the prices are lower, the employers will pay less. And we know, furthermore, that any cost savings to employers likely would greatly exceed any increase in fees paid by employers.

On this record, this horizontal merger therefore would not substantially lessen competition in the market for the sale of insurance services to large employers. The District Court clearly erred in concluding otherwise, and I disagree with the majority opinion's affirmance of the District Court's judgment.

The problem for this merger, if there is one, is in its effects in the upstream market — namely, in its effects on hospitals and doctors as a result of Anthem-Cigna's enhanced negotiating power. Therefore, my approach to this case would require District Court resolution of one remaining question: Would Anthem-Cigna obtain lower provider rates from hospitals and doctors because of its exercise of unlawful monopsony power in the upstream market where it negotiates rates with providers? If yes, then Anthem-Cigna concedes that the merger is unlawful and should be enjoined. If no, then the merger is lawful and should be able to go forward. I would

vacate the District Court's judgment and remand for the District Court to expeditiously resolve that fact-intensive question in the first instance.

I respectfully dissent.

APPENDIX B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

[Filed 02/08/2017]

Civil Action No. 16-1493 (ABJ)

UNITED STATES OF AMERICA, *et al.*,

Plaintiffs,

v.

ANTHEM, INC., *et al.*,

Defendants.

ORDER

Anthem and Cigna, the nation's second and third largest medical health insurance carriers, have agreed to merge. They propose to create the single largest seller of medical healthcare coverage to large commercial accounts, in a market in which there are only four national carriers still standing. The United States Department of Justice, eleven states, and the District of Columbia have sued to stop the merger, and they have carried their burden to demonstrate that the proposed combination is likely to have a substantial effect on competition in what is already a highly concentrated market. Therefore, the Court will not permit the merger to go forward.

Judgment will be entered in favor of the plaintiffs on their first claim, and the merger will be enjoined due to its likely impact on the market for

the sale of health insurance to "national accounts" – customers with more than 5000 employees, usually spread over at least two states – within the fourteen states where Anthem operates as the Blue Cross Blue Shield licensee. So the Court does not need to go on to decide the question of whether the combination will also affect competition in the sale to national accounts within the larger geographic market consisting of the entire United States. The Court also does not need to rule on the allegations in plaintiffs' second claim that the merger will harm competition downstream in a different product market: the sale of health insurance to "large group" employers of more than 100 employees in thirty-five separate local regions within the Anthem states. But the evidence has shown that the proposed acquisition will have an anticompetitive effect on the sale of health insurance to large groups in at least one of those markets: Richmond, Virginia. Finally, given the ruling against the merger, the Court need not reach the allegations in the complaint that the merger will also harm competition upstream in the market for the purchase of healthcare services from hospitals and physicians in the same 35 locations.

What follows is a summary of the Court's opinion and its order in the case. The Court finds first that the market for the sale of health insurance to national accounts is a properly drawn product market for purposes of the antitrust laws, and that the fourteen states in which Anthem enjoys the exclusive right to compete under the Blue Cross Blue Shield banner comprise a relevant geographic market for that product.

The evidence demonstrated that large national employers have a unique set of characteristics and

needs that drive their purchasing processes and decisions, and that the industry as a whole recognizes national accounts as a distinct market. Witness after witness agreed that there are only four national carriers offering the broad medical provider networks and account management capabilities needed to serve a typical national account. Notably, both Anthem and Cigna have established business units devoted to national accounts, and these separate profit and loss centers each have their own executives, sales teams, and customer service personnel. While various brokers and insurance carriers may draw differing lines to define the boundaries of a "national account," the government's use of 5000 employees as the threshold is consistent with how both Anthem and Cigna identify the accounts within their own companies. Moreover, when measured against the appropriate legal standard, the government's definition was sufficient to include reasonable substitutes and to fairly capture the competitive significance of other products.

The geographic market also passes the legal test since the Blue Cross Blue Shield Association rules have a significant impact on the commercial conditions governing the sale of medical coverage to national accounts, and Anthem's exclusive territory is where the acquisition will have a direct and immediate effect on competition.

Next, the Court finds that plaintiffs have established that the high level of concentration in this market that would result from the merger is presumptively unlawful under the U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, which courts regularly consult

for guidance in these cases. The evidence has also shown that the merger is likely to result in higher prices, and that it will have other anticompetitive effects: it will eliminate the two firms' vigorous competition against each other for national accounts, reduce the number of national carriers available to respond to solicitations in the future, and diminish the prospects for innovation in the market.

Within the national accounts market, health benefits coverage is a differentiated product, which means that individually customized policies are sold to customers one at a time – in this case, through a bid solicitation process. National account customers evaluate responses to their requests for proposals based upon a number of factors, including the amount of the fees charged by each carrier for claims administration services; the quality and breadth of the carrier's medical provider network; the extent of the discounts the carrier has negotiated with those providers; whether the carrier is willing to guarantee that the customer's medical costs will not increase by more than a particular percentage; and other features of interest to any particular customer. The expert testimony as well as the firms' internal documents reflect that while Anthem tends to enjoy superior discounts, the two companies are competing head-to-head with respect to many of the other aspects of their offerings, all of which can factor into the employer's total cost per employee for medical benefits.

The defense came forward with evidence to rebut the presumption, shifting the burden back to the government, but the Court concludes based on the entire record that plaintiffs have carried their burden to show that the effect of the acquisition may

be to substantially lessen competition in violation of Section 7 of the Clayton Antitrust Act. Defendants insist that customers face an array of alternatives, and that there are many new entrants poised to shake up the market. But entering the commercial health insurance market is not such an easy proposition. And while third party administrators and new insurance ventures being launched by strong local healthcare systems may be attractive to smaller or more localized customers, it became quite clear from the evidence that the larger a company gets, and the more geographically dispersed its employees become, the fewer solutions are available to meet its network and administrative needs. Thus, regional firms and new specialized "niche" companies that lack a national network are not viable options for the vast majority of national accounts, and they will not ameliorate the anticompetitive effects of this merger.

While defense economists theorized that large customers are free to "slice" their insurance business and contract with multiple carriers to cover different geographic regions and employee preferences, the record shows that there are substantial costs and administrative burdens associated with fragmentation, so employers do not elect to do it very often. The national accounts that do slice tend to use no more than two companies, usually chosen from among the big four national carriers and possibly a particularly strong regional option, such as Kaiser, the uniquely popular health maintenance organization in California. Anthem and its experts made much of the advent of private exchanges – sets of prepackaged plans that afford customers the opportunity to offer their employees a choice of

several options – but those have proved to be largely just another vehicle for delivering the major national carriers' products to the market. The defense repeatedly drew attention to the existence of third party administrators, provider-sponsored plans, and other specialty firms that have recently begun to populate the insurance marketplace. But to the extent these so-called new entrants and competitors are owned by, teamed with, rent networks from, or funnel business to the big four national carriers, they do not alter the competitive landscape, and in fact, they represent multiple additional arenas where the constriction of competition will be felt.

Anthem has taken the lead in defending the transaction, and it contends that any anticompetitive effects will be outweighed by the efficiencies it will generate. It points, in part, to substantial general and administrative ("G&A") cost savings that have been projected to be achieved through the combination of the two companies. And the centerpiece of its defense is its contention that Anthem and Cigna national account customers will save a combined total of over $2 billion in medical expenditures because Cigna members will be able to access the more favorable discounts that Anthem has negotiated with its provider network, Anthem members will have the benefit of any lower rates that Cigna has obtained, and those costs are paid directly by the employers. In short, Anthem maintains that the overriding benefit of the merger is that the new company will be able to deliver Cigna's highly regarded value-based products at the lower Anthem price.

But the claimed medical cost savings are not cognizable efficiencies since they are not merger-

specific, they are not verifiable, and it is questionable whether they are "efficiencies" at all. And the projected G&A efficiencies suffer from significant verification problems as well.

The law is clear that a defendant must both substantiate any claimed efficiencies and demonstrate that they are "merger-specific," which means that it must show that the savings cannot be accomplished by either company alone in the absence of the proposed merger. But here, Anthem and Cigna have already obtained the provider discounts alone. The medical network savings are not merger-specific because they are based upon the application of existing discounts to an existing patient population that the companies have already delivered to the providers; the calculations do not depend upon the expectation that the volume of patients will increase by virtue of the merger.

Furthermore, it is plain that the companies do not have to merge for customers to be able to access Anthem's lower provider rates: any customers that value the discounts above other aspects of the contractual arrangement can choose Anthem as their carrier today. As the Anthem executives responsible for the integration agreed, one of the most likely mechanisms to be employed to achieve the savings – the "rebranding" of Cigna customers as Blue customers – is no different from Anthem's ongoing marketing of its products on a daily basis. Also, there is nothing stopping Anthem from improving its wellness programs, or any other offerings that Cigna now does better, on its own.

It is also questionable whether Anthem's ability to drive a hard bargain with providers by virtue of its size can be characterized as an

"efficiency" at all. The Guidelines define an efficiency as something that would enable the combined firm to achieve lower costs for a given quantity and quality of product. Here, the combined firm will not be selling healthcare. Its "product" in the national accounts market – as Anthem has emphasized since the first day of the trial – is "ASO" or "administrative services only" contracts, which include claims administration, claims adjudication, and access to a network of health providers. So there is no evidence that the claimed network savings will arise because the cost of what the merged firm produces, and what it sells in the relevant market, will go down.

Anthem characterizes this scenario as a supply-side efficiency resulting from the merger, but it has not shown that there is anything about the mere combination of the carriers' two pools of patients that will enable doctors or hospitals to treat patients more expeditiously or at a lower cost. Since the medical cost savings will not be accomplished by streamlining the two firms' operations, creating a better product that neither carrier can offer alone, or even by enabling the providers to operate more efficiently, they do not represent any "efficiency" that will be introduced into the marketplace.

Anthem is asking the Court to go beyond what any court has done before: to bless this merger because customers may end up paying less to healthcare providers for the services that the providers deliver even though the same customers are also likely to end up paying more for what the defendants sell: the ASO contracts that are the sole product offered in the market at issue in this merger. It asks the Court to do this because it is the insurers that negotiate the in-network provider discounts,

access to those rates is part of what the customers are buying when they buy health insurance, and medical costs account for the overwhelming portion of any customer's total healthcare expenditure. In short, Anthem is encouraging the Court to ignore the risks posed by the proposed constriction in the health insurance industry in the relevant market on the grounds that consumers might benefit from the large size of the new company in other ways at the end of the day. But this is not a cognizable defense to an antitrust case; the antitrust laws are designed to protect competition, and the claimed efficiencies do not arise out of, or facilitate, competition. Moreover, Anthem's own documents reveal that the firm has considered a number of ways to capture the network savings for itself and not pass them through to the customers as it insisted in court that it would.

Anthem argues that even if expanding access to provider discounts does not technically qualify as an antitrust efficiency that can offset anticompetitive effects on a dollar-for-dollar basis, it is a factor to be taken into consideration in assessing the overall impact of a merger in a market where it is universally acknowledged that growing costs must be controlled. In short, the Court should decide that the pressure the merger would place on providers would be beneficial to consumers in general. But the record created for this case did not begin to provide the information needed to reveal whether all providers, no matter their size, location, or financial structure, are operating at comfortable margins well above their costs, as Anthem's expert suggested, or whether Anthem's use of its market power to strong-arm providers would reduce the quality or availability of healthcare as the plaintiffs alleged.

And the trial did not produce the sort of record that would enable the Court to make – nor should it make – complex policy decisions about the overall allocation of healthcare dollars in the United States.

More important, Anthem has not been able to demonstrate that its plan is achievable or that it will benefit consumers as advertised. One of the other key strategies Anthem intends to employ to generate the claimed savings is to unilaterally invoke provisions in provider contracts that require physicians or facilities to extend Anthem's discounted fee schedule to Anthem's affiliates. But even the Anthem executives have expressed doubts that the providers will take this lying down, and they have acknowledged that they have no plan in hand for whether they will proceed by rebranding on the customer side, by renegotiating contracts on the provider side, or by enforcing these affiliate clauses in any particular situation.

There was also considerable testimony that an enforced reduction in fees paid to providers through rebranding or contractual mechanisms could erode the relationships between insurers and providers. It would also reduce the collaboration that industry participants agree is an essential aspect of the growing trend to move from a pure fee-for-service based system to a more value-based model as a means of both lowering the cost and improving the outcome of the delivery of healthcare in this country. And here, the Court cannot fail to point out that it is bound to consider all of the evidence in the record in connection with the question of whether the merger will benefit competition, and in this case, that includes the doubt sown into the record by Cigna itself.

This brings us to the elephant in the courtroom. In this case, the Department of Justice is not the only party raising questions about Anthem's characterization of the outcome of the merger: one of the two merging parties is also actively warning against it. Cigna officials provided compelling testimony undermining the projections of future savings, and the disagreement runs so deep that Cigna cross-examined the defendants' own expert and refused to sign Anthem's Findings of Fact and Conclusions of Law on the grounds that they "reflect Anthem's perspective" and that some of the findings "are inconsistent with the testimony of Cigna witnesses." Anthem urges the Court to look away, and it attempts to minimize the merging parties' differences as a "side issue," a mere "rift between the CEOs." But the Court cannot properly ignore the remarkable circumstances that have unfolded both before and during the trial.

The documentary record and the testimony reflect that the pre-merger integration planning that is necessary to capture any hoped-for synergies is stalled and incomplete. Much of the work has not proceeded past the initial stage of identifying goals and targets to actually specifying the steps to be taken jointly to implement them. Moreover, the relationship between the companies is marked by a fundamental difference of opinion over the effect the Anthem strategy to impose lower rates on providers and move members away from Cigna's network will have on the collaborative model of care that is central to the Cigna brand. Both Cigna witnesses and providers have testified that effective collaboration requires more of the physicians and hospitals, and they expect to be paid for it, and the

engagement with members to improve behaviors that can affect wellness requires an investment of resources on the part of the insurer. All of this raises serious questions about when, how, and whether the medical savings can be achieved, whether the G&A savings can be verified, and whether there is any basis in the record to believe in the rosy vision being put forward by Anthem of a new national carrier that delivers the Cigna product at the Anthem price. In sum, the theme of Anthem's defense is that its greater ability to command discounts from providers will save customers money at the end of the day. At the same time, Cigna says that its collaboration with providers will save customers money at the end of the day. Plaintiffs take the position that customers should continue to have a choice between these options, and the Court agrees.

While Anthem has also moved to incorporate quality and cost savings incentives into its provider contracts, Cigna has sought to differentiate itself with its approach towards reducing costs by increasing health. Its message is that better information and clinical management on the provider side, along with encouraging behaviors that support health on the patient side, can reduce a patient's need to be hospitalized or undergo expensive medical procedures at all, and that this decrease in utilization will reduce the total medical cost per employee over time. For this reason, some customers prefer Cigna notwithstanding its discount disadvantage, and there was some testimony from medical personnel that the approach is working. Eliminating this competition from the marketplace would diminish the opportunity for the firms' ideas to be tested and refined, when this is just the sort of

innovation the antitrust rules are supposed to foster. Considering all of these circumstances, and for all of the reasons set forth in greater detail in the Memorandum Opinion docketed separately, the Court is persuaded that the merger should not take place.

Upon consideration of the applicable law, the evidence presented at trial, the argument of the parties, and the entire record before the Court, the Court concludes that the effect of the proposed merger of Anthem, Inc. and Cigna Corp. may be "substantially to lessen competition" in violation of section 7 of the Clayton Act, 15 U.S.C. § 18. Specifically, the proposed merger is likely to lessen competition substantially in the market for the sale of commercial health insurance to national account customers in the fourteen Anthem territories and in the market for the sale of commercial health insurance to large group customers in the Richmond, Virginia market.

It is therefore

ORDERED that the merger of Anthem Inc. and Cigna Corp., as reflected in their merger agreement dated July 23, 2015, is **ENJOINED**.

The Memorandum Opinion accompanying this Order contains references to materials that were discussed in open court but remain sealed at the request of one of the parties or third parties providing information. For this reason, the full opinion is being docketed under seal at this time. In drafting the opinion, the Court has endeavored to avoid the disclosure of the substance of any business sensitive material, and it is the Court's strong preference to place the entire opinion on the public record as soon as possible. Therefore, it is

FURTHER ORDERED that each party shall file notice with the Court by close of business February 9, 2017 of whether it has any objection to the Court unsealing the Memorandum Opinion docketed on this date in its entirety and if so, specifying what portions it believes should remain under seal and why.

/s/ Amy Berman Jackson
AMY BERMAN JACKSON
United States District Judge

DATE: February 8, 2017

APPENDIX C

United States District Court
for the District of Columbia

[Filed 02/08/2017]

Civil Action No. 16-1493 (ABJ)

UNITED STATES OF AMERICA, *et al.*,

Plaintiffs,

v.

ANTHEM, INC., *et al.*,

Defendants.

MEMORANDUM OPINION

Anthem and Cigna, the nation's second and third largest medical health insurance carriers, have agreed to merge. They propose to create the single largest seller of medical healthcare coverage to large commercial accounts, in a market in which there are only four national carriers still standing. The United States Department of Justice, eleven states, and the District of Columbia have sued to stop the merger, and they have carried their burden to demonstrate that the proposed combination is likely to have a substantial effect on competition in what is already a highly concentrated market. Therefore, the Court will not permit the merger to go forward.

Judgment will be entered in favor of the plaintiffs on their first claim, and the merger will be enjoined due to its likely impact on the market for

the sale of health insurance to "national accounts" – customers with more than 5000 employees, usually spread over at least two states – within the fourteen states where Anthem operates as the Blue Cross Blue Shield licensee. So the Court does not need to go on to decide the question of whether the combination will also affect competition in the sale to national accounts within the larger geographic market consisting of the entire United States. The Court also does not need to rule on the allegations in plaintiffs' second claim that the merger will harm competition downstream in a different product market: the sale of health insurance to "large group" employers of more than 100 employees in thirty-five separate local regions within the Anthem states. But the evidence has shown that the proposed acquisition will have an anticompetitive effect on the sale of health insurance to large groups in at least one of those markets: Richmond, Virginia. Finally, given the ruling against the merger, the Court need not reach the allegations in the complaint that the merger will also harm competition upstream in the market for the purchase of healthcare services from hospitals and physicians in the same 35 locations.

What follows is a summary of the ruling on the first claim in the complaint. The Court finds first that the market for the sale of health insurance to national accounts is a properly drawn product market for purposes of the antitrust laws, and that the fourteen states in which Anthem enjoys the exclusive right to compete under the Blue Cross Blue Shield banner comprise a relevant geographic market for that product.

The evidence demonstrated that large national employers have a unique set of characteristics and

needs that drive their purchasing processes and decisions, and that the industry as a whole recognizes national accounts as a distinct market. Witness after witness agreed that there are only four national carriers offering the broad medical provider networks and account management capabilities needed to serve a typical national account. Notably, both Anthem and Cigna have established business units devoted to national accounts, and these separate profit and loss centers each have their own executives, sales teams, and customer service personnel. While various brokers and insurance carriers may draw differing lines to define the boundaries of a "national account," the government's use of 5000 employees as the threshold is consistent with how both Anthem and Cigna identify the accounts within their own companies. Moreover, when measured against the appropriate legal standard, the government's definition was sufficient to include reasonable substitutes and to fairly capture the competitive significance of other products.

The geographic market also passes the legal test since the Blue Cross Blue Shield Association rules have a significant impact on the commercial conditions governing the sale of medical coverage to national accounts, and Anthem's exclusive territory is where the acquisition will have a direct and immediate effect on competition.

Next, the Court finds that plaintiffs have established that the high level of concentration in this market that would result from the merger is presumptively unlawful under the U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, which courts regularly consult

for guidance in these cases. The evidence has also shown that the merger is likely to result in higher prices, and that it will have other anticompetitive effects: it will eliminate the two firms' vigorous competition against each other for national accounts, reduce the number of national carriers available to respond to solicitations in the future, and diminish the prospects for innovation in the market.

Within the national accounts market, health benefits coverage is a differentiated product, which means that individually customized policies are sold to customers one at a time – in this case, through a bid solicitation process. National account customers evaluate responses to their requests for proposals based upon a number of factors, including the amount of the fees charged by each carrier for claims administration services; the quality and breadth of the carrier's medical provider network; the extent of the discounts the carrier has negotiated with those providers; whether the carrier is willing to guarantee that the customer's medical costs will not increase by more than a particular percentage; and other features of interest to any particular customer. The expert testimony as well as the firms' internal documents reflect that while Anthem tends to enjoy superior discounts, the two companies are competing head-to-head with respect to many of the other aspects of their offerings, all of which can factor into the employer's total cost per employee for medical benefits.

The defense came forward with evidence to rebut the presumption, shifting the burden back to the government, but the Court concludes based on the entire record that plaintiffs have carried their burden to show that the effect of the acquisition may

be to substantially lessen competition in violation of Section 7 of the Clayton Antitrust Act. Defendants insist that customers face an array of alternatives, and that there are many new entrants poised to shake up the market. But entering the commercial health insurance market is not such an easy proposition. And while third party administrators and new insurance ventures being launched by strong local healthcare systems may be attractive to smaller or more localized customers, it became quite clear from the evidence that the larger a company gets, and the more geographically dispersed its employees become, the fewer solutions are available to meet its network and administrative needs. Thus, regional firms and new specialized "niche" companies that lack a national network are not viable options for the vast majority of national accounts, and they will not ameliorate the anticompetitive effects of this merger.

While defense economists theorized that large customers are free to "slice" their insurance business and contract with multiple carriers to cover different geographic regions and employee preferences, the record shows that there are substantial costs and administrative burdens associated with fragmentation, so employers do not elect to do it very often. The national accounts that do slice tend to use no more than two companies, usually chosen from among the big four national carriers and possibly a particularly strong regional option, such as Kaiser, the uniquely popular health maintenance organization in California. Anthem and its experts made much of the advent of private exchanges – sets of prepackaged plans that afford customers the opportunity to offer their employees a choice of

several options – but those have proved to be largely just another vehicle for delivering the major national carriers' products to the market. The defense repeatedly drew attention to the existence of third party administrators, provider-sponsored plans, and other specialty firms that have recently begun to populate the insurance marketplace. But to the extent these so-called new entrants and competitors are owned by, teamed with, rent networks from, or funnel business to the big four national carriers, they do not alter the competitive landscape, and in fact, they represent multiple additional arenas where the constriction of competition will be felt.

Anthem has taken the lead in defending the transaction, and it contends that any anticompetitive effects will be outweighed by the efficiencies it will generate. It points, in part, to substantial general and administrative ("G&A") cost savings that have been projected to be achieved through the combination of the two companies. And the centerpiece of its defense is its contention that Anthem and Cigna national account customers will save a combined total of over $2 billion in medical expenditures because Cigna members will be able to access the more favorable discounts that Anthem has negotiated with its provider network, Anthem members will have the benefit of any lower rates that Cigna has obtained, and those costs are paid directly by the employers. In short, Anthem maintains that the overriding benefit of the merger is that the new company will be able to deliver Cigna's highly regarded value-based products at the lower Anthem price.

But the claimed medical cost savings are not cognizable efficiencies since they are not merger-

specific, they are not verifiable, and it is questionable whether they are "efficiencies" at all. And the projected G&A efficiencies suffer from significant verification problems as well.

The law is clear that a defendant must both substantiate any claimed efficiencies and demonstrate that they are "merger-specific," which means that it must show that the savings cannot be accomplished by either company alone in the absence of the proposed merger. But here, Anthem and Cigna have already obtained the provider discounts alone. The medical network savings are not merger-specific because they are based upon the application of existing discounts to an existing patient population that the companies have already delivered to the providers; the calculations do not depend upon the expectation that the volume of patients will increase by virtue of the merger.

Furthermore, it is plain that the companies do not have to merge for customers to be able to access Anthem's lower provider rates: any customers that value the discounts above other aspects of the contractual arrangement can choose Anthem as their carrier today. As the Anthem executives responsible for the integration agreed, one of the most likely mechanisms to be employed to achieve the savings – the "rebranding" of Cigna customers as Blue customers – is no different from Anthem's ongoing marketing of its products on a daily basis. Also, there is nothing stopping Anthem from improving its wellness programs, or any other offerings that Cigna now does better, on its own.

It is also questionable whether Anthem's ability to drive a hard bargain with providers by virtue of its

size can be characterized as an "efficiency" at all. The Guidelines define an efficiency as something that would enable the combined firm to achieve lower costs for a given quantity and quality of product. Here, the combined firm will not be selling healthcare. Its "product" in the national accounts market – as Anthem has emphasized since the first day of the trial – is "ASO" or "administrative services only" contracts, which include claims administration, claims adjudication, and access to a network of health providers. So there is no evidence that the claimed network savings will arise because the cost of what the merged firm produces, and what it sells in the relevant market, will go down.

Anthem characterizes this scenario as a supply-side **e**fficiency resulting from the merger, but it has not shown that there is anything about the mere combination of the carriers' two pools of patients that will enable doctors or hospitals to treat patients more expeditiously or at a lower cost. Since the medical cost savings will not be accomplished by streamlining the two firms' operations, creating a better product that neither carrier can offer alone, or even by enabling the providers to operate more efficiently, they do not represent any "efficiency" that will be introduced into the marketplace.

Anthem is asking the Court to go beyond what any court has done before: to bless this merger because customers may end up paying less to healthcare providers for the services that *the providers* deliver even though the same customers are also likely to end up paying more for what the defendants sell: the ASO contracts that are the sole product offered in the market at issue in this merger. It asks the Court to do this because it is the insurers

that negotiate the in-network provider discounts, access to those rates is part of what the customers are buying when they buy health insurance, and medical costs account for the overwhelming portion of any customer's total healthcare expenditure. In short, Anthem is encouraging the Court to ignore the risks posed by the proposed constriction in the health insurance industry in the relevant market on the grounds that consumers might benefit from the large size of the new company in other ways at the end of the day. But this is not a cognizable defense to an antitrust case; the antitrust laws are designed to protect competition, and the claimed efficiencies do not arise out of, or facilitate, competition. Moreover, Anthem's own documents reveal that the firm has considered a number of ways to capture the network savings for itself and not pass them through to the customers as it insisted in court that it would.

Anthem argues that even if expanding access to provider discounts does not technically qualify as an antitrust efficiency that can offset anticompetitive effects on a dollar-for-dollar basis, it is a factor to be taken into consideration in assessing the overall impact of a merger in a market where it is universally acknowledged that growing costs must be controlled. In short, the Court should decide that the pressure the merger would place on providers would be beneficial to consumers in general. But the record created for this case did not begin to provide the information needed to reveal whether all providers, no matter their size, location, or financial structure, are operating at comfortable margins well above their costs, as Anthem's expert suggested, or whether Anthem's use of its market power to strong-

arm providers would reduce the quality or availability of healthcare as the plaintiffs alleged. And the trial did not produce the sort of record that would enable the Court to make – nor should it make – complex policy decisions about the overall allocation of healthcare dollars in the United States.

More important, Anthem has not been able to demonstrate that its plan is achievable or that it will benefit consumers as advertised. One of the other key strategies Anthem intends to employ to generate the claimed savings is to unilaterally invoke provisions in provider contracts that require physicians or facilities to extend Anthem's discounted fee schedule to Anthem's affiliates. But even the Anthem executives have expressed doubts that the providers will take this lying down, and they have acknowledged that they have no plan in hand for whether they will proceed by rebranding on the customer side, by renegotiating contracts on the provider side, or by enforcing these affiliate clauses in any particular situation.

There was also considerable testimony that an enforced reduction in fees paid to providers through rebranding or contractual mechanisms could erode the relationships between insurers and providers. It would also reduce the collaboration that industry participants agree is an essential aspect of the growing trend to move from a pure fee-for-service based system to a more value-based model as a means of both lowering the cost and improving the outcome of the delivery of healthcare in this country. And here, the Court cannot fail to point out that it is bound to consider *all* of the evidence in the record in connection with the question of whether the merger will benefit competition, and in this case, that

includes the doubt sown into the record by Cigna itself.

This brings us to the elephant in the courtroom. In this case, the Department of Justice is not the only party raising questions about Anthem's characterization of the outcome of the merger: one of the two merging parties is also actively warning against it. Cigna officials provided compelling testimony undermining the projections of future savings, and the disagreement runs so deep that Cigna cross-examined the defendants' own expert and refused to sign Anthem's Findings of Fact and Conclusions of Law on the grounds that they "reflect Anthem's perspective" and that some of the findings "are inconsistent with the testimony of Cigna witnesses." Anthem urges the Court to look away, and it attempts to minimize the merging parties' differences as a "side issue," a mere "rift between the CEOs." But the Court cannot properly ignore the remarkable circumstances that have unfolded both before and during the trial.

The documentary record and the testimony reflect that the pre-merger integration planning that is necessary to capture any hoped-for synergies is stalled and incomplete. Much of the work has not proceeded past the initial stage of identifying goals and targets to actually specifying the steps to be taken jointly to implement them. Moreover, the relationship between the companies is marked by a fundamental difference of opinion over the effect the Anthem strategy to impose lower rates on providers and move members away from Cigna's network will have on the collaborative model of care that is central to the Cigna brand. Both Cigna witnesses and providers have testified that effective

collaboration requires more of the physicians and hospitals, and they expect to be paid for it, and the engagement with members to improve behaviors that can affect wellness requires an investment of resources on the part of the insurer. All of this raises serious questions about when, how, and whether the medical savings can be achieved, whether the G&A savings can be verified, and whether there is any basis in the record to believe in the rosy vision being put forward by Anthem of a new national carrier that delivers the Cigna product at the Anthem price.

In sum, the theme of Anthem's defense is that its greater ability to command discounts from providers will save customers money at the end of the day. At the same time, Cigna says that its collaboration with providers will save customers money at the end of the day. Plaintiffs take the position that customers should continue to have a choice between these options, and the Court agrees.

While Anthem has also moved to incorporate quality and cost savings incentives into its provider contracts, Cigna has sought to differentiate itself with its approach towards reducing costs by increasing health. Its message is that better information and clinical management on the provider side, along with encouraging behaviors that support health on the patient side, can reduce a patient's need to be hospitalized or undergo expensive medical procedures at all, and that this decrease in utilization will reduce the total medical cost per employee over time. For this reason, some customers prefer Cigna notwithstanding its discount disadvantage, and there was some testimony from medical personnel that the approach is working. Eliminating this competition from the marketplace

would diminish the opportunity for the firms' ideas to be tested and refined, when this is just the sort of innovation the antitrust rules are supposed to foster. Considering all of these circumstances, and for all of the reasons set forth in greater detail in this opinion, the Court is persuaded that the merger should not take place.

OUTLINE OF OPINION

BACKGROUND

I. The Parties and Proposed Merger

Anthem is "one of the largest health benefits companies . . . in the United States, serving 38.6 million medical members through [its] affiliated health plans as of December 31, 2015." PX 125, Anthem SEC 10-K Filing, Feb. 19, 2016, at 48. It offers medical healthcare benefits to a variety of customers including individuals, large and small employers, and Medicaid and Medicare enrollees. PX 125; PX 701. The company, which is based in Indianapolis, Indiana, is a member of the Blue Cross Blue Shield Association ("BCBSA"), an association of

thirty-six health insurance companies licensed to use the Blue Cross and/or the Blue Shield brands. *See* Swedish (Anthem) Tr. 222. Anthem holds the exclusive license to use the Blue brands in all or part of fourteen states. PX 125; PX 701.[1] Anthem also owns and operates non-Blue Cross entities, which market health coverage under the Amerigroup, Simply, and CareMore brands in other states. PX 125.

Cigna is a health services company based in Bloomfield, Connecticut. PX 701. It offers products and services to customers, including large employers, in the fifty states and the District of Columbia, as well as health benefits to employers internationally, operating in more than thirty countries. Cigna Answer [Dkt. 144] ¶ 11; Cigna SEC10-K Filing, Feb. 25, 2016, PX 284; DX 333. It covers approximately thirteen million medical members in the United States. Cigna Answer ¶ 11. Cigna also offers various specialty products and services, such as behavioral health, disability insurance, and dental and vision coverage, among others. *See* PX 284.

On July 23, 2015, Anthem and Cigna entered into an Agreement and Plan of Merger, which their

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[1] The fourteen Anthem service areas are California (Blue Cross license only), Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding thirty counties in western Missouri), Nevada, New Hampshire, New York (excluding certain areas), Ohio, Virginia (excluding certain counties near Washington, D.C.), and Wisconsin. PX 125. Throughout the trial, the parties have referred to these territories as the Anthem "states," even though Anthem does not have an exclusive license for all fourteen states in their entirety, and the Court will use that designation in this opinion.

separate shareholders approved on December 3, 2015. PX 125; PX 284. According to Anthem, the transaction is valued at approximately $54.2 billion. Anthem Answer [Dkt. 15] ¶ 1. The planned equity ownership of the combined company is to be comprised of approximately 67% Anthem shareholders and 33% Cigna shareholders, PX 126, and the new firm is slated to provide medical coverage to more than fifty-three million people across its commercial and government segments. DX 325.

The two firms are bound by their merger agreement through April 30, 2017. *See* Anthem's Reply Mem. in Supp. of Mot. for Expedited Status Conf. [Dkt. 17]. But since the initial decision to merge was announced, the relationship between the parties has started to fray. In December of 2015, the companies began to exchange letters and emails related to the integration, *see, e.g.*, PX 2, PX 8, and they grew more heated over time. Through its CEO, Jospeh Swedish, Anthem expressed concerns about the pace and quality of the integration effort and the amount of data and information that was being shared. PX 1; PX 3; *see also* Swedish (Anthem) Tr. 323. Meanwhile, Cigna complained that Swedish was improperly reducing the role that the current Cigna CEO, David Cordani, would play in the new company, PX 4, and it took issue with Anthem's approach towards medical providers and its plans for the movement of members from Cigna to the Anthem brand. Cordani (Cigna) Tr. 492–93. By April of 2016, Cigna's participation in the integration activities had slowed, PX 725, and when this lawsuit was filed, it stopped altogether. *See* Schlegel (Anthem) Tr. 1412–13, 1431–32. By July 2016, counsel for the two

companies began writing letters accusing the other party of breaching the merger agreement. *See, e.g.*, PX 16; PX 17; PX 18; PX 19.

II. Procedural History

On July 21, 2016, plaintiffs the United States, the States of California, Colorado, Connecticut, Georgia, Iowa, Maine, Maryland, New Hampshire, New York, and Tennessee, the Commonwealth of Virginia, and the District of Columbia sued to enjoin the merger. Compl. [Dkt. 1]. Plaintiffs allege that the Anthem-Cigna merger will violate Section 7 of the Clayton Act, 15 U.S.C. § 18, because it will harm competition in the sale of commercial healthcare insurance to two groups of customers: "national accounts" and "large group employers." Compl. ¶ 8.

In their first claim, plaintiffs allege that the acquisition will harm competition in the sale of health insurance to national accounts both within a geographic market consisting of the fourteen Anthem states and in a market consisting of the United States as a whole. Compl. ¶¶ 19–37. The second claim alleges anticompetitive effects in the market for the sale of health benefits coverage to large group employers in 35 separate local regions within those states. Compl. ¶¶ 38–50. And in its third claim, plaintiffs allege that the newly formed company will use its market power to pressure doctors, hospitals, and other providers to lower their prices, so the merger will result in harm to competition in the market for the purchase of healthcare services, or a monopsony, in the same thirty-five geographic markets. Compl. ¶¶ 64–75.[2]

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[2] Plaintiffs also initially alleged that the merger would harm competition for the sale of individual insurance policies on

Anthem answered the complaint on July 26, 2016, and Cigna answered on September 19, 2016. Extensive discovery was undertaken on an expedited schedule under the supervision of a Special Master appointed by the Court with the parties' consent. *See* Order Appointing Special Master [Dkt. 66], Scheduling Order [Dkt. 68], Interim Case Mgmt. Order [Dkt. 74]. The Court divided the presentation of evidence at trial into two phases: the first dealing with the effect of the merger on competition in the sale of commercial insurance to national accounts, and the second dealing with both its effect on competition in the sale to large group employer accounts in the thirty-five markets and the purchase of healthcare services from providers in those markets. Order Am. Order Appointing Special Master and Final Case Mgmt. Order [Dkt. 196] at 4.

The bench trial began on November 21, 2016 and ended on January 4, 2017. The parties presented sixteen fact witnesses in Phase I and thirteen in Phase II, along with deposition excerpts from more than 100 individuals. Plaintiffs presented the testimony of two experts, one of whom testified in both phases. Anthem proffered three experts who each testified twice. Each side introduced more than 800 exhibits in each phase of the trial, and each side submitted two sets of proposed findings of fact and conclusions of law. [Dkt. 401, 404, 416, 417].

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the public exchanges, Compl. ¶¶ 51–63, but they subsequently dismissed that claim. *See* Stip. re Pls.' Allegations Concerning the Sale of Individual Insurance Policies on Public Exchanges [Dkt. 163].

III. Overview of the Commercial Healthcare Industry

This case does not involve healthcare obtained through government programs such as Medicare or Medicaid, or health insurance sold to individuals either directly or through a public exchange. The allegations that were tried relate solely to the commercial market – the sale of medical benefits coverage to employers. To analyze the antitrust implications of the acquisition, it is necessary to have a general overview of how the commercial health insurance industry operates.

A. The customers

Millions of people in this country obtain healthcare insurance for themselves and their dependents through their employers. Commercial health insurance sold to employers is regulated by state and federal statutes;[3] state laws draw a distinction between healthcare insurance sold to "small group" and "large group" employers. Goulet (Anthem) Dep. 13–16. In forty-six states, a small group employer is defined as an employer with two to fifty employees, and in the remainder, small group employers are defined as having up to 100 employees. *See* Bailey (Cigna) Dep. 59–60; Goulet (Anthem) Dep. 14–15. Employers with more than fifty or 100 employees, respectively, are considered "large group" employers. Goulet (Anthem) Dep. 15–16. This case concerns the sale of commercial healthcare insurance to large group employers; the

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[3] The federal Affordable Care Act imposes penalties on large group employers that fail to meet certain minimum value and affordability requirements. 26 U.S.C. § 4980H(b)(1), (c)(3).

employees and their dependents who are covered by the plans are referred to as "members" or "covered lives."

Because purchasing healthcare coverage can be a complex process, particularly for large group employers, these customers often work with consultants and insurance brokers. The consultants assist with determining and ranking the employers' needs, identifying the firms that can meet those needs, issuing requests for proposals ("RFPs"), negotiating with the top bidders, and making a final a contract decision. Abbott (WTW) Tr. 65–66.

Within the industry, large group employers are generally divided into two categories according to size, and the larger entities within the large group segment are referred to as "national accounts." The term is not defined by regulation, and the threshold used varies, but industry participants generally define national accounts by the number of individuals they employ, and many include a requirement that the employees reside in more than one state. Abbott (WTW) Tr. 157–58. Regardless of the numerical limits they apply, insurance carriers, consultants, and brokers tend to market, service, and account for their large group accounts and national accounts separately.

B. The plans

What health insurance carriers offer employers is a combination of claims administration services and access to a network of medical care providers that have agreed to treat the employees and their dependents at a discounted rate. Abbott (WTW) Tr. 74–75. Commercial insurance carriers provide employers with these networks and services through

two types of plans: fully-insured plans and self-insured plans. Self-insured plans are also known as "ASO," or administrative services only, plans. *Id.*

In either case, the insurer processes and adjudicates the members' claims. Fully-insured and ASO plans differ, though, with respect to who pays the medical costs and therefore bears the risk connected with those costs. In fully-insured plans, it is the insurer's obligation to cover the healthcare costs incurred by the employees and their dependents in addition to administering the claims. Thus it is the insurer that bears the risk of the members' medical costs, and it prices the premiums accordingly. Abbott (WTW) Tr. 69.

In self-insured plans, the employer takes on the risk of the medical costs itself. Abbott (WTW) Tr. 69–70. It pays the insurer an ASO fee in return for both the access to the provider network and claims administration and adjudication services. But the employer pays the healthcare costs directly, usually by funding a bank account from which the insurer pays the claims as they are submitted by the providers. Abbott (WTW) Tr. 174. Therefore, ASO fees are lower than full insurance premiums. Abbott (WTW) Tr. 175; *see* Hayes (Aetna) 29–31. Larger employers tend to purchase ASO plans because they can spread the risk of the medical costs over a larger number of covered lives,[4] and smaller employers tend to purchase full insurance because they cannot.

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[4] Employers may also purchase stop-loss insurance to cap their healthcare expenses at a particular level if they suffer any unusually large claims. *See* Abbott (WTW) Tr. 69; Archer (HealthSMART Benefit Solutions) Dep. 35–36.

Finally, employers may purchase ancillary products such as dental coverage and behavioral health coverage from insurers, as well as other services, including employee wellness programs, data analytics to help employers and providers understand and manage their healthcare costs, and the technology to deliver claims information to members electronically. Generally speaking, the larger and more sophisticated the employer, the more customization it will seek when soliciting proposals from insurers. Abbott (WTW) Tr. 77.

C. The networks

Access to a network of medical care providers is an essential component of any commercial health insurance plan. Insurers create networks by entering into contractual arrangements with hospitals, doctors, and other healthcare professionals through which the providers agree to accept payment for services supplied to plan members at a discount in return for the volume of patients that the carrier will deliver to them as in-network providers. Drozdowski (Anthem) Tr. 1643–44. Employees who receive care from out-of-network providers face higher fee schedules with no discounts, Kertesz (Anthem) Tr. 538, so the breadth and depth of a carrier's network factors heavily into an employer's contracting decision.

Anthem gains access to a national network for its customers by virtue of its membership in the Blue Cross Blue Shield Association. Association members enjoy an exclusive license to market insurance under the Blue brands within their individual territories, and therefore, no two Blue companies will ever bid on the same large group or national account, and no

Blue licensee may bid on an account headquartered in another licensee's state without receiving a "cede" from that carrier. Bills (Anthem) Dep. 60, 85, 207–09.

An important feature of the Blue Cross Blue Shield Association is the Blue Card System. Members of any Blue plan – those who carry a "Blue card" – are entitled to access the providers in the Blue networks in every state at the in-network rate. Swedish (Anthem) Tr. 226–27. The Blue Card network is the largest national provider network in the country. PX 208; PX 367.

Blue plans refer to members whose employers are located within their licensed territories as "home" members, and members who receive services through the Blue network outside of their plans' service area as "host" members. Pogany (Anthem) Dep. 89; PX 125. Anthem has approximately 13 million national accounts members, including both home and host members. Pogany (Anthem) Dep. 87. Like all other members of the Blue Cross Blue Shield Association, Anthem receives Blue Card fees for network access and administrative services when it "hosts" a member of another Blue plan. PX 125. With its fourteen states, Anthem has the largest exclusive territory of any Blue Cross licensee; the second largest licensee has the exclusive rights to sell Blue products in five states. Swedish (Anthem) Tr. 222.

D. Other industry participants and options for employers

There are additional options for employers purchasing commercial health insurance that are of significance in this case:

• **Slicing**: When a company employs workers in multiple parts of the country, it may choose to purchase a plan from a single carrier with a broad enough network to serve all its employees. These carriers include United Healthcare, Cigna, Aetna, and Anthem, with its Blue Cross Blue Shield network. Or, it may choose to piece together several plans from multiple carriers, either national or regional, that offer attractive networks in the specific areas where the employees reside. This practice is referred to as slicing. Employers may also slice insurance business across types of plans, to offer its employees a choice between more than one carrier with distinctive offerings or cost structures. Abbott (WTW) Tr. 85–86.

• **Private Exchanges**: In recent years, several of the large consultants in the health insurance industry have begun contracting with local, regional, and national insurers to put together packages of standard plans available in particular geographic areas, and then sell them as a whole to employers as an alternative to purchasing coverage directly from a single insurer. Sharp (Aon Hewitt) Dep. 10–11. Private exchanges give employers a means to offer employees choices among plans without assuming the burden of contracting with multiple carriers. *Id.* Aon Hewitt, Willis Towers Watson, Mercer, and Buck Consulting, owned by Xerox, are large consulting firms that that operate national private exchanges, Kertesz (Anthem) Tr. 662–63, and in response to this "disintermediation" by the consultants and brokers, Schumacher (United) Dep. 114; Hayes (Aetna) Dep. 238, the national carriers have begun building and marketing their own exchanges. Employees who choose Anthem or Cigna

through an exchange are covered members who may access the network providers.

• **Direct Contracting**: Some very large and centralized employers, such as Boeing and Intel, have brought the task of negotiating discounted healthcare services in-house by "direct contracting" with providers for discounted services, bypassing commercial insurers' networks. *See* DX 9; Abbott (WTW) Tr. 122; Bisping (Caterpillar) Dep. 17–20. Some of these employers utilize consultants to negotiate discounted rates for them, *see* Fowdur Tr. 1351–52, and then retain third-party administrators ("TPA") to administer and adjudicate their employees' healthcare claims. Others work with national carriers to create and administer the network. Kendrick (Anthem) Tr. 1190–91.

• **Provider-Sponsored Plans**: Similarly, some healthcare providers have created provider-sponsored insurance plans ("PSPs") to cover their own large employee populations and then be available for purchase by outside groups. *See, e.g.*, Parker (Indiana University Health) Dep. 21; Adams (Centra Health) Dep. 78–79, 83. One way to accomplish this is through a joint venture with a national carrier, and the Virginia hospital system, Inova Health, formed a provider-sponsored plan with Aetna called Innovation Health. Henderson (Innovation Health) Dep. 17–18.

• **Third Party Administrators**: Some employers also look to third party administrators, or TPAs, to design plans and administer claims. Benedict (Cigna) Dep. 28–29. TPAs typically rent providers networks from insurers, including Anthem

and Cigna. *See* Abbott (WTW) Tr. 117; Kertesz (Anthem) Tr. 583–84; Benedict (Cigna) Dep. 30–31.

• **Specialty Services**. Finally, other entities identify a niche and focus on enhancing or replacing particular services that larger carriers offer as an aspect of their plans. For example, Castlight markets a "quality transparency tool" which allows "plan members to understand the cost of services that they're selecting, and the fact that there is price variation among providers, as well as variation in the quality of the outcomes." Abbott (WTW) Tr. 214. It was one of the first companies to "synthesiz[e] that data and to create a consumer-friendly tool designed to better educate the patient or consumer on the variation and cost and potential variations and the quality of care." *Id.* Other examples are Accolade and Quantum, two companies that offer concierge customer services. *See* DX 14 (Accolade is a "[n]iche total population care management carrier" that "performs case management and also advocates employers' turning off DM, nurse line, maternity programs, decision support, etc."); Kertesz (Anthem) Tr. 637; Smith (Cigna) Tr. 786–87 (describing Quantum as a concierge model offering customer service and coaching).

LEGAL STANDARD

Section 7 of the Clayton Act prohibits mergers or acquisitions "where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition." 15 U.S.C. § 18. "Congress used the words '*may* be substantially to lessen competition' . . . to indicate that its concern was with probabilities, not certainties." *Brown Shoe*

Co. v. United States, 370 U.S. 294, 323 (1962); *see also FTC v. H.J. Heinz Co.*, 246 F.3d 708, 719 (D.C. Cir. 2001) (the government is not required to prove the alleged impact on competition "with certainty"). In essence, in a merger trial, the Court is making a prediction about the future. It must engage in a "comprehensive inquiry" into the competitive conditions that will exist in the market in question after the transaction, *United States v. Baker Hughes Inc.*, 908 F.2d 981, 988 (D.C. Cir. 1990), and to meet their burden, plaintiffs must prove that anticompetitive effects are "sufficiently probable and imminent." *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 623 n.22 (1974), quoting *United States v. Cont'l Can Co.*, 378 U.S. 441, 458 (1964); *see also Heinz*, 246 F.3d at 713, quoting S. Rep. No. 1775 at 6 (1950) (the use of the words "may be" means the statute applies "to the reasonable probability of the pr[o]scribed effect" and not "the mere possibility").

In analyzing whether a transaction violates Section 7, courts in this Circuit apply the burden shifting framework set out by the Court of Appeals in *United States v. Baker Hughes*, 908 F.2d at 982.

Plaintiffs bear the initial burden to prove that the merger would result in "undue concentration in the market for a particular product in a particular geographic area." *Baker Hughes*, 908 F.2d at 982; *Heinz*, 246 F.3d at 715, quoting *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 363 (1963) ("[T]he government must show that the merger would produce 'a firm controlling an undue percentage share of the relevant market, and [would] result[] in a significant increase in the concentration of firms in that market.'"). This showing establishes a "presumption" that the merger will substantially

lessen competition, *Heinz*, 246 F. 3d at 715, and the burden then shifts to defendants to rebut the presumption. *Baker Hughes*, 908 F.2d at 982.

If plaintiffs establish the prima facie case, defendants must present evidence to rebut the presumption by "affirmatively showing why a given transaction is unlikely to substantially lessen competition, or by discrediting the data underlying the initial presumption in the government's favor." *Id.* at 991; *Heinz*, 246 F.3d at 715 ("defendants must produce evidence that 'show[s] that the market share statistics [give] an inaccurate account of the [merger's] probable effects on competition' in the relevant market'"), quoting *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975). The threshold the defendants must overcome to shift the burden back to plaintiffs is not high; the defendants are not required to "'clearly' disprove anticompetitive effect," but rather to make "a 'showing.'" *Baker Hughes*, 908 F.2d at 990–91, quoting *Marine Bancorporation*, 418 U.S. at 631. "But the 'more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully.'" *United States v. Aetna Inc.*, No. 16-cv-1494, 2017 WL 325189, at *10 (D.D.C. Jan. 23, 2017), quoting *Baker Hughe*s, 908 F.2d at 991.

If defendants are able to make a showing that rebuts the presumption, "the burden of producing additional evidence of anticompetitive effect shifts to the government, and merges with the ultimate burden of persuasion, which remains with the government at all times." *Baker Hughes*, 908 F.2d at 983; see also *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1340 & n.12 (7th Cir. 1981); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116

(D.D.C. 2004) (plaintiffs "have the burden on every element of their Section 7 challenge, and a failure of proof in any respect will mean the transaction should not be enjoined"). Plaintiffs must prove the alleged Clayton Act violation by a preponderance of the evidence. *United States v. SunGard Data Sys., Inc.*, 172 F. Supp. 2d 172, 180 (D.D.C. 2001). But "section 7 does not require proof that a merger or other acquisition will cause higher prices in the affected market. All that is necessary is that the merger create an appreciable danger of such consequences in the future." *Id.*, quoting *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1389 (7th Cir. 1986).

ANALYSIS

Plaintiffs allege that the merger of Anthem and Cigna will substantially lessen competition for the sale of health insurance, first to national accounts in a geographic market consisting of the fourteen Anthem states and in the United States as a whole, Compl. ¶¶ 19–37, and second, to large group employers in thirty-five local markets. Compl. ¶¶ 38–50. With respect to the national accounts market, the Court finds that each side has met its respective burden under the *Baker Hughes* framework. Plaintiffs have established a prima facie case that the merger is presumptively anticompetitive, defendants have introduced evidence to rebut the presumption, and plaintiffs have carried their ultimate burden of showing that the effect of this merger "may be substantially to lessen competition" in the market for sales to national accounts within the fourteen states. Therefore, the Court will enjoin the merger.

I. Plaintiffs have met their initial burden to show that the merger is presumptively anticompetitive in the market for the sale of health insurance to national accounts within the fourteen Anthem states.

A. The sale of medical health coverage to national accounts within the fourteen Anthem states is a relevant market.

Because the ultimate determination of the legality of a merger involves an assessment of the new firm's market power, and the prima facie case concerns market concentration, "'a necessary predicate' to deciding whether a merger contravenes the Clayton Act" is defining the relevant market. *Marine Bancorporation*, 418 U.S. at 618, quoting *United States v. E.I. du Pont De Nemours & Co.*, 353 U.S. 586, 593 (1957). The relevant market consists of two elements: a relevant product market and a relevant geographic market. *Arch Coal*, 329 F. Supp. 2d at 119; *Brown Shoe*, 370 U.S. at 324 (stating that the two factors are "a product market (the 'line of commerce') and a geographic market (the 'section of the country')"), quoting 15 U.S.C. § 18. A court may enjoin a merger based on proof of probable harm to any market alleged. *United States v. Pabst Brewing Co.*, 384 U.S. 546, 549 (1966) (to prove a violation of Section 7, plaintiffs "may introduce evidence which shows that as a result of a merger competition may be substantially lessened through the country, or . . . that competition may be substantially lessened only in one or more sections of the country").

"Congress prescribed a pragmatic, factual approach to the definition of the relevant market and

not a formal, legalistic one." *Brown Shoe*, 370 U.S. at 336; see also *Pabst Brewing*, 384 U.S. at 549. This is because "[t]he 'market,' as most concepts in law or economics, cannot be measured by metes and bounds." *Times-Picayune Publ'g Co. v. United States*, 345 U.S. 594, 611 (1953). Thus, plaintiffs' relevant market need not include all potential customers or participants. *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 338–46 (3d Cir. 2016) (finding a geographic market definition correct even when 43.5% of a hospital's patients came from outside the defined market).

Here, plaintiffs define the product market as the sale of commercial health insurance to national accounts with 5000 employees or more, and the complaint alleged a diminution of competition for the sale of that product in two geographic markets: the fourteen Anthem states and the entire United States.

1. The sale of health insurance to national accounts with more than 5000 employees is a relevant product market.

The relevant product market refers to the "product and services with which the defendants' products compete." *Arch Coal*, 329 F. Supp. 2d at 119. Since in defining the boundaries of the market, the Court is trying to answer the question of whether particular products "are sufficiently close substitutes to constrain any . . . anticompetitive pricing," *H & R Block*, 833 F. Supp. 2d 36, 55 (D.D.C. 2011), a properly drawn market must include all products that are "reasonable substitute[s]" for, but not necessarily exactly the same as, defendants'

offerings. *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 46 (D.D.C. 1998).

The Supreme Court set out the rules for identifying a relevant product market in *Brown Shoe*, and it started with the proposition that "the outer boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it." 370 U.S. at 325. Both of these concepts relate to the availability of any reasonable substitutes, that is, "whether two products can be used for the same purpose, and if so, whether and to what extent purchasers are willing to substitute one for the other." *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1074 (D.D.C. 1997) ("*Staples I*"), quoting *Hayden Publ'g Co. v. Cox Broad. Corp.*, 730 F.2d 64, 70 n.8 (2d Cir. 1984). Functional interchangeability refers to whether buyers view other products available to them as being "similar in character or use to the products in question;" in other words, are they suitable for use, even if they are not identical products. *Id.*; *see also Brown Shoe*, 370 U.S. at 325; Arch Coal, 329 F. Supp. 2d at 119, quoting *SunGard*, 172 F. Supp. 2d at 182. Cross-elasticity of demand incorporates price, convenience, and availability into the analysis and considers "the responsiveness of the sales of one product to price changes of the other." *E.I. du Pont De Nemours & Co.*, 351 U.S. at 400; *see also, e.g., FTC v. Whole Foods Market, Inc.*, 548 F.3d 1028, 1037 (D.C. Cir. 2008). Simply put, if a substantial price increase of one product would cause purchasers to switch to a different product, and purchasers can do so easily and conveniently, the two products are considered to compete in the same market.

Courts routinely turn to "practical indicia" as "evidentiary proxies for direct proof of substitutability." *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.*, 792 F.2d 210, 218 (D.C. Cir. 1986), quoting *Brown Shoe*, 370 U.S. at 325; *see also FTC v. CCC Holdings Inc.*, 605 F. Supp. 2d 26, 38 (D.D.C. 2009) (using these indicia to "augment the analyses of interchangeability and cross-elasticity of demand"). Following the Supreme Court's guidance in *Brown Shoe*, courts have reiterated that "the boundaries of a relevant market within a broader market 'may be determined by examining such practical indicia as industry or public recognition of the [relevant market] as a separate economic entity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors.'" *H & R Block*, 833 F. Supp. 2d at 51, quoting *Whole Foods*, 548 F.3d at 1037–38. Within the category of practical indicia, defendants' business records are "strong evidence" for defining the relevant product market. *Id.* at 52–53; *see also Whole Foods*, 548 F.3d at 1045; *CCC Holdings*, 605 F. Supp. 2d at 41–42; *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 162 (D.D.C. 2000); *Cardinal Health*, 12 F. Supp. 2d at 49; *Staples I*, 970 F. Supp. at 1076. Courts also consider economic testimony and utilize the "hypothetical monopolist test" set out in the 2010 U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines ("Guidelines") to ascertain whether the market has been properly defined to include all appropriate substitute products.[5]

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[5] The D.C. Circuit Court of Appeals, and other courts, have

But a broad general market may contain smaller markets which separately "constitute product markets for antitrust purposes." *Brown Shoe*, 370 U.S. at 325. Because the relevant product market in any particular case need only include "reasonable substitutes." *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 26 (D.D.C. 2015), the fact that a firm may be considered a competitor "in the overall marketplace does not necessarily require that it be included in the relevant product market for antitrust purposes." *Id.*, quoting *Staples I*, 970 F. Supp. at 1075; *Cardinal Health*, 12 F. Supp. 2d at 47. The Merger Guidelines specifically caution that "defining a market broadly to include relatively distant product or geographic substitutes can lead to misleading market shares." Guidelines § 4.

Market shares of different products in narrowly defined markets are more likely to capture the relative competitive significance of these products, and often more accurately reflect competition between close substitutes. As a result, properly defined antitrust markets often exclude some substitutes to which some customers might turn in the face of a price increase even if such substitutes provide alternatives for those customers.

Id. Courts have similarly recognized that "[m]arkets must be drawn narrowly to exclude any other product to which, within reasonable variations in price, only a limited number of buyers will turn."

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approved the use of the Horizontal Merger Guidelines as guidance in merger cases. *See Heinz*, 246 F.3d at 716 n.9; *Fruehauf Corp. v. FTC*, 603 F.2d 345, 353–54 (2d Cir. 1979); *H & R Block*, 833 F. Supp. 2d at 52 n.10.

Aetna, 2017 WL 325189, at *10, quoting *Times-Picayune*, 345 U.S. at 612 n.31.

a. The proposed product market

Plaintiffs maintain that the sale of commercial health insurance to national account customers is a relevant product market. They define a national account as an employer with 5000 or more employees, and their analysis of concentration in the market looks at both employers with 5000 employees and employers with 5000 employees spread over more than one state. Compl. ¶ 20; Dranove Tr. 877–78; Pls.' Proposed Findings of Fact: Phase I [Dkt. 416] ¶¶ 65–72. Defendants contend that this product market is invalid because: (1) there is no uniform industry definition for what constitutes a national account, (2) it is improper to combine ASO and fully insured plans into a single product market, and (3) and the threshold of more than 5000 employees used by plaintiffs' economics expert in analyzing the market is arbitrary and too large.

Case law provides for the distinction of product markets by customer. *Brown Shoe*, 370 U.S. at 325, citing *E.I. du Pont de Nemours & Co.*, 353 U.S. at 593–95 ("[W]ithin this broad market, well-defined submarkets may exist which, in themselves, constitute product markets for antitrust purposes."); Guidelines § 3 ("When examining possible adverse competitive effects from a merger, the Agencies consider whether those effects vary significantly for different customers purchasing the same or similar products."). A submarket exists when sellers can profitably raise prices "to certain targeted customers but not to others," in which case regulators "may evaluate competitive effects separately by type of

customer." *See, e.g., FTC v. Staples*, 190 F. Supp. 3d 100, 117 (D.D.C. 2016) ("*Staples II*") (recognizing "targeted" or "price discrimination" markets in antitrust law); *Whole Foods,* 548 F.3d at 1037–41 (upholding lower court's finding of a narrower market of core customers for premium, natural, and organic supermarkets rather than grocery store customers generally).

b. National accounts are a unique set of customers with unique needs.

There was considerable evidence presented to establish that there is a distinct type of large employer that is looking for an insurance plan that can deliver a national network, a high degree of plan customization, and sophisticated claims administration, customer service, and data reporting. A review of the wealth of practical indicia in the record shows that the industry universally recognizes that national accounts exhibit different needs and characteristics that drive the design and pricing of their products. As one industry consultant testified:

Large employers, certainly, are by nature more complex. They tend to have more locations, they tend to have more sophisticated requirements just by virtue of their size. Not necessarily so, but generally, they are looking for a broader portfolio of services. They're looking for that national network, and they are also looking for an ability to customize programs, often to a fairly substantial degree.

Abbott (WTW) Tr. 76–78, 159; *see also* Sharp (Aon Hewitt) Dep.76–78 (large employers require customized solutions and benefit plans and may have

different employee populations, such as union and non-union employees). As Anthem's former President of National Accounts, John Martie, explained, "national account purchasers tend to be more sophisticated and tend to appreciate greater levels of innovation." Martie (Anthem) Dep. 84; *see also* Kertesz (Anthem) Tr. 535–37. By the end of the trial, it was crystal clear that just about everyone in the industry, certainly everyone within Anthem and Cigna, has a consistent understanding of exactly what a national account is.

National accounts require carriers that can supply in-network providers in all of the locations where their employees live, work, and travel, and even where they may relocate as retirees. Cordani (Cigna) Tr. 404; Kertesz (Anthem) Tr. 538; Swedish (Anthem) Tr. 226; Martie (Anthem) Dep. 125; Mascolo (Wells Fargo) Dep. 65–66; Kidd (Sodexo) Dep. 20–21; Loring (Applied) Dep. 40–41; Record (Steel Dynamics) Dep. 30; *see also* Burnell (Buck Consultants) Dep. 112–13. The national network is critical; as Anthem's former head of national accounts testified, "you don't really call yourself a . . . national account carrier unless you can cover all 50 states." Goulet Dep. 96.

National accounts are also more likely to demand customized plans, technological platforms that enable employees to access claims information, data reporting so that the customers can understand and manage their healthcare costs, and in light of recent data breaches, sophisticated data security measures. *See, e.g.*, Schumacher (United) Dep. 226–27 (for large, multi-state national employers "there's more customization . . . more interaction from the account management team and the support efforts");

Bierbower (Humana) Tr. 802 (national accounts typically desire "customized data files, customized plan designs, customized clinical programs"); Sharp (Aon Hewitt) Dep. 75–78 (large market clients with more than 5000 employees "tend to be requiring more customized solutions"); *see also* Abbott (WTW) Tr. 77–79, 159; Guilmette (Cigna) Dep. 73–74; Welch (Cigna) Dep. 25; Martie (Anthem) Dep. 161–62; Bailey (Cigna) Dep. 67–68; Parr (Cigna) Dep. 18–19; PX 94. In other words, national account customers demand an individualized, or differentiated, product.

National accounts typically work with consultants to navigate the RFP and selection process used to purchase such a product. *See, e.g.*, Pogany (Anthem) Dep. 34; Martie (Anthem) Dep. 52; Bailey (Cigna) Dep. 66–67; PK 94; Schumacher (United) Dep. 203–04, 228–29. Thus, they are sophisticated customers who bring the expertise of knowledgeable advisors to the task of procuring coverage for their employees.

Furthermore, both brokers and carriers – including the merging parties – manage this segment separately from the rest of the 50+ employee large group segment. Both Anthem and Cigna have established separate profit and loss centers for national accounts, with their own executives and separate marketing, sales, customer relations, and underwriting teams. *See, e.g.*, Swedish (Anthem) Tr. 224–25; Cordani (Cigna) Tr. 404; Williams (Cigna) Dep. 23; Bailey (Cigna) Dep. 66–67; Guilmette (Cigna) Dep. 73–74; Hayes (Aetna) Dep. 24; PX 118 (Aetna document); Schumacher (United) Dep. 230; Jay (Anthem) Dep. 12, 15; Cheslock (Anthem) Dep. 20. Thus, the evidence strongly supports the conclusion that national account

customers are a distinct subset of the health insurance market, with needs that differentiate them from employers on the smaller end of the large group spectrum.

c. 5000 employees is an appropriate definition.

Defendants can hardly contest the existence of a category of "national account" customers within the large group market, but they insist that there is no industry consensus for what the term means, "either as to the number of employees or their geographic spread." Anthem's Phase I Pretrial Br. [Dkt. 324] at 6. So the next question to consider is whether plaintiffs' definition of national accounts as customers with more than 5000 employees is appropriate.

1) Practical indicia support the definition.

Here there is strong evidence coming from the merging parties themselves. The firms' own business records show that they each use the 5000 employee threshold to define their national accounts and manage their lines of business. PX 125 (Anthem SEC 10-K filing); PX 127 (Anthem website); *see also* DDX 88 (defense demonstrative exhibit listing the thresholds used by various carriers and TPAs to define national accounts). The CEO of Anthem testified that Anthem defines national accounts as multi-state employers with more than 5000 eligible employees. Swedish (Anthem) Tr. 225; *see also* PX 127 (at least 5% of employees must be located outside of the headquarter state). Cigna also uses the definition of multi-state employers with 5000 or more fulltime employees. PX 284 (Cigna SEC 10-K filing).

Aon Hewitt, a national consulting firm also finds 5000 to be an appropriate dividing line; it groups its large employer clients into "middle market" customers with fewer than 5000 employees and "large market" customers with more than 5000 employees. Sharp (Aon Hewitt) Dep. 76. The record does reveal, though, that there is also variation in the way other industry participants define the term. The largest national carrier, United Healthcare, defines its national accounts as customers with 3000 or more employees, whether in a single or multiple states. Schumacher (United) Dep. 106. Aetna uses the same definition. Hayes (Aetna) Dep. 22–23. Randall Abbott, a consultant with Willis Tower Watson, agreed that industry participants employ varying definitions: "2500, 3000 or 5000 is very common. Some will . . . have a multi-location requirement. Generally, though, it's a size threshold." Abbott (WTW) Tr. 157–58.

The evidence also indicates that the defendants do not always adhere strictly to the definition in their day to day operations. The Anthem Vice President for National Account Management explained that Anthem has some employers with fewer than 5000 employees managed by its national accounts team because Anthem changed its definition of the segment and some customers were "grandfather[ed]" in as national accounts. Mathai (Anthem) Tr. 1257. She also noted that some customers prefer to continue to remain within that segment even after their workforce is reduced in a divestiture. Mathai (Anthem) Tr. 1257. Similarly, at Cigna, there may be some customers with fewer than 5000 employees managed as national accounts and some with more than 5000 employees managed as

regional accounts because those customers have changed in size over time, or because a customer requested to be managed by the other segment in light of a prior customer service relationship. Thackeray (Cigna) Tr. 740–41.

But these small variations and the existence of some exceptions does not negate the force of the evidence of defendants' own ordinary course of business operations, and the other practical indicia of the defining characteristics of a national account customer. This real world evidence reinforced and verified the conclusions reached by plaintiffs' economics expert, notwithstanding the defendants' efforts to counter him with experts of their own.

2) Economic expert testimony supports the definition.

A second category of evidence that courts consider at the market definition stage is testimony from experts, and a primary tool used by economists to determine whether the alleged set of products is relevant for antitrust purposes is called the hypothetical monopolist test. *See* Guidelines § 4.1.1; *H & R Block*, 833 F. Supp. 2d at 51–52. This test asks whether a "hypothetical profit-maximizing firm," that was the only seller of all of the products within a proposed market, would be likely to impose "a small but significant and non-transitory increase in price ("SSNIP") on at least one product in the market, including at least one product sold by one of the merging firms." Guidelines § 4.1.1. The Guidelines consider a SSNIP to be a price increase of 5% or more. *Id.* § 4.1.2.

The test is designed to measure whether a higher price "would drive consumers to an alternative

product" or to forego purchases altogether. *Whole Foods*, 548 F.3d at 1038. The question of whether the hypothetical monopolist could profitably impose a SSNIP depends upon the number of substitutes outside the market under consideration. "If enough customers are able to substitute away from the hypothetical monopolist's product and thereby make a price increase unprofitable," then the market has been drawn too narrowly for purposes of the antitrust laws and more substitutes must be included. *Sysco*, 113 F. Supp. 3d at 33. If enough customers would continue to purchase the products in the proposed market despite the price increase rather that switch to an alternative, that set of products constitutes an appropriate product market for antitrust analysis. *See* Guidelines § 4.1.1. Only those products that prevent a hypothetical monopolist from significantly increasing prices should be included in the relevant market. *H & R Block*, 833 F. Supp. 2d at 51–52.

Here, the question is whether it would be hypothetically useful to have a monopoly over all health insurance products sold to national account customers because a monopolist could profitably raise prices for those products by 5% or more; or whether there would be no reason to monopolize the market because substitution and price competition would restrain a potential monopolist from profitably raising prices.

a) Plaintiffs' expert

To derive an answer, plaintiffs' economic expert, David Dranove, Ph.D., considered what employers with 5000 or more employees purchasing group health insurance would do in the face of a SSNIP.

His definition of the relevant product market included both ASO and fully-insured group health plans purchased from carriers, as well as coverage obtained through TPA's, private exchanges, or direct contracting. Dranove Tr. 2245, 2247. Using this definition, Dr. Dranove concluded that there would be only two alternatives for employers that sought to avoid the price increase: managing all aspects of their employees' health benefits coverage themselves or foregoing the purchase of commercial insurance entirely, and neither is a reasonable substitute for purchasing commercial health insurance. Dranove Tr. 861–65. Therefore, he concluded a hypothetical monopolist in the alleged market would likely be able to impose a SSNIP.[6] Dranove Tr. 863–66.

b) Defense experts

Defendants challenged plaintiffs' definition of the relevant product market with testimony of the first of its three experts: the economist, Lona Fowdur, Ph.D. Dr. Fowdur criticized plaintiffs' expert for using the 5000 employee threshold to define national accounts and insisted that the products those customers purchase are "reasonably interchangeable" with insurance products purchased by customers with fewer than 5000 employees. Fowdur Tr. 1304. As she put it, "to the extent that the products sold to national accounts of size 5000

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[6] Dr. Dranove calculated the critical elasticity in the market based on data obtained from the insurers, and that exercise led to the conclusion that 6% of national accounts would drop their coverage if the price went up 5%. Dranove Tr. 864. But studies of the industry revealed that the marketplace is actually much less responsive, and that insurers do not eliminate this important employee benefit even if the price goes up. Dranove Tr. 865.

plus are alternatives for groups that are less than 5000 in size, the two products' markets become reasonably interchangeable, so this bright line that plaintiffs are arguing about becomes blurry."[7] Fowdur Tr. 1304. In Dr. Fowdur's view, including customers with 3000 or 1000 employees in the relevant market would more fairly reflect the presence of the smaller players in the market. *See* Fowdur Tr. 1303–06.

It is true that some customers with fewer than 5000 employees may have geographically dispersed employees or other needs and characteristics similar to national accounts. But the question is not simply whether one product competes to some extent with another; it is whether consumers in the market in general view the products as "reasonable substitutes." *Cardinal Health*, 12 F. Supp. 2d at 46. Here, the defense critique assumes that an insurance product suitable for a customer with 3000 (or 1000)[8] employees is an adequate substitute in all instances, and that theoretical proposition is contrary to the

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[7] While Anthem argued there is no economic basis for combining ASO and fully-insured plants into a single product market for national accounts, Anthem Pretrial Br. at 5–6, Dr. Fowdur did not take issue with this particular aspect of Dr. Dranove's hypothetical market. "I think the source of the confusion is not between ASO and fully insured. I think the source of the confusion stems from the fact that plaintiffs have arbitrarily established this bright-line threshold at 5000 plus enrollees." Fowdur Tr. 1303.

[8] Dr. Fowdur steadfastly resisted offering her own opinion as to what number would have been the correct one to choose, confining her opinion to what was wrong with plaintiffs' selection of 5000 as a place to draw the line. Fowdur Tr. 1364–65.

evidence of the actual conditions in the market and the firms' internal business records.

The evidence of industry practice discussed above made it clear that the larger a customer becomes, it requires greater customization, sophistication, and network coverage, and its range of choices narrows. A parade of industry participants testified that given the distinct requirements of national accounts, only a handful of carriers can serve their needs. Peter Kilmartin, a partner at Mercer, emphasized that only the four "large national carriers" can deliver effectively in the vast majority of geographies, because they offer the provider networks with the requisite scope along with the necessary level of account management and customer service. Kilmartin (Mercer) Dep. 123. He identified United, Anthem, Cigna, and Aetna as the four options, and Tucker Sharp of Aon Hewitt, another consulting firm, agreed. "[T]he national carriers tend to be Aetna, Anthem, Cigna, and UnitedHealthcare . . . . We don't tend to include anyone else in that list." Sharp (Aon Hewitt) Dep. 91; *see also* Burnell (Buck Consultants) Dep. 29, 87 (there are only four national carriers, and Kaiser is not a national carrier).

The fact that Anthem and Cigna themselves use the 5000 employees threshold to structure and account for their lines of business is "strong evidence" that supports Dr. Dranove's use of that figure in his analysis. *H & R Block*, 833 F. Supp. 2d at 53. And Anthem's own salesforce records revealed that many of its national accounts are considerably larger than the firms Dr. Fowdur opined would be comparable. As of June 2016, many of Anthem's more than 500 national accounts included more than

20,000 or 50,000 members – significantly more than would be generated by 5000 employees – and some represented membership of over 100,000 and even 200,000. *See* DX 687. So the suggestion that what might be good for some would be good for all is not a practical one.

Here, the fact there may be some overlap between plans purchased by some customers with 3000 employees and those sold to customers with 5000 employees does imply that all of the products suitable for smaller customers should be part of the relevant market for the purpose of merger analysis. "[P]roperly defined antitrust markets often exclude some substitutes to which some customers might turn in the face of a price increase even if such substitutes provide alternatives for those customers." Guidelines § 4. The agencies' guidance makes it clear that some substitutes may be excluded – indeed should be excluded – to more accurately reflect the extent of competition between closer, reasonable substitutes.

The competitive significance of distant substitutes is unlikely to be commensurate with their shares in a broad market. Although excluding more distant substitutes from the market inevitably understates their competitive significance to some degree, doing so often provides a more accurate indicator of the competitive effects of the merger than would the alternative of including them and overstating their competitive significance as proportional to their shares in an expanded market.

Id. So while Dr. Dranove's 5000 employee threshold may exclude some products that would meet the needs of smaller employers and even some

national accounts, it is more consistent with how the industry actually operates, and it focuses the competitive analysis on the products that industry participants appear to agree are preferred by customers with more than 5000 employees. This narrower definition is "more likely to capture the relative competitive significance of these products, and often more accurately reflect competition between close substitutes." Guidelines § 4.[9]

At one point during the trial, defendants' expert, Dr. Fowdur, complained that plaintiffs had failed to supply "conclusive proof" of the relevant market. Fowdur Tr. 4211. And during closing argument, counsel for Anthem cited *United States v. SunGard*, 172 F. Supp. 2d at 172, as support for Anthem's view that plaintiffs' delineation of the product market lacked sufficient economic rigor. Curran (Def. Counsel) Tr. 4895–96. However, in that case, the district court did not articulate any new or more stringent standard, and there is no need for "conclusive proof" at this point. The court recited all of the applicable tests, starting with the statement that a plaintiff must show that a pending acquisition is "reasonably likely" to cause anti-competitive effects, *SunGard*, 172 F. Supp. 2d at 180, and that the court must follow the *Baker Hughes* analytical approach. *Id.* The opinion does emphasize the importance of defining the relevant market properly,

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[9] Indeed, the evidence showed that there could be some national accounts of 5000 employees or more that do not require highly individualized plans, or are sufficiently concentrated that regional plans may satisfy their network needs. But products sold to those employers were included in the market even if doing so overstated their significance to the group as a whole.

and the impact that will have on assessing competitive effects, *id.* at 181, but it also quotes *Brown Shoe*, 370 U.S. at 325, for the proposition that in addition to following the Horizontal Merger Guidelines and looking at the hypothetical monopolist and the SSNIP test, the court should consider "practical indicia" because "the determination of the relevant market in the end is a matter of business reality." *Id.* at 182, quoting *Cardinal Health*, 12 F. Supp. 2d at 46. And when the court applied the law to the facts, it seemed more affected by the heterogeneity of the customers and the conflicting evidence of how the market is perceived and what the adequate substitutes might be rather than by any failure of economic rigor. So the observation of the Supreme Court in *Times-Picayune* that the market "cannot be measured by metes and bounds," 345 U.S. at 611, still pertains, and *SunGard* does not require a change in the Court's analysis. Here, the "business reality" is entirely consistent with plaintiffs' economic analysis, and the Court holds that the market for the sale of health insurance to national account customers, defined as employers with more than 5000 employees, is a relevant antitrust product market.

Anthem also argued there was no economic basis for combining both ASO and fully-insured plans into a single healthcare coverage product market for national accounts. Anthem Pretrial Br. at 5–6. But this combination does not invalidate the proposed market. The law is clear that the "product" that comprises the market need not be a discrete good for sale. "We see no barrier to combining in a single market a number of different products or services

where that combination reflects commercial realities." *United States v. Grinnell Corp.*, 384 U.S. 563, 572 (1966); *Phila. Nat'l Bank*, 374 U.S. at 356, (citation omitted) (finding that "the cluster of products . . . and services . . . denoted by the term 'commercial banking'. . . composes a distinct line of commerce"). While most national accounts purchase ASO plans, the narrow distinction between these types of plans does not alter their key elements: the network being supplied and the claims administration services delivered to the customer. Neither Anthem nor Cigna carve fully insured customers out of their national accounts divisions or track or manage them separately. *See, e.g.*, Swedish (Anthem) Tr. 246; PX 123 (Anthem financial document); *see also* Hayes (Aetna) Dep. 30–31, 74–75. So fully insured plans with carriers that can otherwise handle the national needs of these customers are "reasonable substitutes" for national ASO accounts for purposes of the market definition. *Cardinal Health*, 12 F. Supp. 2d at 46. And in the end, this dispute had little practical bearing on the market share calculations that flowed from the market definition since "virtually all" national accounts have ASO plans. *See* Abbott (WTW) Tr. 169.

2. The fourteen Anthem states comprise a relevant geographic market.

With respect to the second component of the market definition, plaintiffs allege that the fourteen Anthem states combined comprise a relevant geographic market for the sale of healthcare insurance to national accounts. Compl. ¶¶ 24–25.

A relevant geographic market identifies "where, within the area of competitive overlap, the effect of the merger on competition will be direct and immediate." *Phila. Nat'l Bank*, 374 U.S. at 357; *see also Marine Bancorporation*, 418 U.S. at 620–21 (defining it as "the area in which the goods or services at issue are marketed to a significant degree by the acquired firm"); *Cardinal Health*, 12 F. Supp. 2d at 49 (a geographic market is the area "to which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition"), quoting *Morgenstern v. Wilson*, 29 F.3d 1291, 1296 (8th Cir. 1994); *Arch Coal*, 329 F. Supp. 2d at 123 (it is "the region in which the seller operates, and to which the purchaser can practicably turn for supplies"), quoting *Cardinal Health*, 12 F. Supp. 2d at 49.

As with a product market, a relevant geographic market must "correspond to the commercial realities of the industry and be economically significant." *Brown Shoe*, 370 U.S. at 336–37 (footnote omitted) (internal quotation marks omitted). While this market "must be sufficiently defined so that the Court understands in which part of the country competition is threatened," *Cardinal Health*, 12 F. Supp. 2d at 49, it need not be defined with "scientific precision," since an "element of 'fuzziness would seem inherent in any attempt to delineate the relevant geographical market.'" *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974), quoting *Phila. Nat'l Bank*, 374 U.S. at 360 n.37.

When analyzing the proposed geographic market, the Court may again consider economic testimony, which often also consists of the results of a hypothetical monopolist test that asks whether a

hypothetical firm that sells all the relevant products sold in that particular geographic area could profitably impose a SSNIP. *See* Guidelines § 4.2.

Plaintiffs allege that the fourteen Anthem states combined are a single relevant geographic market. Compl. ¶ 24. The defense contends that this proposed market is "gerrymander[ed]" and "lacks economic coherence." Anthem Pretrial Br. at 8.

Dr. Dranove testified that the fourteen Anthem states comprise a relevant geographic market because that is where Anthem is licensed to use the Blue brand and so the merger will directly affect competition by eliminating Cigna as a competitor. Dranove Tr. 866–68 ("[T]he Anthem territories are the territories where Anthem has the right to sell and, therefore, this merger eliminates head-to-head competition between Anthem and Cigna. It's the market that has the greatest potential, therefore, for direct, competitive harm. If you are headquartered in this area and you want a national accounts vendor, you want one of the big four, you now get a choice of one of the big three.").

The economist also conducted a hypothetical monopolist test on the geographic market. Again, he defined the product market as all health insurance purchased by national accounts, whether from carriers, direct contracting, TPAs, or other channels. Dranove Tr. 868–69. Using this definition, he concluded that national accounts headquartered in the Anthem states could only respond to a SSNIP by forgoing providing health insurance for their employees or relocating their headquarters to a non-Anthem state, neither of which is a realistic option. Dranove Tr. 868.

The defense objects to the geographic market on the grounds that aggregating the fourteen states into a single geographic market improperly diminishes the competitive significance of regional firms. Its economist, Mark A. Israel, Ph.D. testified that there are regional competitors, such as Kaiser in California or Harvard Pilgrim of Massachusetts, within the geographic market as a whole that account for a significant share in their localities but are not a factor elsewhere. Israel Tr. 2001–02.

Dr. Fowdur also opposed the combination of the fourteen states into one market, and she opined that the geographic market is "ill-defined" because it is "very geographically dispersed" and national accounts with sufficient enrollees outside the Anthem states could slice or move to a private exchange "to impose competitive discipline on this hypothetical monopolist." Fowdur Tr. 1311–14.

Finally, Robert D. Willig, Ph.D., found the 5000 employee definition to be problematical, too. Willig Tr. 2224–25. He pointed out that the studies Dr. Dranove relied upon to determine the elasticity of the market were based on companies of 1000 employees or more, and therefore, in his view, there was no proper SSNIP test supporting the use of 5000. Willig Tr. 2224–25.

The Court finds that the fourteen Anthem states comprise a relevant geographic market. It has everything to do with how Anthem conducts its business on a day to day basis. The Blue Cross Blue Shield association imposes exclusivity rules, which are defined by geography. They bar other Blue licensees from pursuing national account customers within the Anthem territory, and they prohibit

Anthem from competing for customers headquartered outside its fourteen states without a "cede," that is, permission from the Blue licensee in that state to do so. Swedish (Anthem) Tr. 235–36; Kendrick (Anthem) Tr. 1205; Bills (Anthem) Dep. 60, 85–86, 207–09. This means that right now, Anthem competes directly against Cigna for national accounts in the fourteen states at the very least, and that the merger would eliminate Cigna as a direct competitor there. Since the fourteen Anthem states comprise an "area of competitive overlap, the effect of the merger on competition will be direct and immediate." *Phila. Nat'l Bank*, 374 U.S. at 357. Indeed, the Anthem executive heading the integration team referred to the fourteen states as the "overlap markets" when describing the new company's strategy for achieving saving or going to market. *See* Matheis (Anthem) Tr. 1483, 1524. As Dr. Dranove put it, "[f]or companies headquartered in those markets, this is effectively, slice business notwithstanding, a four to three merger." Dranove Tr. 2251.

Furthermore, there is no evidence that the lack of contiguity of the fourteen states matters, especially since the employees of national accounts may be scattered across non-contiguous geographies. Abbott (WTW) Tr. 68 (some employers are "very, very centralized," with "a home office and then perhaps a couple of manufacturing locations, there may be a distribution facility" and others like a retail bank might have "hundreds, if not thousands of locations"); *see also* Dranove Tr. 871. Defendants did not articulate any way in which the shape of the market should be viewed as significant in light of the undeniable fact that the fourteen states are exactly

where Anthem competes with Cigna and the other major national and regional carriers for national account business, and they are where the new firm's products will be marketed to a significant degree.

While a proposed geographic market would be too narrow if customers could respond to a SSNIP by shifting to products produced outside the geographic area, *Arch Coal*, 329 F. Supp. 2d at 123, citing Guidelines § 1.21, there was no testimony that customers could avail themselves of that option in this case. Geography is a significant constraint on the purchase of health insurance; while someone in the market for a new car might head to a neighboring state to avoid a price gouging hypothetical monopolist in his own, medical care is local, and a large group employer headquartered in a particular state must purchase insurance from a carrier licensed to do business in that state that offers its employees a network in the same state.[10]

Dr. Fowdur's assertion that national account customers can defeat a price increase does not posit

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[10] There is evidence that healthcare providers in the fourteen Anthem states draw some patients from outside the fourteen states. *See* Wilhelmsen (SNHHS) Dep. 77, 176 (approximately 5% of patients at the Southern New Hampshire Health System's Nashua hospital came from Massachusetts and its service area includes four Massachusetts towns). But the relevant question is not how patients (employees) would respond to a SSNIP in the market for national accounts health insurance but how the employers that are the customers – would. *See, e.g., Penn State Hershey Med. Ctr.,* 838 F.3d at 338–46 (holding that basing geographic market on patient flow data in a hospital merger case "failed to properly account for the likely response of insurers in the face of a SSNIP"). Dr. Fowdur frequently blurred this distinction. Fowdur Tr. 4215–16.

that there is any means to solve the problem when buying coverage for employees residing within the hypothetical monopolist's fourteen states. But she calculated the critical loss in this instance to be 9.2%, which means that if 9.2% of the monopolist's business moved to plans offered in another geographic region, the 5% price increase would become unprofitable. Fowdur Tr. 1319–20. Since a large number of employees covered by plans issued to employers within the fourteen states live outside those states, she reasoned that slicing the dispersed employees would be enough to reach the critical loss figure. *See* Fowdur Tr. 1319–20. But even if this is sensible as a matter of economic theory, it ignores the practical impediments involved in slicing and cannot be reconciled with the persuasive testimony that the current trend in the industry is to avoid this kind of fragmentation.

Randall Abbott, a healthcare consultant with Willis Towers Watson, detailed the "frictional cost" involved in contracting with a new entity:

[T]here's simply the cost of change. It's setting up new data interfaces, it's printing new communication material, it's typically changing open enrollment materials, it's adjusting all needed filings under ERISA, it's staff time required to redefine the plans with a new partner. Often there are minor variations in plan design that have to be adjusted for. And increasingly now, with larger companies, there's a focus on contract negotiations that can be very extensive, and, also, data security considerations, technology interfaces, information security penetration testing and the like that all require time. But I would say the primary frictional concern is the risk of change for employees and their

families, because . . . healthcare is very immediate for . . . a company's people.

Abbott (WTW) Tr. 71. He added that each of the major health plans has a set of in-network providers, and that if an employee's provider is not in the new plan's network, "that would create a disruption in the doctor-patient relationship, which would be a concern. The same could hold true of specialist relationships or hospital facilities or outpatient facilities, as well." Abbott (WTW) Tr. 72. Similarly, "[t]he disadvantages of slicing are those frictional costs . . . . Every relationship requires contracting, every relationship requires data interfaces. There will be some variations, perhaps, in the plan of benefits offered. There will be differences in the various wellness care management, condition management services. And to the extent there are differences, those have to be reflected in either . . . required statutory filings . . . or in employee communication material. Each additional health plan requires added effort at open enrollment . . . ." Abbott (WTW) Tr. 111–12; *see also* Kilmartin (Mercer) Dep. 137 ("[I]t takes effort and resources for an employer to maintain and actively manage the carrier relationships.").

Given these costs and administrative burdens, there has been a "pendulum swing" by national accounts towards using fewer carriers, and "since the mid-'90s the focus has been on consolidating with one national health plan." Abbott (WTW) Tr. 111. According to Peter Kilmartin of Mercer, 73% of his clients use only one carrier. Kilmartin Dep. 137. Customers agree. *See* Monti (Kroger) Dep. 31–32 (using one carrier to cover as many associates as possible provides "administrative simplicity": having

more insurers is more expensive to administer due to such issues as the need for multiple data feeds and additional communications to employees); Loring (Applied) Dep. 37–38.

It is also important to consider that Dr. Fowdur's point was that national account employees are spread broadly throughout the United States – not that customers tend to have one or two discrete satellite locations. But the national accounts that do slice typically do so among only one or two national carriers, or they incorporate one large regional carrier such as Kaiser or Harvard Pilgrim; they do not slice among multiple carriers. Abbott (WTW) Tr. 199 ("[T]he vast majority [of major employers] use one national health plan with occasional regional solutions . . . ."); *id.* at 207 (offering four or more carriers is "rare"); Kilmartin (Mercer) Dep. 68 (slicing for national accounts is typically one large national with one regional).

Dr. Fowdur's vision of the slicing that is possible also stood in contrast to what the Anthem executives testified is more probable. John Martie, currently the Senior Vice President of Integration for the Cigna acquisition and formerly the Anthem President of National Accounts, observed that the customer trend today is to reduce the number of carriers, Martie Dep. 257–58, and Ken Goulet, the former Anthem President of Commercial and Specialty Business, which includes national accounts, repeated that the trend is moving towards consolidation, usually with two big carriers side by side. Goulet Dep. 122. Vice President and Head of New Sales for Anthem National Accounts, Jerry Kertesz, also avowed that national accounts are consolidating relationships, and that it is "rare" for a customer to contract with

more than two carriers.[11] Kertesz (Anthem) Tr. 560, 588.

Further, Dr. Fowdur's testimony that as an abstract matter national accounts could avoid a SSNIP by turning to private exchanges does not comport with the evidence detailing the drawbacks of these relatively new products and their failure to take hold in the marketplace. *See, e.g.*, Schumacher (United) Dep. 182; Hayes (Aetna) Dep. 144–52 (reported in October 2015 Quarter Business Review that only 4% of the national accounts market will have adopted an exchange for 2016); section III.D.4 below. Moreover, if the hypothetical monopolist in the relevant market were to raise prices on all plans sold to national account customers, prices would go up on the exchanges as well, since the exchanges are just an alternative means to bring plans sold by the existing carriers in the market to the customer. *See* Kilmartin (Mercer) Dep. 27–28 (Mercer's Marketplace is a private exchange "is a technology-enabled platform that allows carriers to compete for business"); Kertesz (Anthem) Tr. 636.

Finally, while aggregating the fourteen states when calculating market share may understate the local power of a particular regional carrier, it does not give an inaccurate picture of the overall conditions in the national accounts market, and therefore, it does not fall short of the relatively flexible standard imposed by the Guidelines and the case law. Both Anthem and Cigna generate internal

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[11] None of this is inconsistent with Dr. Fowdur's conclusion, based on Dr. Dranove's data, that 60% of the 126 Anthem national accounts she reviewed were sliced. Fowdur Tr. 1347.

reports that discuss national accounts in the aggregate. *See, e.g.*, DX 697. Although the record shows that competitive conditions across the fourteen states may vary, *see* Mathai (Anthem) Tr. 1263,1270, some oversimplification is inevitable when defining a geographic market, *see* Guidelines § 4.0, and aggregating across the fourteen states will provide a useful measure of the competitive impact of this acquisition in the territory in which Anthem and Cigna compete most directly. Therefore, plaintiffs have established the existence of both a relevant product and geographic market.[12]

B. Market share and concentrations in the relevant market establish the presumption.

Having defined the relevant market, the next step in analyzing the prime facie case is to calculate the market share and level of concentration in the market. *Heinz,* 246 F.3d at 716; Guidelines §§ 5.2–5.3. The level of concentration in a market "is a function of the number of firms in a market and their

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[12] Ultimately, Dr. Fowdur's theory that reducing the number of employees to 3000 or 1000, or disaggregating the states, would radically alter the picture and reveal the strength of numerous smaller market participants, was not borne out by the evidence introduced in Phase II. Since the allegations in the second phase of the trial concerned all large group employers, the market share data that was introduced related to employers with as few as 50 or 100 employees, and tightly drawn geographic regions. Yet the dominance of the four national carriers, and therefore, the level of market concentration that would exist in the wake of a merger of two of them remained striking in the majority of plaintiffs' thirty-five sample markets. *See* PDX 28; PX 751; Dranove Tr. 3719–23.

respective market shares." *Staples II*, 190 F. Supp. 3d at 128, quoting *Arch Coal,* 329 F. Supp. 2d at 123.

Merger law "rests upon the theory that, where rivals are few, firms will be able to coordinate their behavior, either by overt collusion or implicit understanding, in order to restrict output and achieve profits above competitive levels." *FTC v. PPG Indus.*, 798 F.2d 1500, 1503 (D.C. Cir. 1986). Market concentrations above certain levels are thought to raise the likelihood of "interdependent anticompetitive conduct." *Id.* A merger that produces "a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Phila. Nat'l Bank,* 374 U.S. at 363–64 (holding that "[w]ithout attempting to specify the smallest market share which would still be considered to threaten undue concentration, we are clear that 30% presents that threat").

The Herfindahl-Hirschmann Index ("HHI") is a formula used by the U.S. Department of Justice Antitrust Division and the Federal Trade Commission to employ market shares to calculate the level of concentration in a particular market. *See* Guidelines § 1; *Staples I*, 970 F. Supp. at 1081 n.12. "The HHI is calculated by totaling the squares of the market shares of every firm in the relevant market." *Heinz,* 246 F.3d at 716 n.9.[13] According to the 2010

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[13] For example, a market with four firms having market shares of 45%, 30%, 18% and 7% has an HHI of 3298 (45^2 + 30^2 + 18^2 + 7^2). If the firms with 18% and 7% market shares

Horizontal Merger Guidelines, a post-merger market is "highly concentrated" when the HHI is 2500 or greater. Guidelines § 5.3. Further, if the HHI increases by more than 200 points as the result of a merger, the merger is "presumed to be likely to enhance market power," Guidelines § 5.3, and is presumptively unlawful. *H & R Block*, 833 F. Supp. 2d at 71–72; *see also Heinz*, 246 F.3d at 716 ("Sufficiently large HHI figures establish the [plaintiffs'] prima facie case that a merger is anticompetitive.").

While economic measures play a role in antitrust analysis, plaintiffs "need not present market shares and HHI estimates with the precision of a NASA scientist. The "closest available approximation" often will do." *Sysco*, 113 F. Supp. 3d at 54, quoting *PPG Indus.*, 798 F.2d at 1505. This makes sense because as the President of Anthem Virginia cautioned, "[i]t's very difficult to track market share or to have an accurate market share estimate in health insurance, because it's difficult to know which market segment customers are in; and it's difficult to know what the entire population is, which you need for the denominator in order to calculate market share." King (Anthem) Tr. 3041.

1. Plaintiffs' expert's calculations

Dr. Dranove calculated the market shares and HHI for the national accounts market in the fourteen Anthem states based largely on the data gathered during the Antitrust Division's investigation. The Department of Justice issued twenty-eight Civil

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were to merge, the new HHI would be 3550 ($45^2 + 30^2 + 25^2$), so the HHI would increase by 252 points (3550 - 3298). *See Heinz*, 246 F.3d at 716 n.9.

Investigative Demands ("CIDs") to health insurance carriers and received twenty-six responses. *See* Dranove Tr. 1102–03. To determine market shares, Dr. Dranove used carrier enrollment numbers, which is how carriers determine their own market shares. *See* Dranove Tr. 1107–08; PX 36. Since some industry participants define national accounts purely based on number of enrollees and others include a geographic requirement, *see, e.g.*, PX 36; Abbott (WTW) Tr. 157–58, Dr. Dranove calculated market shares two ways: based on enrollment in plans sponsored by employers with more than 5000 employees ("NA5") and based on enrollment in plans sponsored by employers with more than 5000 employees and at least 5% of members residing outside of the state with the largest proportion of employees ("NA5G"). Dranove Tr. 876–78. Since both definitions are consistent with how the industry defines the term, Dr. Dranove ran the numbers both ways as "a robustness check" to ensure accuracy. Dranove Tr. 878.

The numerator in Dr. Dranove's individual market share fraction is each carrier's number of national account enrollees who reside within the geographic market. Dranove Tr. 884–88. In calculating Anthem's market share, he combined Anthem's enrollees in the fourteen states, Anthem's home lives, with the enrollees of other Blues carriers located in the fourteen states, Anthem's host lives.[14]

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[14] Dr. Dranove made an exception for Blue Shield of California, which competes against Anthem in California under a separate Blue Shield license, and is therefore treated as a distinct competitor from Anthem in calculating market shares. Dranove Tr. 883–84.

The denominator in Dr. Dranove's market share fraction is an estimate of the total number of national account enrollees who reside in the geographic market. Dranove Tr. 888. Dr. Dranove used two alternatives data sets to generate a denominator. The first set identified was potential enrollees based on publicly-available census data. Dranove Tr. 888. Dr. Dranove used this approach to capture small regional insurers that did not receive or respond to the CIDs and therefore did not appear in the data collected by the government. Dranove Tr. 889–90. Dr. Dranove called this the census approach. Dranove Tr. at 888 ("There's a lot of different data reported in a number of different censuses . . . that allows one to estimate the total number of enrollees in a given geographic area who work for large employers. And so, I took the combination of the data from these different censuses to estimate the total size of the national accounts market in the Anthem footprint . . . ."). The second approach was to generate a sum derived from the enrollment data produced to the United States by the twenty-six insurers that responded to the CIDs. Dranove Tr. 890–91. This group included the four national carriers, many of the other Blues, and several major regional carriers, including Humana, Kaiser, Harvard Pilgrim, and Health Net. *Id.* at 891; *see* DDX 2. Dr. Dranove called this the build-up approach. Dranove Tr. 890–92.

To include the largest possible number of market participants in his denominator, Dr. Dranove used the larger of the sums derived from the two approaches, which in five of the six calculations turned out to be the build-up method total. Dranove Tr. 891–92, 1115. He described this as a

"conservative approach" since a larger denominator would result in "smaller estimated market shares and smaller estimated measures of market concentration." Dranove Tr. 891–92.

Armed with these numbers, Dr. Dranove calculated market shares for the national accounts market in the fourteen Anthem states and concluded that the market shares that would result from the merger would be presumptively anticompetitive. Dranove Tr. 940. For the NA5 definition of national accounts with 5000 employees that does not include a geographic component, Anthem's share combined with the lives of other Blues carriers in the Anthem states is 41%, and Cigna's share is 6%, so their combined market share would be 47%. Dranove Tr. 899; PDX 5.

Looking at the NA5G definition of national accounts that includes the geographic element, Anthem's share is 40%, Cigna's share is 8%, and their combined share would be 48%. Dranove Tr. 899; PDX 5.

Dr. Dranove also calculated the merging companies' share of the national accounts market for ASO products alone – "[w]ithout speculating on whether ASO constitutes [a] well-defined market, because [he] did not do the SSNIP test specifically to ASO . . . ." Dranove Tr. 899. He found that the post-merger shares would be even higher than with ASO and fully-insured plans in combination: a post-merger combined share of 54% using the NA5 data, and 50% using the NA5G (geographic spread) data. Dranove Tr. 899–900; PDX 5.

Dr. Dranove used these market shares to calculate market concentration using the HHI, and

he concluded that the concentration resulting from the merger would be presumptively anticompetitive. *See* Dranove Tr. 940. According to the Merger Guidelines, market concentration in excess of HHI over 2500 is a highly concentrated market and is presumed to be anticompetitive, and an increase in market concentration of 200 or more will also trigger the presumption. Guidelines § 5.3.

For national accounts using the NA5 definition – based solely on the number of employees – the post-merger HHI will be 3000, and the increase in HHI is 537. Dranove Tr. 898–99, 941; PDX 5.

For the NA5G national accounts with 5000 employees, 5% of whom reside outside the state where the employees are most concentrated, the post-merger HHI will be 3124, with an increase in HHI of 641. Dranove Tr. 899, 941; PDX 5.

The post-merger HHIs for the market for the sale of ASO products alone were even larger than with ASO and fully-insured combined. Dranove Tr. 899–900, 941; PDX 5 (showing for NA5 a post-merger HHI of 3663 and an increase of 771 and for NA5G a post-merger HHI of 3675 and a change of 880).[15]

All of these numbers are well over the presumptive limits in the Merger Guidelines.

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[15] Dr. Dranove also calculated market shares and the HHI with looking at Anthem's share alone, without combining it with any host lives covered by the other Blues. He testified that "the merger would still put the market concentration above the presumptive threshold [and] . . . the [change in] HHI would also still be above the presumptive thresholds." Dranove Tr. 1169.

2. Defense experts' critiques

Anthem criticizes Dr. Dranove for doing a market share calculation in the first place, asserting that the Horizontal Merger Guidelines recommend using tools other than market share, such as econometrics, diversion ratios, and merger simulation models, to assess the competitive effect of a merger in an industry involving differentiated products. *See* Willig Tr. 2164–66. The Guidelines do recommend using those tools to look at competitive effects, Guidelines § 6.1, but at this stage of its analysis, the Court is not assessing the competitive effect of the merger. It is only assessing whether plaintiffs have made out a prima facie case.

The Merger Guidelines make clear that calculating market shares and applying them in the HHI is a predicate step to determining whether agencies need to investigate a potential merger further.

> [The HHI] thresholds . . . provide one way to identify some mergers unlikely to raise competitive concerns and some others for which it is particularly important to examine whether other competitive factors confirm, reinforce, or counteract the potentially harmful effects of increased concentration. The higher the post-merger HHI and the increase in the HHI, the greater are the Agencies' potential competitive concerns and the greater is the likelihood that the Agencies will request additional information to conduct their analysis.

Guidelines § 5.3. Further, controlling authority provides that "[s]ufficiently large HHI figures establish the [plaintiffs'] prima facie case that a

merger is anti-competitive." *Heinz*, 246 F.3d at 716. So it was entirely proper for Dr. Dranove to begin with market shares and an HHI analysis.

Anthem also raises a number of concerns about how plaintiffs' economist went about calculating the shares. Dr. Willig testified that combining the enrollment of Anthem and the other Blues improperly overstates the competition between Anthem and Cigna and inflates the share of the post-merger entity. Willig Tr. 2213–14. But as was the case with the objection to the use of the 5000 employee cut–off, or the consideration of both ASO and fully-insured plans in one market, the refutation of the defense expert's criticisms can be found in Anthem's own files.

First of all, Anthem counts these lives itself. Anthem covers the home lives within its territory and receives income from the other Blues for allowing their members – the host lives – to access the Anthem network, and when analyzing its national accounts enrollment, it takes both sets of lives into account. Kertesz (Anthem) Tr. 559; PX 63 (Anthem internal document tracking national account market shares for United, Cigna, Aetna, and "BCBS"); *see also* PX 494 (Anthem document reporting combined market share of "We the Blues"); Martie (Anthem) Dep. 190 (when an Anthem business record refers to the national accounts market as "Blue, UHC, Aetna, and Cigna," "Blue" means "Blue plans, wherever they competed").

Second, the Blue network is an integral part of Anthem's ability to win and woo national accounts and the source of Anthem's greatest competitive strength: its discounts. The evidence shows that

Anthem and the other Blues work together to win national business; as the company stated in litigation in another court: "[a]bsent cooperation, Blue Plans could not effectively service (and thus would not compete effectively) for national employers . . . ." *See* PX 216 (discussed at Swedish Tr. 233). It is the combination of Blue networks that enables Anthem's customers to obtain a single national network for their employees. *See* PX 216; Swedish Tr. 233 ("BlueCard also allows multi-state employers to gain access to multiple Plans' networks in a single transaction rather than cobble together the needed coverage."). And the discounts Anthem can offer, no matter where the customer's employees reside, factor prominently into any Anthem bid for a national account. *See* Abbott (WTW) Tr. 90, 107–08; PX 310, 494.

A key selling point, according to Anthem's Ken Goulet, is that Anthem is offering its own assets plus the Blues' networks. Goulet (Anthem) Dep. 117 (if Anthem decides it is competitively necessary to do so, "we will go out and just offer a zero trend guarantee. What customer wouldn't want to avoid future trends by switching to Anthem and Blue Cross Blue Shield networks and that's what we instituted in 2014"). Certainly industry participants view them in tandem, often lumping them together as "the Blues" or referring to the four national carriers as "BUCA" – Blues, United, Cigna, and Anthem. *See, e.g.*, Kilmartin (Mercer) Dep. 122–23 (if multistate employers want a single carrier, "[t]ypically it falls back to Cigna, United, Blue Cross and Aetna"). Given this evidence, the Court holds that it was appropriate for Dr. Dranove to combine the Blues when calculating market shares.

Dr. Willig testified that using the build-up method improperly excluded many competitors. Willig Tr. 2219–20 (stating "the 26 CIDs understates the market because it leaves out hundreds of market participants," including all TPAs). But while the Merger Guidelines consider "[a]ll firms that currently earn revenues in the relevant market" to be "market participants," Guidelines §5.1, they permit market concentration to be measured using the "significant competitors" in the market, particularly "when there is a gap in market share between significant competitors and smaller rivals . . . in the relevant market." Guidelines § 5.3.

There is no dispute that many healthcare insurance carriers and TPAs in the market did not receive CIDs from the government. But the evidence at trial showed conclusively that there are not hundreds of participants gaining any significant traction in the national accounts market, and that the Big Four carriers are by far the most significant competitors for national accounts. *See* PX 63 (internal Anthem document showing that the Big Four account for more than 80% of the market for commercial health plans sold to national accounts); *see* section I.A.1.c.2)b) above.

Anthem, Cigna, Aetna, and United were among the twenty-six companies that responded to CIDs, so they were included in Dr. Dranove's buildup method. Dranove Tr. 891; DDX 2. The CID data included the company generally viewed as number five on the national scene, or at least, a particularly strong regional company: Humana. The buildup method also included data from Kaiser and Harvard Pilgrim, the key carriers that came up most often in testimony as strong regional forces. According to Dr.

Dranove, adding the regional firms' membership to the denominators understated the national carriers' market shares across the Anthem territory since Kaiser and Harvard Pilgrim only compete for national accounts in their limited geographic areas. Dranove Tr. 891–92, 894. But they were included nonetheless. Since the buildup denominators account for the most significant carriers, as required by the Merger Guidelines, § 5.3, and they go even further to include an additional twenty-two carriers, the Court holds that Dr. Dranove's methodology appropriately measured market concentrations. Dr. Dranove tested his results against the census data, and that examination did not expose the presence of a major competitor that had not been accounted for. Use of the 26 CIDs was not only appropriate as a matter of practice, but it leads to a conclusion that is entirely consistent with the ordinary course evidence and testimony of market participants.[16] The build-up approach was conservative, if not outright generous, and if anything, it understated the power of the two merging parties.

Dr. Fowdur stated that the calculations fail to account for slicing, and therefore, Dr. Dranove overstated the merging parties' market share. Fowdur Tr. 1349–51. The economist added that her own analysis of 126 Anthem and Cigna national accounts revealed that 40% were sliced with Kaiser and about 15% are sliced with other carriers. Fowdur

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[16] While plenty of industry witnesses agreed that TPA's exist, none supplied evidence of anything other than anecdotal evidence of their connection to a handful of national accounts. Thus, they appeared to be "significant" competitors in this market only to defendants' economists.

Tr. 1349–51. But Kaiser was included in the CID data along with the other logical slice recipients. Dr. Dranove testified that his review of Anthem's internal data showed that when national accounts sliced, "they almost always sliced to the big four." Dranove Tr. 2254–56. This is borne out by a review of the company's Salesforce records depicting all of Anthem's national account slice business. DX 697.

The data available on this issue for the economists to analyze may have been imperfect with respect to the smallest participants in the market, but given that "scientific precision" is not required in calculating market shares, *Conn. Nat'l Bank*, 418 U.S. at 669, Dr. Dranove's market shares and market concentration figures include the significant competitors, and the expert analysis fairly reflects the actual business conditions, defendants' concerns do not undermine Dr. Dranove's conclusions.[17]

C. Evidence of price effects supports the prima facie case.

Dr. Dranove was asked to consider whether the merger would lead to "static harm," that is, effects on prices, as well as "dynamic" or long term effects, such as impacts on quality or innovation. As part of his economic analysis then, in addition to calculating market share and concentration, he conducted a merger simulation to analyze the merger's likely

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[17] Dr. Willig also testified that Dr. Dranove's census method is improper because the census number was lower than the buildup number in five out of six of Dr. Dranove's calculations, which suggests that census-based denominators understated the total market size. Willig Tr. 2219; *see also* Fowdur Tr. 1330–31. But if even both sets of data were imperfect, the fact that they mirrored each other is important.

effects on price in the relevant market. *See* Dranove Tr. 956–57; *Sysco*, 113 F. Supp. 3d at 67 (evidence of a merger's likely price effects through economist's merger simulation "strengthen[ed] the FTC's prima facie case"); *H & R Block,* 833 F. Supp. 2d at 88 (stating that merger simulations have "some probative value in predicting the likelihood of a potential price increase after the merger").

Based upon several different economic analyses, Dr. Dranove concluded that the merger will lead to static harm in the Anthem states in the form of higher health insurance premiums and ASO fees. Dranove Tr. 844–45. His merger simulation resulted in a calculation of $219.7 million of static harm in the fourteen Anthem states. Dranove Tr. 845, 959–60. Using an Upward Pricing Pressure (UPP) analysis, Dr. Dranove predicted static harm totaling $383.8 million. *Id.* And when he performed the UPP analysis again, this time incorporating the fact that win/loss data suggests that Anthem and Cigna are close competitors, the exercise led to a total of $930.3 million in static harm in the relevant market. *Id.*

Anthem's expert, Dr. Israel, criticized Dr. Dranove's merger simulation and UPP model because they focus on the fees to be charged by the newly formed carrier for claims administration services and do not account for any of the savings in medical costs that Anthem claims will flow to the customers from its greater network discounts. Israel Tr. 1867–69. He informed the Court that if just 33% of the medical cost savings he had calculated were factored into Dr. Dranove's model, the merger would turn out to be procompetitive. Israel Tr. 1867, 2012–13. Dr. Israel then described his own merger simulation. It was performed considering all large

group employers, not just the national account customers which the Court has found to comprise the relevant market, because the witness rejected the distinction. Israel Tr. 2017. He reported his conclusion that in the fourteen Anthem states, the merger would result in a net average cost of care savings of $4.50 per member per month ("PMPM"), or $1.5 billion in net consumer benefits. Israel Tr. 2017–19; DDX 15. He explained that the savings would apply to all 27 million ASO customers in the Anthem states, not only those that choose the new company, because his models "take into account that . . . a stronger Anthem or Cigna will put more competitive pressure on United and Aetna." Israel Tr. 2018. When he limited the analysis to the national account market, he found that the merger would remain procompetitive, and he predicted a total PMPM cost savings of $5.04. Israel Tr. 2025–26; DDX 15.

All of Dr. Israel's calculations assume that it is appropriate to factor in differences in provider rates obtained by Anthem and Cigna for members in their networks. So his entire critique of Dr. Dranove's conclusions rises and falls with Anthem's efficiencies defense, which the Court rejects for a number of factual and legal reasons in section IV below.

There were also more nuanced differences in the manner in which each expert structured his analysis, but regardless of the particular methodology employed, both economists found that the merger will result in some level of anticompetitive effects if one sets the medical cost savings aside. Dranove Tr. 2285–86, 2295 ("[B]oth approaches predict there will be price effects in the absence of substantial efficiencies."); *see also* Israel Tr. 2017–19 (medical

cost savings were balanced "against the loss of Anthem/Cigna competition"). Therefore, plaintiffs' evidence of price effects bolsters the presumption created by the market shares and market concentration evidence, and plaintiffs have established their prima face case.

II. Defendants have come forward with evidence to rebut the prima facie case.

Because plaintiffs have established the prima facie case, the Court must next determine whether defendants have presented evidence to rebut the presumption that the likely effects of the merger will be anticompetitive. The standard for the quantum of evidence defendants must produce to shift the burden back is relatively low. *Baker Hughes*, 908 F. 2d at 991, quoting *Phila. Nat'l Bank,* 374 U.S. at 363 (defendants are not required to "'clearly' disprove anticompetitive effect," but rather to make merely "a 'showing'").

Defendants may rebut the presumption either by "affirmatively showing why a given transaction is unlikely to substantially lessen competition, or by discrediting the data underlying the initial presumption in the government's favor." *Id.*; *see also Heinz*, 246 F.3d at 715; *Citizens & S. Nat'l Bank*, 422 U.S. at 120. They may rely on "[n]onstatistical evidence which casts doubt on the persuasive quality of the statistics to predict future anticompetitive consequences . . . ." *Heinz*, 246 F.3d at 715 n.7, quoting *Kaiser Aluminum*, 652 F.2d at 1341. To rebut the presumption established by the government's prima facie case, Anthem presented evidence on a number of relevant issues.

Competition between Anthem and Cigna: The defense presented evidence to show that United, not Cigna, is Anthem's closest competitor for national accounts and that Cigna competes more directly with Aetna. *See, e.g.*, Curran (Def. Counsel) Tr. 53, 2703–04; Kendrick (Anthem) Tr. 1198 (United is "clearly [Anthem's] most formidable competitor"); Schell (Anthem) Dep. 233 (Anthem's closest competitor for national accounts business is United); Goulet (Anthem) Dep. 97, 108–11 (United and Anthem have the best discounts and United is a "formidable competitor" for national accounts business, while Aetna and Cigna are "second tier" competitors); DX 35 (internal win/loss data); Manders (Cigna) Dep. 207 (Aetna's "value proposition historically has been more aligned to [Cigna's]" and thus Aetna has been one of the hardest competitors for Cigna because they are "more similar to [Cigna] than others").

Anthem also presented economic testimony to show that Cigna is not Anthem's closest competitor. Dr. Israel conducted a diversion analysis and testified that the level of direct competition between the merging parties for national accounts is smaller than their market shares would imply. Israel Tr. 1995–96; DDX 15.

Customer sophistication and bargaining power: The defense presented evidence that national accounts have the level of sophistication to thwart any effort by the merged company to raise prices. National accounts rely upon experienced and sophisticated consultants to advise them, and they are well-informed about industry trends, and pricing in the marketplace, and the array of competitive offerings, including non-carrier options. Abbott

(WTW) Tr. 64–66, 155; Kendrick (Anthem) Tr. 1212–13; Fowdur Tr. 1360; Thackeray (Cigna) Tr. 751.

New entrants and expansion: The defense presented evidence that new entrants in the market will also constrain the ability of the merged company to increase prices. It showed that some existing regional competitors compete for national accounts or slices of national account business, and that they are expanding or seeking to expand. *See* Fowdur Tr. 1319–20; Gray (Key Benefit Administrators) Dep. 43–44; Edwards (HealthSCOPE Benefits) Dep. 54. Witnesses also offered proof that TPAs, provider-sponsored plans, and other firms have recently entered the market or are expanding their existing share. *See* DX 2 (showing that twenty-five new PSPs entered in sixteen states between 2012 and 2014); Batniji (Collective Health) Dep. 85–86; DX 19 (identifying acquisitions by a TPA to facilitate its expansion beyond its existing geographic region). They also presented evidence that some of these entities have been successful in securing national accounts business: some TPAs have won some national accounts, Schumacher (United) Dep. 305; Kendrick (Anthem) Tr. 1197; providers, such as hospital systems, have teamed with health plans to offer their own provider networks to national accounts, Henderson (Innovation Health) Dep. 26–27; Spooner (Tufts Health Plan) Dep. 36, 155–56; and some very large national accounts have bypassed insurance carriers altogether by directly contracting for certain services. Bisping (Caterpillar) Dep. 12–13; McHugh (HTA) Dep. 13–1, 19–20, 40–42; *see also* Batniji (Collective Health) Dep. 58–61, 63–64; Hatch (AmeriBen) Dep. 21–22; Edwards (HealthSCOPE Benefits) Dep. 15, 87; Horvath (CoreSource) Dep. 63;

see also section III.D.4. Defendants also showed that other specialized entities, innovators, or "niche players" are competing for portions of the services that the major carriers offer to national accounts. *See* Thackeray (Cigna) Tr. 746–47, 760; *id.* at 748–49 (Quantum and Accolade are beginning to offer utilization management services); *see also* DX 2 (BCBS presentation on emerging competitors and market innovators). And, as discussed above, Dr. Fowdur testified that her critical loss calculation shows that the mere presence of the other national competitors, along with the additional regional and newly emerging competitors, will impose price discipline on the market since customers can slice, or even simply threaten to slice or move their business entirely. Fowdur Tr. 1319–20, 1324, 1330, 1361–63 (bluffing "imparts competitive discipline").

To demonstrate the ease of entry into the marketplace, the defense presented evidence about the legal and regulatory requirements for serving ASO customers. *See* Gray (Key Benefit Administrators) Dep. 43–44, Edwards (HealthSCOPE Benefits) Dep. 54; Major (UCHealth) Dep. 76–78. The defense presented testimony that fully-insured plans can receive state regulatory approval in less than a year, *see* Spooner (Tufts Health Plan) Dep. 79–80; Roberts (Harvard Pilgrim) Dep. 114, and that provider networks can be rented or created within a few months to a year. Fowdur Tr. 1336; Archer (HealthSmart Benefit Solutions) Dep. 140–41; Bierbower (Humana) Tr. 836.

Innovation: The defense presented evidence in an effort to show that the merger will enhance innovation. Beginning with Joe Swedish, the Anthem witnesses touted Anthem's leadership in innovation,

particularly in the fields of value-based and accountable care. Swedish Tr. 295–96; Drozdowski (Anthem) Tr. 1670; Kendrick (Anthem) Tr. 1200–01 (discussing Anthem's innovation laboratory in Atlanta); *see also* DX 106; DX 155. Anthem's economist testified that after the merger, the new company will have increased incentive to continue innovating. Israel Tr. 2032–33 (the merged company will be a stronger competitor with "more opportunity to recoup the investments in innovation . . . [because] their innovations become more profitable"). This would be consistent with the trend across the industry towards value-based care and provider collaborations, DX 362 (Kaiser document on growth of ACOs and provider-owned health plans); Austen (MVP Health Care) Dep. 31–33 (discussing plans to increase value-based reimbursements), and the need to respond to the new entrants offering innovative programs to national accounts. Fowdur Tr. 1353–54; Guptill (Kaiser) Dep. 103–04 (non-traditional players such as UberHealth, CVS Health, and Walmart are launching "consumer friendly tactics that have the potential to disrupt traditional care of delivery models"); *id.* at 117–18 (providers such as Inova, MedStar, Johns Hopkins, and Sentara, that have or are developing insurance products).

Anthem also presented evidence of efficiencies to be discussed in greater detail in section IV below. Applying the *Baker Hughes* burden-shifting rubric, the Court finds that the defense has rebutted the presumption that the merger will likely result in anticompetitive effects in the market, and the burden of persuasion shifts back to plaintiffs.

III. Plaintiffs have carried their burden to establish that the merger is likely to harm competition.

The Supreme Court has adopted a "totality-of-the-circumstances approach to the statutes, weighing a variety of factors to determine the effects of particular transactions on competition." *Baker Hughes*, 908 F.2d at 984. These factors may include: ease of entry in the marketplace, the significance of market shares and concentration; the likelihood of express collusion or tacit coordination; prevalent marketing and sales methods; the absence of a trend toward concentration; industry structure; any weakness of the data underlying the prima facie case; elasticity of industry demand, product differentiation; and the prospect of efficiencies from the merger. *Id.*

Courts examine two types of effects that may arise from mergers: coordinated effects and unilateral effects. Coordinated effects refer to markets with few competitors, in which firms may "coordinate their behavior, either by overt collusion or implicit understanding in order to restrict output and achieve profits above competitive levels." *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 568 (6th Cir. 2014), quoting *H & R Block*, 833 F. Supp. 2d at 77. An example of this would be parallel pricing by two gas stations located across the street from each other in a remote small town. *Id.* at 568–69. Unilateral effects refers to a merger's elimination of competition between the two merging companies, which "may alone constitute a substantial lessening of competition." *Id.*, quoting Guidelines § 6. "The most obvious example of this phenomenon is a 'merger to monopoly' – *e.g.*, where a market has only

two firms, which then merge into one – but unilateral effects 'are by no means limited to that case.'" *Id.*, quoting Guidelines § 6.

Relevant evidence of a merger's potential unilateral effects include the merging companies' ordinary course of business documents, testimony of industry participants, and the history of head-to-head competition between the two merging parties. *See, e.g., Staples II*, 190 F. Supp. 3d at 131–33; *H & R Block*, 833 F. Supp. 2d at 73–75, 81–82; *Heinz*, 246 F.3d at 717–18; *Swedish Match*, 131 F. Supp. 2d at 169–70.

The Court finds that the merger will have the anticompetitive effects of eliminating direct competition between the two firms, reducing the number of national carriers from four to three, and diminishing innovation, and that new entrants and other market conditions identified by the defense are not sufficient to forestall price increases and ameliorate these effects.

A. The merger will have the unilateral effect of eliminating the existing head-to-head competition between Anthem and Cigna.

The Horizontal Merger Guidelines advise that "[u]nilateral price effects are greater, the more the buyers of products sold by one merging firm consider products sold by the other merging firm to be their next choice." Guidelines § 6.1. But "mergers that eliminate head-to-head competition between close competitors often result in a lessening of competition." *Staples II*, 190 F. Supp. 3d at 131; *Staples I*, 970 F. Supp. at 1083 (holding that "the elimination of a particularly aggressive competitor in

a highly concentrated market [is] a factor which is certainly an important consideration when analyzing possible anti-competitive effects"). And this is true even where the merging parties are not the only two, or even the two largest, competitors in the market. *Aetna*,2017 WL 325189, at *29; *see also Sysco,* 113 F. Supp. 3d at 62; *Heinz,* 246 F.3d at 717–19; *H & R Block*, 833 F. Supp. 2d at 83–84.

Given this standard, Anthem's insistence that United, not Cigna, is its "closest" competitor, is beside the point. The acquired firm need not be the other's closest competitor to have an anticompetitive effect; the merging parties only need to be close competitors. *Staples II*, 190 F. Supp. 3d at 131; *see also* Guidelines § 6.1 ("The elimination of competition between two firms that results from their merger may alone constitute a substantial lessening of competition.").

The evidence in this case, including Anthem records and testimony from Anthem witnesses, firmly establishes that United, Cigna, Aetna, and the Blues compete against each other for national accounts, and that together, they dominate the market. *See* PX 63 (internal Anthem document reporting that BCBS, United, Cigna, and Aetna have 83% of the market share for commercial health plans sold to national accounts); PX 121 (Anthem affiliate WellPoint document describing market as "consolidated"); Abbott (WTW) Tr. 109–11; Martie Dep. 177–81, 186, 189–91, 193–200; PX 259; Guilmette (Cigna) Dep. 187–88; Mascolo (Wells Fargo) Dep. 156–57.

But insurance products are not sold off-the-shelf to every customer for a single price; health benefits

coverage sold to national accounts is a "differentiated product," and the carriers compete by submitting bids to individual customers. Therefore, both sides engaged in economic analyses to ascertain what the level of direct competition between Anthem and Cigna has been within the tightly packed national accounts environment. *See* Guidelines § 6.1 (in differentiated product industries, "the extent of direct competition between the products sold by the merging parties is central to the evaluation of unilateral price effects").

Dr. Dranove conducted a diversion analysis, which is used in markets with differentiated products, to examine the level of competition between merging companies. Dranove Tr. 2257–80. He explained that customers buying group health insurance are "trying to play the top bidders against each other," economists consider the procurement process for group health insurance to be what the Guidelines and economists refer to as an "auction," and this means that this merger will affect competition most significantly when Anthem and Cigna are both among the top bidders. Dranove Tr. 2280–84.

For that reason, Dr. Dranove analyzed the company's internal data to first isolate the occasions when the two companies had been the top two bidders for any national account's business and then determine how often each won or lost against the other in that situation. *See* Dranove Tr. 2280–81.[18]

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[18] Dr. Dranove testified that each company tracks when it wins or loses business and who the incumbent is when it bids for business, but they do not track when they were the top two bidders for an account. Dranove Tr. 2281–82, 2285.

He then compared the data to the market shares he had calculated for the prima facie case.

Dr. Dranove looked first at situations when the merging companies lost business to each other. He determined that the market shares for national accounts in the Anthem territories indicate that Anthem should win 44% of the contracts where Cigna is the incumbent and loses. Dranove Tr. 952–53; PDX 5. But Cigna's internal win/loss data showed that Anthem wins those contracts more than the market shares predicted: Anthem won 60% of those solicitations. Dranove Tr. 952–53 (using Cigna's SalesForce.com win/loss data from 2011 to 2017); PDX 5.

Similarly, the market shares indicated that Cigna should win "about 10 percent" of the contracts when Anthem is the incumbent and loses. Dranove Tr. 953–54; PDX 5. But Anthem's internal win/loss data showed that Cigna won "about 17 percent" of those sales. Dranove Tr. 953–54 (using Anthem's iAvenue win/loss data); PDX 5.

Looking at situations when the merging companies won business away from each other, Dr. Dranove testified that market shares predict that Cigna should have won business from Anthem 44% of the time. Dranove Tr. 954; PDX 5. But Cigna's

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To approximate that information, Dr. Dranove narrowed the competitive situations he analyzed to those situations where Anthem was the incumbent and a customer switched away to Cigna and vice versa. *Id.* at 2281–82. He reasoned that 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 and fifth" since ordinarily, "the incumbent doesn't lose because it's not well-liked" but "because somebody jumped over them." *Id.* at 2285.

data showed that when Cigna wins an account, it does so about 54% of the time from Anthem. Dranove Tr. 954–55 (using Cigna SalesForce.com win data from 2011 to 2017); PDX 5. And looking at Anthem's wins, its market share for national accounts would give rise to the prediction that 11% of the wins would be in situations where Cigna was the incumbent and lost. Dranove Tr. 954–55; PDX 5. But Anthem's data showed that when Anthem won a contract from an incumbent, Cigna was the incumbent almost 35% of the time. Dranove Tr. 954–55 (using Anthem's SalesForce data from 2015 to 2017); PDX 5. In sum, the data showed that Anthem and Cigna are winning business from and losing business to each other more than their market shares would predict.

Given these results, Dr. Dranove concluded that his HHI calculations – which are dramatic in and of themselves – actually understate the competitive significance of the merger, because the underlying market shares understate the closeness of competition between the merging firms. Dranove Tr. 953.

Not surprisingly, Anthem's expert conducted a diversion analysis that reached the opposite conclusion: the level of competition between the merging parties for national accounts is smaller their market shares imply. Israel Tr. 1995–96 (referencing DDX 15). To calculate his diversion ratios, Dr. Israel matched Anthem's and Cigna's bid information from 2015 and 2016 to identify instances in which both companies bid. *Id.* at 1995, 2004. Using each company's win/loss bid data and customer lists, he calculated how often Anthem and Cigna lost a solicitation that the other company won. *Id.* at 1995, 1997 (referencing DDX 15).

Dr. Israel testified that if Anthem and Cigna were particularly close competitors, then when they both bid for an account, Anthem would be expected to lose more frequently to Cigna than the rate implied by Cigna's overall market share and, similarly, Cigna should lose more frequently to Anthem than the rate implied by Anthem's overall market share. *See* Israel Tr. 1996. But his diversion ratio calculations found that they lost to each other less frequently than the market shares would suggest. *Id.* at 1996.

Dr. Israel's diversion analysis also examined each company's pricing patterns to discover whether one reacted to the presence of the other as a competitor by offering more competitive ASO bids. Israel Tr. 2006–07. He concluded that Anthem's presence or absence as a competitor on a given bid had no statistically detectable effect on Cigna's bids, and that the same was true for Anthem's bids with respect to Cigna's presence. *Id.* at 2007. So, he found that the loss of direct competition between the two would have little or no effect on the merged company's bids. *Id.* at 2007–08.

In addition, Dr. Israel searched Anthem's data to cull out the competitive situations in which Anthem must have viewed Cigna as a particularly weak competitor because Cigna's discounts were six to eight percentage points lower than Anthem's. Israel Tr. 2010–11. He explained that if Cigna were a close competitor, Anthem would be expected to raise its price when Cigna's discounts were not competitive to its own. Israel Tr. 2011. But he found that Cigna's competitiveness on the discount factor had no

statistically significant effect on Anthem's bid. Israel Tr. 2011.[19]

Each witness went to great lengths to discredit the other's economic evaluation of the intensity of the direct competition between the two companies. As noted above, Dr. Dranove compared the RFP bidding situation to the economic model of an auction, *see, e.g.*, Dranove Tr. 943 ("[I]t's the competition between the two top bidders that ultimately drives the price."), while Dr. Israel favored the model of a negotiation. Dr. Dranove maintained that Dr. Israel's negotiation model unrealistically assumed that customers would be armed with perfect knowledge about the carriers' actual costs and profit margins when responding to a bid, and that they would know "exactly how much the insurance company is willing to sell the product for." Dranove Tr. 2291–93.[20] According to Dr.

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[19] This analysis does not take into account the fact that even with its discount advantage, Anthem has been forced to fend off Cigna not by lowering its ASO fees, but by offering trend guarantees or making other concessions. *See, e.g.*, Kertesz (Anthem) Tr. 575–76.

[20] In the Court's view, neither economic model provides a perfect analogy. Dr. Dranove's criticism that customers would not have the level of information assumed in Dr. Israel's model has some force; notwithstanding the evidence that customers were aided by brokers who gather considerable intelligence concerning discounts and other factors, the notion that customers would be certain of a carrier's bottom line was not established by the evidence. But there was testimony from brokers in Phase II to support Dr. Israel's supposition that at least in some instances, the customer may initiate another round of negotiation after the final two bids have been submitted and ranked. *See, e.g.*, Hawthorne (Scott Insurance) Tr. 2992–93.

Dranove, incorporating this assumption into the merger simulation meant that Dr. Israel's calculation "dramatically reduce[d] the amount of harm resulting from the price increases." Dranove Tr. 2294. Dr. Dranove also criticized Dr. Israel for failing to factor in incumbency, and the role that would play in the outcome of any solicitation. Dranove Tr. 2281–82, 2284–85, 2415–16 ("There's a final two bidders in every single RFP . . . . What's relevant for the win-loss is finding out when they are one and two. As I've testified, we don't know who's two, so I conditioned on incumbency."). In response, Dr. Israel insisted that it was important to consider all instances where one of the carriers bid and lost instead of just those situations when an incumbent was unseated. He characterized Dr. Dranove's diversion analysis as a switching study that used too small a sample and inappropriately assumed that the incumbent was always the customer's second best option. Israel Tr. 2003–05. Meanwhile, Dr. Dranove observed that Dr. Israel's regression analysis, which was based on the ASO fees in Anthem bids, did not take into account occasions when Anthem may have made other concessions to improve its offer without reducing its fees. Dranove Tr. 2274, 2279.

Faced with these differences of opinion, the Court notes that these were both highly qualified and articulate economists. As Dr. Israel was wont to emphasize, he has been retained by the Department of Justice in other merger cases. *Sysco*, 113 F. Supp. 3d at 34. Putting aside the technical differences in the two approaches, one thing the diversion analyses had in common was that they were predicated on economic assumptions underlying the various

methodologies, and not on the internal communications that shaped and chronicled these events in real time. And, here again, Anthem's ordinary course documents tell a consistent story that contravenes the firm's litigation position.

The documentary record shows that Anthem unquestionably competes directly and aggressively against Cigna for national accounts. *See* PX 47; PX 59; PX 62; PX 63; PX 77. In 2011, Anthem found itself losing national accounts to Cigna. *See* PX 138; *see also* PX 59 (internal email stating that Anthem needed to be more aggressive; "Aetna and Cigna should not exist"). In 2012, Anthem specifically set out to win national accounts from Cigna and Aetna by offering zero percent trend guarantees to customers moving to Anthem from either company. Kertesz (Anthem) Tr. 575–76; Martie Dep. 235 (Anthem was offering trend guarantees against Cigna pre-merger even though it already beat Cigna on cost); PX 62 ("[W]e will guarantee a 0% trend whenever replacing Cigna or Aetna."). And in 2014, Anthem encouraged this direct competition by offering "strategic alignment bonuses" to national accounts team members who were able to fully replace Cigna, Aetna, or United business with Anthem. Kertesz (Anthem) Tr. 578–79; *see also* PX 77 (March 2015 sales meeting: "develop strategy to bury Cigna and Aetna in the national space"); Goulet (Anthem) Dep. 306 (Cigna was a competitor in provider collaborations and accountable care relationships). As late as February of 2016, Anthem's head of sales for national accounts proclaimed, "we are viewing Cigna as a competitor until we are not."

PX 348.[21] In light of this evidence, and the considerable volume of material presented at trial that exposed the ongoing, direct competition between Anthem and Cigna, the Court finds that Dr. Dranove's analysis is more persuasive, and the merger will in fact result in the loss of head-to-head competition between Cigna and Anthem for national accounts in the fourteen Anthem states.[22]

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[21] The Phase II evidence told similar story. The Vice President and General Manager of California large group business exhorted her sales team to go after Cigna ("Wanted – Dead or Alive!") at both the 2015 and 2016 Annual sales and management workshops, as Cigna was identified as a top competitor and Cigna's level funded plan posed a "new competitive threat." PX 548, PX 737; Rothermel (Anthem) Tr. 4123–28.

[22] Because the Court is enjoining the merger on the basis of the national accounts market in the fourteen Anthem states, it does not need to consider and its decision does not turn on a finding related to the national accounts market for the entire United States. The Court notes that while it does credit the testimony of Anthem representatives that they look forward to competing under the Cigna brand without needing to obtain a cede, *see* Kertesz (Anthem) Tr. 656 (it would be "exhilarating" to be an national plan that operates in fifty states); *see also* DeVeydt (Anthem) Tr. 1689, 1735–36; Mathai (Anthem) Tr. 1259, there is no question that merger will also eliminate some head-to-head competition in the thirty-six non-Anthem states as Anthem has historically sought cedes to sell to prospective customers headquartered there. Dranove Tr. 992–93; PX 136 (discussing a potential cede); PX 56 (showing Anthem sought permission of Blue licensee to bid on account in non-Anthem state); PX 135 (showing Anthem sought the permission of Blue licensee in non-Anthem states to compete against Cigna). It was also established that there are important aspects of Blue Cross Blue Shield Association membership – in particular, the mutuality and cooperation involved in the cedes, the potential for Blue Card revenue,

B. The merger will reduce the number of significant competitors in the market.

In light of the consolidation already present in the national accounts segment, the Court also finds that reducing the number of national carriers from four to three is significant. As the Merger Guidelines explain:

> [a] merger between two competing sellers prevents buyers from playing those sellers off against each other in negotiations. This alone can significantly enhance the ability and incentive of the merged entity to obtain a result more favorable to it, and less favorable to the buyer, than the merging firms would have offered separately absent the merger.

Guidelines § 6.2. The courts have echoed this assessment: "[i]f two competitors merge, buyers will be prevented from playing the sellers off one another in negotiations." *Sysco*, 113 F. Supp. 3d at 61–62.

Industry participants confirm that in this market in particular, the combination of Anthem and Cigna will affect the solicitation of proposals and reduce the avenues for negotiation with the bidder for national accounts. Robert Burnell of Buck Consulting explained during his deposition that once responses to proposals are received, the potential candidates are not immediately reduced to the two lowest bidders; often, the bidders are first informed of how they are positioned compared to all of the

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and the best efforts rules – that redound to the benefit of the Association as a whole, and that these give rise to an inherent conflict of interest that could affect Cigna's competitive conduct in the 36 states.

others, and they are encouraged to revise their proposals. Burnell (Buck Consultants) Dep. 144–46. If one of the four major carriers exited the market, and another chose not to bid for any reason, customers would lose "that interim step of where we tell them where they're ranked and then try to push them down." *Id.*; *see also id.* at 57–58 (stating "[t]he more vendors we have, the more competitive . . . the responses are going to be"); Sharp (Aon Hewitt) Dep. 92–95 (discussing the importance of more competition at the RFP stage).

Reducing the number of national carriers from four to three also shrinks the number of options available to be packaged and sold via the private exchanges, spreads the rent paid by TPA's to gain access to networks over a smaller group, and decreases the number of potential joint partners for the innovative "new entrants" in the industry, all of which serve to concentrate the market even further.

C. National account customer sophistication and bargaining power are not sufficient to ameliorate the anticompetitive effects.

In some cases, customer sophistication may avert the effects of a merger on competition in the relevant market. *Baker Hughes*, 908 F. 2d at 986 (stating highly sophisticated customers can "promote competition even in a highly concentrated market"); Guidelines § 8 ("The Agencies consider the possibility that powerful buyers may constrain the ability of the merging parties to raise prices."). However, "the presence of powerful buyers alone" is not presumed to prevent adverse competitive consequences from

the merger. Guidelines § 8. "Normally, a merger that eliminates a supplier whose presence contributed significantly to a buyer's negotiating leverage will harm that buyer." *Id.*

As set forth above, the evidence established that national account customers are typically sophisticated companies with substantial resources, and that they benefit from the assistance and advice of brokers and consultants. *See generally* Abbott (WTW) Tr. 63–66; 155, and section III.A above. Plaintiffs do not appear to contest this proposition. But as noted above, the evidence also shows that loss of one competitor from the four major carriers alters the RFP and negotiating dynamic, even with strong advocates on the other side. This loss of leverage undermines the defense contention that customers will be able to wield their seasoned human resource managers and consultants to counteract the anticompetitive effects of the merger.

D. New entrants and expansion will not be a constraint on the new firm.

As part of the effort to predict the likely future effects of a merger, courts also consider the existence and significance of barriers to entry or expansion into the relevant market by new competitors: "In the absence of significant barriers, a company probably cannot maintain supracompetitive pricing for any length of time." *Baker Hughes*, 908 F. 2d at 987. If barriers to entry are low, even "the *threat* of entry can stimulate competition in a concentrated market, regardless of whether entry ever occurs." *Id.* at 988.

Entry or expansion into a relevant market must be "timely, likely, and sufficient in its magnitude, character, and scope" to counteract a merger's

anticompetitive effects. *H & R Block*, 833 F. Supp. 2d at 73 (quoting Guidelines § 9). Determining ease of entry requires "an analysis of barriers to new firms entering the market or existing firms expanding into new regions of the market." *CCC Holdings*, 605 F. Supp. 2d. at 47 (quoting *Cardinal Health*, 12 F. Supp. 2d at 55). Defendants bear the burden of demonstrating ease of entry into the relevant market. *See Swedish Match*, 131 F. Supp. 2d at 170–71.

To be timely, "entry must be rapid enough to make unprofitable overall the actions causing those effects and thus leading to entry, even though those actions would be profitable until entry takes effect" and "rapid enough that customers are not significantly harmed by the merger, despite any anticompetitive harm that occurs prior to the entry." Guidelines § 9.1.

To be likely, entry must be "profitable, accounting for the assets, capabilities, and capital needed and the risks involved, including the need for the entrant to incur costs that would not be recovered if the entrant later exits." *Id.* § 9.2. "The history of entry into the relevant market is a central factor in assessing the likelihood of entry in the future." *Cardinal Health*, 12 F. Supp. 2d at 56; *see also CCC Holdings*, 605 F. Supp. 2d at 47–49 (finding past entrants unpersuasive because they either were unsuccessful or gained only a small market share relative to defendants, among other reasons). Also, "[r]eputation can be a considerable barrier to entry where customers and suppliers emphasize the importance of reputation and expertise," *CCC Holdings*, 605 F. Supp. 2d at 54–55, as can the expense of entry into a market that

requires significant upfront investment. *See Sysco*, 113 F. Supp. 3d at 80.

Finally, to have the magnitude, character, and scope to counteract a merger's anticompetitive effects, the entry must "fill the competitive void that will result" if the merger proceeds. *Id.* Entrants must be significant enough to "compete effectively, *i.e.*, affect pricing," *CCC Holdings*, 605 F. Supp. 2d at 59, and be "of a sufficient scale to compete on the same playing field" as the merged firm. *Chi. Bridge & Iron Co. v. FTC*, 534 F.3d 410, 430 (5th Cir. 2008).

The defense's evidence of entry does not outweigh the evidence of the merger's likely anticompetitive effects, and it particularly fell short in connection with the third factor. The defense did not produce persuasive statistical evidence of the significance of potential entry or expansion. Much of the information it presented was anecdotal, and not necessarily tied to the relevant geography. And what was presented established the mere existence, and not the growing market significance, of any of the alternatives to the major carriers. Plaintiffs, on the other hand, presented significant evidence, including from defendants' ordinary course documents, showing that at best, potential entrants nip at the heels of the Big Four in competing for national accounts, and that in many instances, these "entrants" *are* the Big Four, merely repackaged and selling their services through alternative channels.

1. There are significant barriers to entry and history shows a lack of success by new entrants.

A would-be insurance carrier cannot simply hang out a shingle. First and foremost, to sell health

benefits coverage to national accounts, a firm must offer a provider network with a geographic footprint large enough to cover employees and their dependents spread across the country. *See, e.g.*, Kertesz (Anthem) Tr. 538 (these customers want providers where their employees live and work). And, once it has associated with those providers, it must be able to offer competitive provider discounts. *See, e.g.*, Bierbower (Humana) Tr. 796–97, 799–800 ("[I]f 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."). In addition, the new firm must be able meet the complex administrative, analytical, and technological demands of today's national accounts at a competitive fee, while protecting the privacy of the members' data. *See* Bierbower (Humana) Tr. 803; Guilmette (Cigna) Dep. 269–75; PX 251. To sell to national accounts, the insurer must develop a strong enough reputation to be recommended by the consultants guiding the employers through the contracting process, *see* Abbott (WTW) Tr. 67, and be backed by a brand recognized by their workers. *See, e.g.*, Edwards (HealthSCOPE Benefits) Dep. 113–14 ("Members like having a name they recognize on their ID card . . . .").

It is clear that building this capability from scratch takes time and resources. Developing a provider network alone can take months, if not years, and that is not all there is to the process. Bierbower (Humana) Tr. 793, 797 (it takes a large and experienced regional carrier nine to twelve months on average to establish a network); Roberts (Harvard Pilgrim) Dep. 184 (it took "multiple years" to establish a complete network in New Hampshire);

Spooner (Tufts Health Plan) Dep. 57–58, 151, 155, 157, 177–78, 186 (it took two years to enter New Hampshire even with existing provider contracts and membership).

And developing a network with attractive discounts takes more than time – it also takes membership. Bierbower (Humana) Tr. 801 (negotiating competitive provider discounts requires membership volume); PX 378 ("[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."). In a metaphor that may have been repeated a bit too often during the trial, Dr. Dranove called this "the chicken-and-the-egg" problem. *See, e.g.*, Dranove Tr. 1004. All of this is contrary to Dr. Willig's breezy assurances that "[i]t's really not all that difficult to assemble a network . . . it's not a big barrier to entry or expansion, it seems to me." Willig Tr. 4566.

The history of entry in the national accounts market, as presented by the defendants' expert, also demonstrates that entry is not particularly easy. Dr. Willig created a chart that was meant to show that there has been plenty of "meaningful" entry into the large group customer market, which includes not only national accounts, but also companies with as few as 50 or 100 employees.[23] Willig Tr. 4566–70;

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[23] This chart was presented during Phase 2 of the trial, which addressed competition in the market for the sale of health insurance to large groups. A large group customer was defined based on the applicable state regulation for large group insurance: employers with 50 or more employees or 100 or more employees *including* those with 5000 or more employees. *See* Dranove Tr. 4689–90. Accordingly, while Dr.

DDX 497. Companies were considered "entrants" when they achieved 1% of the market share, and the chart listed thirty-two companies that had entered in twenty-three states between January 2012 and January 2016. *See* DDX 497. Notably, seven of the names on the list were all the same company, which had entered seven different states at once. *See* DDX 497. Four "new entrants" actually represented acquisitions of existing plans, and one was a provider-sponsored plan whose executive testified at trial that its own employees made up 80% of its membership. *See id.*; Berfiend (IU Health) 2860.

Of the thirty-two entrants listed, only one had grown during that time period to attain a double digit market share, and the company with the second highest share stood at 6%. *See* DDX 497. The other thirty all still had less than 3% of the market share in their states – and several of them had lost market share over the five-year period and were hanging on with less than 1%. *See id.* Dr. Willig also conceded on cross examination that one of the firms does not sell large group insurance at all, and one that had entered in 2015 is going out of business completely. Willig Tr. 4643–47.

Dr. Willig sought to downplay the implications of this trend, emphasizing that the *number* of entrants – both coming and going – showed "dynamism" in the market. Willig Tr. 4569. But mere movement in the market – and especially movement down or out – cannot be equated with the achievement of "character" or "magnitude." And the inability of new firms to gain traction within the entire large group

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Willig's chart concerns entry into a broader market, that market includes national accounts.

segment, which includes customers that are much smaller and more localized than national accounts, does not bode well for their prospects on the big stage. Thus, the data supplied by the defense reinforces the testimony describing how difficult it is for new entrants to "compete on the same playing field" as the merged firm in this market. *Chi. Bridge & Iron Co.*, 534 F.3d at 430.

2. Large regional carriers are not an option.

Even large, established regional carriers have not succeeded in taking significant national accounts business from the Big Four. *See* Martie (Anthem) Dep. 198–200 (estimating that from 2011 to 2015, Anthem lost ten or fewer national accounts to Kaiser and fewer than five to Humana);[24] Guilmette (Cigna) Dep. 113–14 (Cigna does not lose entire national accounts to Kaiser because Kaiser cannot offer health plans everywhere that national accounts have employees); Hayes (Aetna) Dep. 211–12, 283–84 (was unfamiliar with Harvard Pilgrim and could not recall any instance in which it competed with Aetna for a national account); Manders Dep. 203–04 (Cigna does not "really run into Humana" except in the individual and small group markets); [TEXT REDACTED BY THE COURT] Dep. 283 ("I didn't know [Humana] competed in the national account space."); Burnell (Buck Consultants) Dep. 90–91 (no employer in his experience has switched to Kaiser from a national carrier on a full replacement basis). Smaller regional players also do not contend for

[24] Anthem has approximately 550 national accounts. Mathai (Anthem) Tr. 1257.

national accounts business. *See* Martie (Anthem) Dep. 196–97; Hayes (Aetna) Dep. 284.

The executives from two of the most prominent regional carriers confirmed that they are not positioned to enter the national accounts market on a full replacement basis. [TEXT REDACTED BY THE COURT] of [TEXT REDACTED BY THE COURT] testified that [TEXT REDACTED BY THE COURT] is a regional player that cannot expand [TEXT REDACTED BY THE COURT] nationally, and she explained that the company's preferred provider organization and point of service products do not cover employees that live outside of its geographic territory. [TEXT REDACTED BY THE COURT] Dep. 53, 151–53. Beth-Ann Roberts of the New England carrier, Harvard Pilgrim, agreed that Harvard Pilgrim is not "a viable option for employers who need a national network." Roberts (Harvard Pilgrim) Dep. 79, 178–79. At most, these carriers can bid for a portion of a national account's business, if it falls within their geographic area. *See* Abbott (WTW) Tr. 84 ("[B]ecause [Kaiser], generally, ha[s] a limited footprint, they would be bidding on a portion."); DX 724; DX 591. Indeed, another large regional carrier, Humana, has stopped competing for new national accounts all together. Bierbower (Humana) Tr. 794; *see also* Abbott (WTW) Tr. 109–10 (Humana is "not a national player with a network breadth and depth to fall in the national category").

3. Slicing is not a practical solution.

The defense asserts that national accounts can easily satisfy their needs by creating a patchwork of coverage across the country supplied by regional and local players. But only the economists seemed to

believe this was actually going to happen. As discussed in section I.A.2. above, the evidence established that on the whole, national accounts prefer to use fewer carriers, not more. Abbott (WTW) Tr. 78–79 ("Larger employers, typically, like to consolidate their plans. They like to have one service provider, for all of the reasons I mentioned, contracting, data security, data reporting and the like. That's a general statement, but that's, certainly, been the preference in the last several decades."); *id.* at 86 ("[T]here's been a strong preference, again, to one national provider and a preference not to do slicing . . . ."); *see also* Bierbower (Humana) Tr. 807; PX 63 (internal Anthem document stating that "National accounts are consolidating their carrier relationships"); Guptill (Kaiser) Dep. 181 (in the last "five to seven years, the trend has been to eliminate as many carriers as possible").

This is because slicing is more expensive and cumbersome for employers. National carriers offer better rates to customers that can deliver more members to them and charge higher fees to customers that do not. As Jerry Kertesz of Anthem testified, 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." Kertesz (Anthem) Tr. 546. Cigna [TEXT REDACTED BY THE COURT] do the same. *See* Thackeray (Cigna) Tr. 726–27; [TEXT REDACTED BY THE COURT]. Utilizing multiple carriers also multiplies the employers' internal administrative costs and burdens. Abbott (WTW) Tr. 71, 111–12 (having multiple carriers requires managing additional data interfaces, communication

materials, ERISA filings, contract negotiations, technology interfaces, and data security protections).

The evidence shows that when national accounts slice, they do so to offer their employees unique plan options, such as an HMO, or to access a highly regarded network or superior discounts in a particular area, not to lower their premiums or ASO fees. Bierbower (Humana) Tr. 837; Guilmette (Cigna) Dep. 133–34. And as detailed above, customers generally usually slice only among the four national carriers, or possibly with a strong regional firm like Kaiser. Abbott (WTW) Tr. 85–86.

This phenomenon suggests that defendants have vastly overstated the likelihood that slicing will operate as a competitive force dampening the effects of the merger. And while the fracturing of a national account relationship may mean that a carrier will end up with less than the 100% of the membership it had before, it also presents a carrier with the opportunity to harvest a share of new members from a customer it had previously failed to penetrate at all. [TEXT REDACTED BY THE COURT] Cain Hayes, the President of National Accounts at Aetna, confirmed that Aetna benefits from slicing. Hayes (Aetna) Dep. 248. And as for Anthem, Swati Mathai summarized the slicing state of affairs in the national accounts profit and loss center as "net/net we are slightly positive." Mathai (Anthem) Tr. 1263. So while slicing can have an impact on an incumbent's share of any particular customer's membership, overall it is not likely to alter the market share picture dramatically, and it presents just one more example of how reducing the number of national carriers from four to three limits the options available to employers.

4. Other options do not serve national accounts' needs and are often alternative distribution channels for the Big Four.

The defense points to TPAs, private exchanges, and other vehicles for the delivery of health coverage as potential competitive forces that will expand in the market and impose price discipline on the merged company. But the weight of the evidence shows that these "disintermediators" inserting themselves between traditional health insurers and their customers, *see* Abbott (WTW) Tr. 209, are not market participants of the "magnitude, character, and scope" sufficient to fill the void that Cigna's acquisition will create. *See H & R Block* at 73, quoting Guidelines § 9. And the coverage they deliver is often obtained from the Big Four in any event.

TPAs: National accounts generally do not use TPAs. Burnell (Buck Consultants) Dep. 115–16 (he is not aware of national accounts that use TPAs); Sharp (Aon Hewitt) Dep. 91 ("[l]ess than 1 percent" of its 1100 clients use TPAs); Abbott (WTW) Tr. 116 ("For our large employer segment, TPAs are not commonly used."); Kilmartin (Mercer) Dep. 167 (only a "minority" of his clients use TPAs); Monti (Kroger) Dep. 96–97; Record (Steel Dynamics) Dep. 28–29; Martie (Anthem) Dep. 197–98 (in five years Anthem has lost fewer than five national accounts to TPAs on a full replacement basis).

Why would national accounts steer clear of TPAs? They tend to be more expensive than the national insurers because they typically have to rent provider networks from other insurers. [TEXT REDACTED BY THE COURT] explained, "when you

rent a network, the economics are not as competitive as when you have your own proprietary network," and it is difficult for a TPA to be "competitive on a unit cost basis" if it must rely upon a rental network. [TEXT REDACTED BY THE COURT] Dep. 197–99; *see also* Kertesz (Anthem) Tr. 583–84; Kilmartin (Mercer) Dep. 167 ("[T]he provider networks that the TPAs have access to don't have the depth of discounts that a carrier provider network might. So the discounts aren't as deep, which could results in claim costs that are more costly from the employer's perspective."); [TEXT REDACTED BY THE COURT] (internal email from a national carrier stating it is "hard to believe" a TPA renting a network would offer a "positive position from a unit cost perspective"); Archer (HealthSmart Benefit Solutions) Dep. 106–07, 115 (the Cigna and Aetna networks offer larger provider discounts than the HealthSmart TPA); Record (Steel Dynamics) Dep. 28–29 (a national provider can offer "a deeper discount and better claims processing" than a TPA). Also, TPAs generally do not offer the full suite of medical benefit and administrative services that national accounts demand. *See, e.g.*, Hayes (Aetna) Dep. 272, 285–88 (TPAs do not provide care management services); Austen (MVP Health Care) Dep. 105 (unlike the "standard" competitors "that offer[ ] a full array of products[,]" TPAs are "folks that just do third-party services").

Accordingly, most TPAs do not target national accounts, and national brokers and consultants do not seek them out for that purpose. *See* Major (UCHealth) Dep. 12–15; Archer (HealthSmart Benefit Solutions) Dep. 32–33, 56–57, 74 (HealthSmart serves primarily employers with 150

to 1500 employees); Edwards (HealthSCOPE Benefits) Dep. 104–105 (HealthSCOPE's average client has between 500 and 1000 members).

Private exchanges: While private exchanges were initially thought to be the wave of the future, national accounts have not migrated to them as expected. Pam Kehaly of Anthem testified that in early 2014, "everybody was rushing" to explore private exchanges, but "customers just never really flocked to it like people were thinking they would." Kehaly (Anthem) Dep. 105–107, 109–10; *see also* Hayes (Aetna) Dep. 152–53 (he has no reason to believe that the adoption by national account customers of private exchanges has grown past 4%);[25] Hayes (Aetna) Dep. 235–36 ("I haven't seen anything to indicate that there's been significant uptake in private exchanges."); [TEXT REDACTED BY THE COURT] Dep. 182, 317 (private exchange projections were written by the consultants who were creating them but their membership has not expanded at the estimated pace); PX 125 (internal Anthem document stating that "adoption levels" of private exchanges by employers "have been lower than analyst predictions"); Kertesz (Anthem) Tr. 596; Guptill (Kaiser) Dep. 167; Mascolo (Wells Fargo) Dep. 148. One explanation for this is that with a private exchange, the customer loses the ability to select the carriers to choose from, control of its benefit plan design, and negotiating leverage with the carrier. *See* Kidd (Sodexo) Dep. 145–46, 160.

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[25] Aetna defines national accounts to mean 3000 employees or more, Hayes (Aetna) Dep. 221–22, so this estimate would be even smaller using a definition of 5000 employees or more.

Further, the testimony shows that to date, neither private exchanges nor the threats to move to an exchange that Dr. Fowdur considered to be so important have imposed price discipline on the market. The Vice President and Head of New Sales for Anthem's National Accounts division stated: "[H]owever 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." Kertesz (Anthem) Tr. 598. David Guilmette, who has served as both President of National Accounts and President Global Employer and Private Exchanges at Cigna was similarly definitive that Cigna does not change pricing strategy or set ASO fees based on whether a customer is considering moving to a private exchange. Guilmette (Cigna) Dep. 178–79; *see also* Martie (Anthem) Dep. 277–78 (customer's interest or lack thereof in a private exchange is "irrelevant" to Anthem's ASO pricing). And any cost savings an employer may realize from moving to a private exchange is not a result of additional competition in the market, but rather, benefit "buy down," as employees will receive fewer benefits from the pre-packaged, more limited plan offerings available on the exchange than they could before. Kertesz (Anthem) Tr. 676–77; DX 100.

PSPs: Provider-sponsored plans also do not serve the market in a meaningful way, and the evidence does not show them poised to compete with the merged company. *See* Abbott (WTW) Tr. 120–21 (he does not offer PSPs as an option to national accounts independent from a national health plan); Mascolo (Wells Fargo) Dep. 80 (there is a trend of provider-sponsored competitors entering the market

but "acceptance has been slow" and advisers are cautioning clients "to go slow"); *see also* Berfiend Tr. 2860 (approximately 80% of Indiana University Health's commercial membership is made up of its own employees).

Direct Contracting: A handful of very large national accounts do contract directly with certain providers, but they do so under limited circumstances: an employer must have a very large concentration of employees in one geographic area to contract directly with providers effectively. Abbott (WTW) Tr. 121–22. And even those companies that are positioned to contract themselves may still offer their employees a national plan; they do not necessarily use direct contracting as a complete substitute for a national health insurer. *See* Bisping (Caterpillar) Dep. 10, 12–15; Kilmartin (Mercer) Dep. 187–88 (health insurers drive better provider discounts "than any individual employer could obtain on [its] own"); Torcom (Sentara Healthcare) Dep. 43–44. Thus, while defense witnesses could point to isolated success stories, notably Boeing, Mathai (Anthem) Tr. 1268, consultants are not presenting direct contracting as a practical option to their clients. *See* Abbott (WTW) Tr. 122–24 (he has recommended direct contracting to his clients "very rarely;" direct contracting for specified medical procedures is much more common than contracting directly as a complete substitute for a national insurer); Burnell (Buck Consultants) Dep. 142–43 (Buck does "not consider direct contracting to be a viable complete solution," but only a supplement or slice to existing coverage).

Even if some of these alternatives to traditional insurance coverage eventually do catch on in the

national accounts market, they will not put the membership in the hands of anyone new. The evidence revealed that often, these types of new "entrants" in the market are not really entrants at all, but just the same four national carriers selling their plans through different "storefronts" or "distribution channels."

The Big Four carriers own TPAs, including the two largest: UMR, which is owned by United, and Meritain, which is owned by Aetna. Schumacher (United) Dep. 128, 134–35; Hayes (Aetna) Dep. 271. Further, three of the Big Four rent their networks to TPAs, including Cigna and Anthem, which sells access to the entire Blues network. Benedict (Cigna) Dep. 30–31; Kertesz (Anthem) Tr. 584; Hayes (Aetna) Dep. 271.[26] And these rental agreements contain contractual provisions that specifically prohibit TPAs involved from competing against the carriers for national accounts. Kertesz (Anthem) Tr. 584; Novack (Cigna) Dep. 78 ("[T]he rules of engagement are that a TPA will not compete with us when . . . it's an existing piece of business."); Espinoza (CNIC Health Solutions) Dep. 90 (TPAs cannot bid for an account where Aetna or another TPA administering the Aetna network is the incumbent).

The same names appear again in connection with private exchanges. Both Anthem and Cigna offer health plans on the major private exchanges. *See* Fontneau (Cigna) Dep. 33–34; PX 125; Burnell (Buck Consultants) Dep. 109–10 (estimating that on the Buck private exchange, half of the customers use

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[26] United does not rent its network to TPAs. Schumacher (United) Dep. 164, 265.

Anthem, 20% use Cigna, and 25% use Aetna); PX 109 (Cigna document showing that national carriers had practically all the share of the WTW private exchange in September 2015); *see also* PX 287; DX 207. Anthem executives are well aware that while consultants created private exchanges to get their own piece of the healthcare dollar, "ultimately they're our distribution channel for our products." Kertesz (Anthem) Tr. 636; *see also* Mathai (Anthem) Tr. 1287–88; Dranove Tr. 1006–07; Abbott (WTW) Tr. 114–15; Guilmette (Cigna) Dep. 179–80; Martie (Anthem) Dep. 115–16; Fontneau (Anthem) Dep. 121–22.

Not only do the four national carriers sell plans on the national consultants' private exchanges, but United and Aetna responded to the consultants' assault on their territory by creating their own private exchanges. Schumacher (United) Dep. 114; Hayes (Aetna) Dep. 238. Aetna has found its private exchange to be an "opportunity for growth," Hayes (Aetna) Dep. 239–40,[27] and Anthem has a strategy to develop or acquire its own private exchange for the same reason. Martie (Anthem) Dep. 113; PX 125 (Anthem sees the private exchanges as a growth opportunity); *see also* Kidd (Sodexo) Dep. 107–09 (carriers are forming their own exchanges to retain clients).

Provider-sponsored plans and direct contracting can also be connected to the national carriers. Provider-sponsored plans often team with a big national carrier to obtain administrative services or

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[27] So while the defendants emphasized the fact that Starbucks went onto an exchange, Kertesz (Anthem) Tr. 634, it turned out to be Aenta's exchange. Hayes (Aetna) Dep. 238.

a broader network. *See* Abbott (WTW) Tr. 120–21 (national customers may access PSPs "through the major health plans" because "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"). So rather than competing with national carriers, they may become part of the national carriers' networks.

And the record shows that national carriers will not be entirely displaced when employers seek to engage in direct contracting with providers. Anthem's current President of National Accounts, Charles Kendrick, explained that the role of the carrier would be to carve a local network out of the carrier's broad national network exclusively for the employer. It would receive, at the very least, fees for administering the network, and the carrier might also handle claims administration, dispute resolution, and other customer service and clinical management functions such as managing the web portal for the employees. Kendrick (Anthem) Tr. 1190–92. He added that Anthem has been "in discussion with existing business and prospective employers on direct contracting on their behalf." Kendrick (Anthem) Tr. 1992.

So while the Court recognizes that new participants have indeed entered the commercial health insurance market to some extent, and that they are disrupting the relationship between the carriers and some customers, they do not possess the capacity to take on the larger, more geographically dispersed employers, and they do not offer a viable, complete solution to customers seeking a unified plan. These alternative arrangements do

not replace national carriers; at most, they have shown themselves to be able to garner a small slice of a national account's business. And national carriers have been nimble in finding ways to reinsert themselves back into the relationship. Thus, the Court finds that the new and existing entities that the defense predicts will enter or expand into the national accounts market and impose price discipline are simply not "of a sufficient scale to compete on the same playing field" as the merged firm. *Chi. Bridge & Iron Co.*, 534 F.3d at 430.

E. The merger will reduce innovation in the market.

A merger can substantially lessen competition by diminishing innovation if it would "encourag[e] the merged firm to curtail its innovative efforts below the level that would prevail in the absence of the merger." Guidelines §§ 1, 6.4; *H & R Block*, 833 F. Supp. 2d at 79 (finding that the relevant market would lose an "aggressive competitor" with an "impressive history of innovation" and its "history of expanding the scope of its high-quality, free product offerings has pushed the industry toward lower pricing"), quoting *Staples I*, 970 F. Supp. at 1083.

Witnesses from both of the merging parties, and executives from the other major carriers who were deposed, incorporated a fair amount of public relations into their testimony, trumpeting their firms' leadership in bringing new approaches and value to the commercial health insurance industry. Fortunately, the Court does not need to decide who was first to move in a particular direction or which company innovates more. The question to be decided is whether the transaction would reduce the new

firm's incentive to innovate in the relevant market, and in connection with that issue, it is important to note that national accounts in particular are considered to be the "innovation incubators" for the entire industry. Kendrick (Anthem) Tr. 1180. They push carriers to enhance plan design, customer service, technology, and data security, and the innovations they spur are often deployed to other customers and segments. *See, e.g.*, PX 94; Cordani (Cigna) Tr. 403–04 (national accounts demand innovation and are early adopters of value-based programs such as health engagement incentive programs, biometric screenings, and other innovative, cost-saving programs).

Because innovation is important to national accounts customers, Anthem emphasizes its leadership and creativity in its efforts to win their business. PX 174 (presentation to large national account stating "[w]e are changing how we reimburse providers to drive better quality while increasing access" and highlighting "[o]nline & mobile resources," "transparency tools," and an innovation credit "[u]seable for projects, pilots, communications, etc."); Kendrick (Anthem) Tr. 1199–1201 (describing Anthem's focus on innovation within national accounts). Cigna markets itself this way too, highlighting its value based reimbursements and customer engagement. Guilmette (Cigna) Dep. 48–50; Phillips (Cigna) Dep. 174–75; Cordani (Cigna) Tr. 401–02, 407.

Indeed, because its provider discounts were not as strong as other carriers' discounts, particularly those offered by Anthem and the Blues, Cigna has relied upon innovation to compete, directing its focus on ways to improve member health and employer

cost outcomes. Cordani Tr. 406–08 (Cigna offers "differentiated value" to customers "seeking more of the full engagement of resources than a thin administrative service"); Dranove Tr. 968, 984 (Cigna could not compete based on provider discounts alone and had to innovate to bring different value to the market); Dranove Tr. 2302 ("[C]ollaborative 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"); *see also* Drozdowski (Anthem) Tr. 1666–69 (competitors who do not have the same discounts that Anthem has have had to find other ways to compete; "if you don't have strong discounts, you need to either achieve strong discounts or be creative"); Hayes (Aetna) Dep. 217 (a "compelling value proposition" can differentiate Aetna from a competitor, and help against a Blue carrier).

Cigna's innovation in the market, in turn, spurred even those carriers with strong provider discounts to improve their products. *See, e.g.*, PX 572 (internal Anthem e-mail chain in which Anthem personnel, after learning about a national account was happy with its Cigna collaboration, inquired about doing "something more collaboratively, along the lines of . . . the 'Cigna' model"); *see also* Hurst (Piedmont) Dep. 39–41 (suggesting that Anthem became more willing to discuss its provider collaborations because of competition from Cigna). And testimony from industry participants indicates that clinical engagement and value-based contracting will continue to expand. Hayes (Aetna) Dep. 133 (medical management is a means to improve business: the ability to deliver solutions to

improve health is important to larger national account customers); *id.* at 221–22 (employer group surveys indicate "a high interest in adding value-based contracts in the next five years").

Finally, the Court notes that there was evidence that the planned movement of Cigna members to the Blue brand that will be necessary to accomplish the integration in accordance with the rules of the Blue Cross Blue Shield Association, *see* section IV.C.2 below, will also inhibit Cigna's incentive to innovate. As executives from both defendants testified, efforts to move members out of Cigna's network, or to require Anthem network providers to apply Anthem rates to Cigna patients, will erode Cigna's relationships with it providers. *See* Matheis (Anthem) Tr. 1602–07; Cordani (Cigna) Tr. 436–441. Because these relationships are fundamental to Cigna's ability to advance its model of collaborative care, Cigna's capacity to innovate in this area will be harmed as well.

For all of these reasons, the Court finds that the merger is likely to slow innovation in the market.[28]

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[28] The likelihood of greater risk of collusion or coordination is also a basis upon which a court may prohibit a merger. *See PPG Indus.,* 798 F.2d at 1503. Plaintiffs presented evidence about Blue licensees discussing "strategy" within the BCBSA and allegedly exchanging competitive intelligence, arguing that coordination between Cigna and non-Anthem Blues is a "likely" anticompetitive effect. *See* PX 145; Pls.' Proposed Findings of Fact: Phase I ¶ 196. But plaintiffs accord too much significance to references in Anthem's files to our "Blue brethren" or "comrades in arms," Kertesz (Anthem Dep. 206); Pogany (Anthem) Dep. 122, and certain discussions of "strategy" within the Association. Swedish (Anthem) Tr. 269–70. Defense expert Dr. Israel testified that the health insurance industry is not conducive to

IV. The claimed efficiencies do not outweigh the anticompetitive effects of the merger.

A. Anthem has presented some evidence of efficiencies.

1. Medical Cost Savings

The central element of Anthem's efficiencies defense is the projection that the newly merged company will be able to realize more than two billion dollars worth of medical cost savings that, according to counsel, will be entirely passed through to consumers. *See, e.g.*, Curran (Def. Counsel) Tr. 40–41 (opening statement); Anthem Pretrial Br. at 1–3; Israel Tr. 1831. The analysis is based on the fact that virtually all of the national accounts self-insure. Abbott (WTW) Tr. 69–70. That is, large multi-state employers contract with an insurance carrier to provide claims administration and adjudication, but with respect to the payments to doctors and hospitals for medical care rendered to the employees, the employer is the "true payer" that "is actually paying the actual cost of the claim." Bisping (Caterpillar) Dep. 39; Drozdowski (Anthem) Tr. 1641. The medical costs are paid out of a bank account funded by the employer, Abbott (WTW) Tr. 174; Israel Tr. 4359,

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coordination because of confidential bidding, powerful buyers, highly differentiated products, and many different firms with different footprints and different offerings. Israel Tr. 1986. And plaintiffs' own expert Dr. Dranove found no evidence of collusion, price-fixing, or bid-rigging among any competitors in the healthcare industry, including by Anthem and the other Blues licensees. Dranove Tr. 1018–21. Therefore, the Court is not predicating its decision on a finding that plaintiffs have meet their burden to prove that the merger results in a greater risk of collusion or coordination.

and they constitute approximately 90 to 95% of the customer's total medical "spend." Abbott (WTW) Tr. 175; Dranove Tr. 1057.

Anthem maintains that after the merger, Cigna customers will enjoy the benefits of the larger discounts that Anthem has been able to negotiate with medical care providers due to the volume it delivers – along with the other Blue licensees – to the providers in the Blue Cross Blue Shield network. It points to three sources for its evidence of these savings: the testimony of the Anthem members of the integration planning team and their consultants; the testimony of Anthem's expert, Dr. Israel, and the government's own allegations.

As part of the pre-merger integration planning effort, a team comprised of Anthem and Cigna representatives was tasked to work with consultants from McKinsey & Co., led by Shubham Singhal, to develop an estimate of the anticipated medical cost savings based upon a review of actual claims data. Matheis (Anthem) Tr. 1480–84; Drozdowski (Anthem) Tr. 1644–47. This resulted in a calculation of $2.6 to $3.3 billion in projected annual savings. Matheis Tr. 1487; Drozdowski Tr. 1649.

Dennis Matheis, Anthem's Senior Vice President for Integration Planning, and Colin Drozdowski, the Anthem Vice President for National Provider Solutions, who led the network cost savings team for Anthem, described the process that was used to calculate the network savings. The analysis started with a substantial volume of raw claims data from both companies from January through August of 2015. This data was made available to the McKinsey actuaries cleared to review the sensitive business

material the two companies had deposited into a "clean room." Singhal (McKinsey) Tr. 1784, 1786–87; Matheis (Anthem) Tr. 1481. For each provider within the fourteen states with whom both insurers had more than $100,000 of claims experience, the team determined which insurer received the "better net-effective rate." Matheis Tr. 1482–83. It then applied the claims data to those rates to calculate the value of moving Cigna members to Anthem rates where Anthem rates were lower and Anthem members to Cigna rates where Cigna rates were lower. Matheis Tr. 1481–83; Drozdowski Tr. 1645–48, 1652.[29] The integration team also quantified the savings that could be achieved outside of the fourteen states if Anthem took Cigna customers headquartered within the Anthem states and "branded them Blue," and their employees spread across the country could access the local Blue Cross Blue Shield licensees' networks through the BlueCard system. Matheis Tr. 1484, 1487–88; Drozdowski Tr. 1660. This category of savings represents approximately $500–700 million of the integration team's $2–3 billion total estimate. Matheis Tr. 1487–88.

When asked how the transfer of the Anthem fee structure to Cigna members could be accomplished, Matheis explained that Anthem "could turn on our affiliate language" in its contracts with providers,

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[29] The calculation was based on claims experience that both companies had in common and was not limited to use of claims from providers who participated in both networks. While the majority of the providers overlapped, there were some Anthem providers who were not part of the Cigna network. In those cases, the difference between the Anthem price and the Cigna out-of-network price would have been even more significant. *See* Drozdowski Tr. 1652.

and that the merged company could also enter into new contracts with providers to establish new combined rates. Matheis Tr. 1484–85. A typical Anthem fee agreement with a provider states:

"Affiliate" means any entity that is: (i) owned or controlled, either directly or through a parent or subsidiary entity, by Anthem, or is under common control with Anthem, and (ii) that is identified as an Affiliate on Anthem's designated web site as referenced in the provider manual(s). Unless otherwise set forth in the Participation Attachment(s), an Affiliate may access the rates, terms and conditions of this Agreement.

See DX 393; DX 395; DX 396; DX 397. And Matheis testified that Anthem has a similar provision authorizing it to require providers to extend the Anthem fee schedule to its affiliates "in the predominance of [its] agreements." Matheis Tr. 1485.[30] Anthem's Drozdowski stated that the company's current intention is to proceed with a hybrid approach of both enforcing the affiliate provisions in contracts with providers and "convert[ing] [Cigna customers] to Blue." Drozdowski Tr. 1656. He added that the company could achieve 80% of the Cigna to Anthem rate savings unilaterally by invoking the affiliate clause. *Id.* at 1657–58, 1681.

According to Matheis, the fact that Cigna disengaged from the integration planning effort in the spring of 2016 should not undermine confidence

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[30] According to Matheis, initially Anthem "just assumed, whole cloth, [it] would turn on the affiliate language, regardless of the net effective value." Matheis Tr. 1489–90. But with Cigna's input, it refined the calculation to include a value for where Cigna had the better rates. *Id.*

in the projected medical cost savings since they were based on actual claims data. Matheis Tr. 1484. But he acknowledged that it has not yet been determined how the merged company would go about achieving the savings; deciding which "levers to pull" to generate the savings will require collaboration and discussion between the two firms as circumstances will vary from region to region and provider to provider. Matheis Tr. 1489–90, 1596–1600; *see also* PX 723.

The medical cost savings calculation was repeated by one of the defendants' economic experts, Dr. Israel, who reached similar results. Using a methodology he called a "best-of-best" approach, Dr. Israel reviewed actual claims data for a twelve month period. Israel Tr. 1845, 1853. He matched claims by provider, provider location, service type, and insurance product, and he compared the discount rates for Anthem and Cigna for each matched line item. Israel Tr. 1843–46, 1855. Utilizing only these claims submitted by identical providers treating both Anthem and Cigna members in identical venues, Dr. Israel then calculated what the savings would be if the lowest provider rates already negotiated by Anthem were made available to existing Cigna customers, and if the prevailing Cigna rates were made available to existing Anthem customers in the few instances where the Cigna rates were lower. *See* Israel Tr. 1846–54. He assumed that in any future negotiations with providers, the combined firm, with its combined patient volume, would be able to achieve the best price that either firm had obtained separately, and the "combined firm will close the gap." Israel Tr. 1848, 1851. Dr. Israel testified that medical costs for

current Cigna customers would thereby be reduced by approximately $1.5 billion, and medical costs for current Anthem customers would be reduced by $874 million, for a total of $2.4 billion in savings. Israel Tr. 1854, 4396; DDX 15.[31]

Although Dr. Israel offered his view that the merged company would ultimately be able to achieve even larger discounts, his best-of-best model assumes only that the merged firm will achieve the better of the two rates that existed prior to the merger. Israel Tr. 1854.[32] The economist explained that his

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[31] To put that figure in context, Dr. Israel also said that while medical costs are 95% of the employer's total healthcare spend, the discount differential is actually an extremely small percent of that expenditure – less than 1%. Israel Tr. 4417, 4420–21 ($2.4 billion is less than 1% of medical spending in the fourteen states).

[32] Beyond pointing to "basic economics," Dr. Israel did not detail how the merged company would actually be able to improve upon the current Anthem volume-based discounts. He stated, "I certainly don't think that the reduction in Anthem pricing comes from Anthem pushing its current provider rates below where they are today . . . . ," Israel Tr. 1835, and one of Anthem's other experts, Dr. Willig, also testified that Anthem has already achieved the benefits of scale in its dealings with providers, and that increased volume would not enable it to obtain greater discounts. Willig Tr. 2230–31 ("Anthem's already past the threshold of having enough size to do what it needs to do in terms of offering volume to providers."). This is consistent with the testimony of the Anthem CEO, Joe Swedish, who insisted that the merger would not result in the new company's paying less to all providers – "certainly not less than what we are paying now as Anthem." Swedish Tr. 294; *see also id.* at 290 ("Q: [I]f this merger goes through, your plan is to use the merger to get even bigger discounts, right? A: I don't think that's the plan."). In the end, Dr. Israel's calculation of savings for Anthem customers is based solely

calculation was not premised upon any additional volume; he attributed the savings to "bulk buying." Tr. 1849. And Anthem's expert made it clear that his calculation did not depend in any way upon the details of what the strategy would be use to implement these savings; it was based purely on the application of the economic principle that the merged firm will do no worse than the two firms did separately. Israel Tr. 1847; *see also* Israel Tr. 4383 (the affiliate language "isn't part of my analysis at all").

Finally, Anthem points out that plaintiffs' monopsony allegations also depend upon the factual premise that the merger will result in the reduction of provider prices. *See* Compl. ¶ 71; Israel Tr. 4365–66 ("[T]here seems to be agreement that provider rates will go down . . . . And I would say agreement that [the reduction] is merger-specific from the point of view that the allegation is that the merger will cause those lower rates to occur."). According to Anthem, these reduced medical costs more than offset the alleged amount of anticompetitive harm, and the savings to customers at the end of the day are efficiencies that weigh heavily against enjoining the merger.

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on the limited number of instances in which Cigna's rate is lower, and according to him, those savings amount to a reduction of substantially less than 1% of Anthem customers' provider costs. Israel Tr. 1835. And the record is devoid of any evidence explaining what steps would actually be taken to enable Anthem customers to avail themselves of those Cigna rates.

2. General and Administrative Savings

Anthem maintains that the merger will result in other cognizable efficiencies as well. The executives heading the integration effort testified concerning the approach taken to calculate estimated general and administrative ("G&A") savings arising out of the combination of the two firms. The planning process began in approximately October of 2015 with the creation of multiple teams consisting of representatives from both Anthem and Cigna with expertise in specific subject areas. Their task was to analyze actual data from both organizations to identify and quantify potential synergies and eliminate duplication, utilizing first a "top down" approach to develop savings targets, followed by a "bottom up" approach to identify the specific steps to be undertaken to achieve them. Matheis (Anthem) Tr. 1493–98; DX 690. The analysis was facilitated by the McKinsey team that had access to each firm's confidential material. Singhal (McKinsey) Tr. 1783–84. Singhal explained that the goal of the effort was to identify costs that would be made redundant by the merger or by adopting the better practices and cost structures either firm had to offer. Singhal Tr. 1782–84.

By February of 2016, the combined leadership team had approved the integration team's top–down projection of $2.36 billion in G&A cost savings (separate and apart from the projected medical cost savings), and it directed the integration teams to develop plans to capture those savings through the bottom–up process. Matheis (Anthem) Tr. 1499–1500, 1505–10; DX 238. The companies calculated a range of synergy savings of $1.7 to $2.3 billion, and it

was announced to Wall Street that "the mid point of that range, $2 billion" would benefit shareholders. Schlegel Tr. 1399–1401, 1444; Matheis Tr. 1611. The estimate includes $515 million in annual variable cost savings, based on a "best-in-breed" approach that builds on the functions that each of the merging parties manages more efficiently or successfully. Matheis Tr. 1502–03; *see also* Singhal (McKinsey) Tr. 1783–84. This figure was factored into the experts' merger simulations. Israel Tr. 4409.

Both Matheis and Singhal emphasized the rigor, the volume of actual data, and the level of detail that went into the top down analysis and the bottom up work that has been done to date. *See, e.g.*, Matheis (Anthem) Tr. 1480–84, 1508–09; Singhal (McKinsey) Tr. 1783–84. Matheis testified that a significant chunk of bottom up work has already been completed and that the teams supporting the eight project work streams have already identified over 400 cost savings initiatives, such as utilizing Cigna's more efficient system for generating ID cards. Matheis Tr. 1494, 1502, 1508–09. But the record reflects that Cigna began to disengage from the process in April of 2016, *id.* at 1587, and Cigna ceased participation completely in July when the Antitrust Division sued to stop the merger.

B. The Court may consider evidence of efficiencies.

Anthem correctly observes that while the Supreme Court has yet to recognize an efficiencies defense in a Section 7 case,[33] several circuit courts

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[33] The Supreme Court stated in *FTC v. Procter & Gamble Co.*, 386 U.S. 568, 579 (1967), that "[p]ossible economies cannot be used as a defense to illegality" in *Section 7* merger cases,

and courts in this district have stated that, in some circumstances, evidence of efficiencies may be introduced to rebut the government's prima facie case. *Sysco*, 113 F. Supp. 3d at 81, citing *Heinz*, 246 F. 3d at 720. As the Department of Justice and the Federal Trade Commission recognize in their own Horizontal Merger Guidelines:

> [A] primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products. For example, merger-generated efficiencies may enhance competition by permitting two ineffective competitors to form a more effective competitor, e.g., by combining complementary assets.

Guidelines §10. But the agencies credit only "merger-specific" efficiencies, i.e., "those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects." *Id.; see also* U.S. Dept. of Justice & Fed. Trade Comm'n Merger Commentary § 4 (2006) ("Merger Commentary") ("Any efficiency that enables the combined firm to achieve lower costs for a given quantity and quality of product than the firms likely would achieve without the proposed merger is merger-specific."). The classic example of such a circumstance would be "if a merged firm would combine the production from

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and as the court observed in *Staples I*, 970 F. Supp. at 1088–89, this statement has prompted some courts and commentators to question whether economic efficiencies will ultimately be found to be a viable legal defense.

two small or underutilized facilities (one from each of the merging firms) at one facility that has lower costs, and if such a cost reduction could not practically be achieved without the merger (e.g., by one of the merging firms combining two of its own underutilized facilities or through rapid internal growth) . . . ." Merger Commentary § 4.

The Horizontal Merger Guidelines also require that the claimed efficiencies be verifiable: "it is incumbent upon the merging firms to substantiate the efficiency claims." Guidelines § 10. This admonition has been echoed by the courts: the opinions that discuss the potential availability of the defense underscore that courts must "undertake a rigorous analysis of the kinds of efficiencies being urged by the parties to ensure that those 'efficiencies' represent more than mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 721. The court in *Arch Coal* reiterated that "the government will only consider those efficiencies that are merger-specific and verifiable by reasonable means." 329 F. Supp. 2d at 150.[34]

Finally, as the court considering the merger of health insurance carriers Aetna and Humana recently noted, "high market concentration levels . . . require, in rebuttal, proof of extraordinary efficiencies." *Aetna*, 2017 WL 325189, at *70, citing *Heinz*, 246 F.3d at 720; *see also id.* at *72 (reiterating the need for "extraordinary" efficiencies); Guidelines

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[34] In a somewhat misleading citation, Anthem points to this general statement in *Arch Coal*, but asserts: "[t]o be cognizable, merger efficiencies *need only* be 'merger-specific' and 'verifiable by reasonable means.'" Anthem COL ¶ 64 (emphasis added).

§ 10 ("The greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to consumers.").

None of the courts that recite the general principles set forth in the efficiencies section of Anthem's Conclusions of Law ultimately concluded that the claimed efficiencies were sufficiently verifiable or merger-specific to offset the competitive harm, *see, e.g., Arch Coal*, 329 F. Supp. 2d at 151–53;[35] *H & R Block*, 833 F. Supp. 2d at 90–92, and the defense has not pointed the Court to a single litigated case in which the merging parties were

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[35] In the merger of coal companies in *Arch Coal*, the court declined to recognize the claimed savings that would have resulted from actions the companies could have taken alone on the grounds that they were not merger-specific. 329 F. Supp. 2d at 151–52. Savings related to inventory reduction, the need for fewer haul trucks, and the anticipated elimination of equipment were found to lack evidentiary support. *Id.* at 152–53. In short, while the court agreed that some efficiencies would result from the combined operation of adjacent mines, it concluded that most of the purported savings had "been called into question as either non-existent or overstated" and that therefore, the efficiencies defense was not sufficient alone to overcome the evidence of anticompetitive effects. *Id.* at 153. The court did state that the fact that Arch would "achieve some measure of lower costs and higher productivity" was relevant to an assessment of the post-merger market, and that those efficiencies "provide[d] some limited additional evidence to rebut the claim of post-merger anticompetitive effects" even though they had not been quantified. *Id.* Ultimately, though, the court concluded on other grounds, including the relative weakness of the acquired company, that defendants had rebutted the presumption that the merger would substantially lessen competition.

successful in overcoming the government's case by presenting evidence of efficiencies.

Here, the efficiencies evidence fails to supply a defense for several reasons: the medical cost savings are not merger-specific; a significant portion of the medical cost savings and the G&A savings have yet to be verified; and it is questionable whether the medical cost savings can be characterized as an "efficiency" at all.[36] Thus, the defense has not presented evidence that could outweigh the anticompetitive harm, no matter which expert's method for calculating competitive effects is adopted.[37] Courts have noted that "even where evidence of efficiencies in the relevant market will not support an outright defense to an anticompetitive merger, such evidence is relevant to the competitive effects analysis of the market required to determine whether the proposed transaction will substantially lessen competition."

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[36] Anthem directs the Court to a statement in the recent *Aetna* opinion that efficiencies must be shown to benefit the consumer. *See* Anthem's Supp. Conclusions of Law [Dkt. 495] ¶ 1, quoting *Aetna,* 2017 WL 325189*,* at *70, which quotes *Sysco*, 113 F. Supp. 3d at 82. It is true that this language in both the *Aetna* and *Sysco* opinions means that any claimed savings must inure to the benefit of the customer in order to *qualify* as an efficiency, but neither court altered the test in the Guidelines to single out pass through as the defining touchstone of an efficiency. So even if the savings and the pass through could be verified – and both are questionable – the entire theory fails because the medical cost savings are not merger-specific.

[37] *See* Israel Tr. 4406–10 ("[T]he real bottom line difference between the two simulations is whether you include the medical cost savings or you don't . . . . The single most important thing is medical cost savings.").

Arch Coal, 329 F. Supp. 2d at 151. But the Court finds that the United States has carried its burden notwithstanding Anthem's introduction of this evidence, and there is no support for Anthem's contention that the Court should consider claimed benefits to consumers or society in general when assessing the legality of a proposed merger's impact on competition within the relevant market under the antitrust laws.

C. The claimed savings are not cognizable efficiencies.

1. The medical network savings are not merger-specific.

Anthem asserts that the medical cost savings "relate to this merger." Anthem FOF ¶ 301.[38] But that is not the relevant inquiry. The courts that have considered efficiencies evidence insist that the defendants bear the burden of demonstrating that their claimed efficiencies are "merger-specific." *Sysco*, 113 F Supp. 3d at 82, citing *H & R Block*, 833 F. Supp. 2d at 90. This means that the defendants must show that the "efficiencies . . . cannot be achieved *by either company* alone . . . ." *Heinz*, 246 F. 3d at 722 (emphasis added);[39] *see also H & R Block*,

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[38] *See also* Israel Tr. 4372 ("[L]ower costs *are a result of* the merger.") (emphasis added).

[39] Counsel for Anthem argued at the close of the case that this is no longer the governing standard because the *Heinz* court lifted it from a version of the Horizontal Merger Guidelines that was subsequently modified. Curran (Def. Counsel) Tr. 4900. ("DOJ and the FTC said they have learned from their experience and that they are, therefore, modifying their standards."). But while *Heinz* cited the 1992 Guidelines for the proposition that efficiencies must be merger-specific, it cited a leading antitrust treatise for its explanation of what

833 F. Supp. 2d at 89 (a "'cognizable' efficiency claim must represent a type of cost saving that could not be achieved without the merger" and without the loss of a competitor).

In the merger of coal companies in *Arch Coal*, the court rejected the notion that plans made by Arch, the acquiring company, to recover coal from mines operated by Triton, the acquired company, would be a merger-specific efficiency since Triton could mine the coal on its own, albeit on a slower schedule. 329 F. Supp. 2d at 151–52. The court also concluded that the fact that Triton could be covered more cheaply under Arch's insurance policy was not a merger-specific efficiency, since Triton could have purchased its own policy on similar terms. *Id.* at 152. Similarly, in the *H & R Block* case, the court

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that means. See 246 F. 3d at 722, citing 4A Phillip E. Areeda, Herbert Hovenkamp & John L. Solow, *Antitrust Law*, ¶ 973 (1998). No court has revised the legal test in the wake of the 2010 revision to the Guidelines. *H & R Block*, cited by Anthem, still used it in 2011, see 833 F. Supp. 2d at 52, and *Sysco* also relied upon by Anthem, set forth the same test in 2015. 113 F. Supp. 3d at 81–82. Indeed, it is not at all clear what counsel was referring to when he told the Court that this particular aspect of the Guidelines had been changed; in *Cardinal Health*, 12 F. Supp. 2d at 60, the court quoted the requirement in the 1992 Guidelines that a cognizable efficiency must be "unlikely to be accomplished in the absence of . . . the proposed merger" which is identical to the language that appears in the 2010 Guidelines, and is the very standard that Anthem urged the Court to apply. Curran Tr. 4900–01. Therefore, the admonition in *Cardinal Health* that "[i]n light of the anti-competitive concerns that mergers raise, efficiencies, no matter how great, should not be considered if they could also be accomplished without a merger," 12 F. Supp. 2d at 60, still pertains today.

emphasized that "[i]f a company could achieve certain cost savings without any merger at all, then those stand-alone cost savings cannot be credited as merger-specific efficiencies." 833 F. Supp. 2d at 90. The court then found that the post-merger plans to adopt more rigorous cost-cutting practices and improved IT procedures were not merger-specific since the companies could independently implement such internal improvements at any time. *Id.* More recently, the court in *Sysco* also refused to credit a substantial portion of the claimed efficiencies because the defendants had failed to show that the savings could not be achieved independent of the merger; each of the companies had already separately initiated the "category management" efforts that were expected to generate savings in the merchandising category, and either could have adopted the merged company's planned e-commerce platform for customer orders on its own. 113 F. Supp. 3d at 84–85.

Applying all of these principles, the Court finds that the projected medical cost savings are not merger-specific and therefore, are not cognizable efficiencies. The integration team's $2.6 to $3.3 billion calculation of medical cost savings is expressly based upon the application of existing provider rates to those providers' existing patient volume, largely through the means of contractually forcing providers to extend the fee schedules that Anthem has already secured. Not one penny of these savings derives from anything new, improved, or different that the combined company would bring to the marketplace that neither company can achieve alone; to the contrary, the medical network calculation is specifically based on pricing that one or

the other of the companies *has already achieved* alone. *See* Matheis Tr. 1485–86 ("I guess the important point here is this is all, again, the assumption, and I believe it's a sound one, is it's not requiring us to renegotiate. It's already rates that providers have agreed to in the marketplace with both organizations."). And Anthem's Colin Drozdowski confirmed that the predicted savings are not dependent upon the delivery of new members to the providers; they are derived from moving the providers' existing Cigna population to the Anthem rates. Drozdowski Tr. 1675–76; PX 54.

Dr. Israel also simply calculated what the difference would be if existing Cigna enrollees received the existing Anthem rates from providers where Anthem's rates were already lower, and if existing Anthem members received the existing Cigna rates from those providers that charge Cigna lower rates right now. Israel Tr. 1846–54. So his $2.4 billion number does not depend on any rate structure or increased volume that will flow from the merger either. Indeed, a second defense expert specifically opined that Anthem has already obtained the lowest provider rates it can achieve; it is not anticipated to secure lower ones, even if it attracts additional volume. Willig Tr. 2230–31. Thus, with respect to the medical costs, the merger introduces no new opportunity to the marketplace; any national account customer that values the superior discounts that Anthem receives from providers is free to purchase health insurance from Anthem today.

It is true that Dr. Israel posits as part of his economic model that there would be a hypothetical negotiation with providers, and he points to economic principles that suggest that the two companies'

combined volume will affect the outcome. *See, e.g.*, Israel Tr. 4392 ("[T]he larger payer is going to get at least as good or better rates than the smaller payer."); *id.* at 4370 ("[T]he prediction of that economic framework is that the combined firm will get prices at least as good as what Anthem gets."). But even if he is envisioning that the new health insurance company will eventually end up across the bargaining table from the healthcare providers, his calculations turn upon the application of the lowest rate that one carrier or the other has already received, and he is simply applying that to claims of patients that the providers already treat. And while negotiation may be part of the model he brings to bear as an academic matter, one cannot assume that it will take place given the testimony of Anthem's own witnesses that the company plans to achieve a significant portion of these savings by unilaterally invoking affiliate provisions in Anthem's contracts with providers.[40]

Even if Anthem elects to attempt to capture this claimed value through rebranding Cigna customers downstream, rather than through use of the affiliate clause with providers upstream, the savings would not be not merger-specific. Rebranding is nothing more than marketing the Anthem product to existing Cigna customers and persuading them to buy it, and Cigna customers can do that now. *See* Matheis Tr. 1599 (in the short term, rebranding is "no different than if you're out selling new business in the market

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[40] When Dr. Israel acknowledged that he was not even taking the affiliate clauses into account, Israel Tr. 4383, he revealed his analysis to be largely abstract and diminished its relevance to the actual business circumstances at hand.

on a day-to-day basis"). So to the extent that any of the Cigna customers within the fourteen Anthem states move their business to Anthem and realize reduced medical costs, one cannot include those dollars in an estimate of merger-specific savings.

This is important because the evidence has established that there will be a significant push for the new company to implement a unified brand strategy within the geographic market at issue. This strategy is necessary to ensure compliance with the Blue Cross Blue Shield "best efforts" rules that are designed to strengthen and protect the Blue brand.

Under the terms of the licensing agreement between Anthem and the Blue Cross Blue Shield Association, 80% of the revenue Anthem earns within its fourteen state exclusive territory must be branded Blue, and 66% of the revenue it takes in nationwide must also be Blue-branded. Swedish Tr. 237; Dranove Tr. 996; Schlegel (Anthem) Tr. 1406. Anthem executives testified that the company will be out of compliance the moment the merger is consummated, Swedish Tr. 237; Schlegel Tr. 1411; PX 79, and it will be required to submit a plan for achieving compliance to the association's Brand Enhancement and Protection Committee, within 120 days. Schlegel (Anthem) Tr. 1412, 1415.[41]

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[41] A failure to comply with the best efforts rule could result in Anthem's loss of its license to do business under the Blue Cross and Blue Shield brands, and the company would face the sanction of a fee of close to $3 billion to fund the establishment of a replacement Blue plan in its exclusive service area. PX 704, PX 125; Schlegel Tr. 1423–24. CEO Joe Swedish specifically testified that given the importance of the Blue brand to Anthem's business, Anthem has every intention of complying. Swedish Tr. 223. So there is no

Given that imperative, Anthem's stated intention is to move as many Cigna customers within its fourteen states to Anthem as it can. *See* Matheis (Anthem) Tr. 1600 ("[C]ertainly we have to get a lion's share of the Cigna customers in our local 14 markets to migrate to the Blue brand to ultimately be compliant."); *see also* Swedish Tr. 241, citing Swedish Dep. 135–36 (acknowledging that he agreed in his deposition that Anthem "planned to move as many Cigna members as possible"); Schlegel (Anthem) Tr. 1431 (agreeing that rebranding is "high on the list" of "levers" to be utilized to attain compliance).[42] Schlegel explained that while Anthem's planning documents reveal that the company is contemplating rebranding Cigna lives

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evidentiary basis for Dr. Willig's speculation that the best efforts rules do not constitute a credible threat that would influence Anthem's behavior. *See* Willig Tr. 2160.

[42] This is another area in which the expert's economic model diverges from the reality of the business circumstances. Dr. Israel testified, "[i]n my analysis, it's not really a rebranding . . . it's the combination of the volumes from the two firms." Israel Tr. 1847. But this is not an academic exercise, and the fact of the rebranding makes a difference to the legal analysis. Dr. Israel also opined, "[i]f you think about [it] from the point of view of the Cigna network, there are going to be some providers where Cigna just has more volume today, the better cost position . . . , my analysis would say, those are going to stay Cigna, the Cigna contract is going to be what it's built from." Israel Tr. 4382. But the actual requirements of the Blues' best efforts rules militate against sustaining or building upon the Cigna business within the 14 states, so this aspect of the analysis is not supported by the facts. *See* PX 79 (detailing the ways in which the national best efforts requirement "restricts growth post compliance;" "NewCo must manage total revenue growth to not outpace Blue revenue growth").

outside of the fourteen states as well,[43] rebranding the existing Cigna business within the fourteen states alone would be enough to meet the two-thirds threshold. Swedish (Anthem) Tr. 237; Schlegel (Anthem) Tr. 1414, 1418–19. According to Schlegel, this could be accomplished by offering such an attractive Anthem product that Cigna customers would choose to switch, or by simply declining to renew existing Cigna contracts. Schlegel (Anthem) Tr. 1429–30.[44] Anthem witnesses emphasized that the choice of carrier would be left up to the customer, Schlegel Tr. 1417–18; DeVeydt (Anthem) Tr. 1696, 1699–1700, but that is not consistent with any plans to decline to renew existing contracts. And Cigna CEO David Cordani cast doubt on whether there would be much value to the choice if it were offered: "[t]he current plan has it such that the only way a client of Cigna, current client of Cigna, would get access to the improved medical costs of NewCo is to migrate the business to a Blue Cross offering. So . . . the choice would be limited." Cordani (Cigna) Tr. 491.

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[43] Schlegel testified that the Anthem synergy estimates include not only those employees of rebranded Cigna customers headquartered within the Anthem states who live within the 14 states, but also the employees who live elsewhere. Schlegel (Anthem) Tr. 1414. He explained that rebranding those lives would be automatic if a customer insured all of its employees nationwide under a single contract and did not slice out other geographic regions. *Id.* at 1436–37.

[44] Schlegel did note that the more successful Anthem turns out to be at growing its Blue-branded Medicare Advantage business, or selling Cigna specialty products to its Blue customers, the less it would need to rely on rebranding. Schlegel (Anthem) Tr. 1416–17.

Thus, a large portion of the projected $1.5 million of Cigna customer medical cost savings is attributable to the planned transfer of existing Cigna customers to the Anthem brand to comply with the best efforts rules, and since rebranding cannot be considered to be merger-specific, those dollars should not have been included.

Furthermore, the record includes testimony that Cigna has been successful in some markets in negotiating lower provider prices on its own, which, in accordance with the teaching of *H & R Block* and *Arch Coal*, would also indicate that obtaining favorable discounts is not a merger-specific outcome. *See, e.g.*, Huggins (Cigna) Dep. 235 (Cigna has a competitive cost position in Richmond, Virginia). Through the implementation of a "Go Deep" strategy of identifying markets in which it was best positioned, and committing more sales and clinical resources there, Cigna has been able to produce higher than average growth in certain locations, Cordani (Cigna) Tr. 409–11, and its ability to use its leverage to negotiate provider discounts in the future has been enhanced.

Dr. Israel likens the network savings to a bulk discount, but using that approach is still not enough to transform the claimed savings into merger-specific efficiencies. Israel Tr. 1945. First, his comparison is not apt since the numbers utilized to derive the efficiency calculation were equal to the number of each carrier's members who were already utilizing the providers in question – the calculation does not depend upon delivering new volume. Dr. Israel maintains that the savings are merger-specific nonetheless because the *combination* of patient volume is a result of the merger even if the total

number of patients remains the same. Israel Tr. 1848. But it has not been shown that it is the combination of the two pools of members under a single blue banner that will lead to the application of the improved rates; invoking a contractual provision that requires providers to settle for a lower fee no matter how much Cigna volume is added can hardly be characterized as bulk purchasing.

Moreover, the evidence established that Anthem has already attained the benefits of scale and any increase in volume is not likely to depress the fee schedule further. *See* Willig Tr. 2230–31; Israel Tr. 1835 ("I certainly don't think the reduction in Anthem pricing comes from Anthem pushing its current provider rates below where they are today . . . ."). Even if the combined firm is able to grow its business within the fourteen states beyond its substantial combined share, there is no evidence that further volume will change the per-patient cost for any provider.[45]

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[45] Thus, the situation can be distinguished from the bulk discount referenced in the Guidelines. *See* Guidelines §12 ("A merger that does not enhance market power on the buying side of the market can nevertheless lead to a reduction in prices paid by the merged firm, for example, by reducing transactions costs or allowing the merged firm to take advantage of volume-based discounts. Reduction in prices paid by the merging firms not arising from the enhancement of market power can be significant in the evaluation of efficiencies from a merger, as discussed in Section 10."). There is no evidence of any reduced transaction costs for the providers – it costs what it costs to treat a patient, Berfiend (IU Health) Tr. 2873 – and the defense calculation does not depend upon the negotiation of new rates based on the carriers' combined volume or bulk purchasing. No provider testified that it would be

Dr. Israel's bulk discount theory is also at odds with his attempt to paint the outcome of the merger as the delivery of the Cigna product at a lower Anthem price. Israel Tr. 1837 ("In a nutshell, the key competitive benefit of the merger . . . is that you can combine the Cigna innovative products and wellness programs and whatever else people like about the Cigna offering . . . with a more effective discount structure."). He testified that "the merger-specific benefit is the creation of a Cigna product with whatever people value about Cigna combined with an Anthem discount structure," Israel Tr. 1871, and explained that this opportunity to buy Cigna's offerings at the Anthem price would not be available absent the merger. Israel Tr. 1838 ("By bringing those things together, that creates an offering that isn't in the marketplace today. That's a product that doesn't exist today, is Cigna's offerings with Anthem's discounts."); *see also* Schlegel (Anthem) Tr. 1417 ("The plan is to, of course, integrate the capabilities of both organizations and develop compelling value options for the customer . . . . [Y]ou're putting a Blue brand on an enhanced product offering, or we could also . . . put the Blue brand on existing business in our 14 states, as well.").

This reveals the second problem with the economist's best-of-best cost savings analysis. One could only obtain a "bulk purchasing" discount if one were actually combining two sets of purchases of

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appreciably cheaper to deal with one carrier instead of two; they stated that there would be no difference at all. *See* Brendt (Sutter Health Plus) Dep. 120; Hurst (Piedmont) Dep. 47–48; Atwood (Stanford Health) Dep. 25–26.

identical products – two "buckets" into one. *See* Israel Tr. 1848. Yet when Dr. Israel makes his Cigna-product-at-the-Anthem price argument, or Anthem executives tout an "enhanced" product, they are tacitly acknowledging that what Cigna is selling is different from what Anthem is selling. And that means that what Cigna is buying from the providers is often different from what Anthem is buying. Both Cigna CEO David Cordani and the succession of healthcare providers who testified in Phase II made it clear that the Cigna model depends upon collaboration, and that it takes a higher level of compensation to encourage and enable physicians and hospitals to participate in the arrangements that are aimed at lowering utilization and are central to the value based approach and medical cost trend guarantees that Cigna is selling. *See, e.g.*, Cordani Tr. 415–423; Rowe (Granite Health) Tr. 2808–10; Berfiend (IU Health) Tr. 2877–78.

If Anthem and Cigna are not buying the same service from providers – and the record reflects that they are not – the bulk purchasing analogy falls apart. So the savings cannot be categorized as merger-specific based on a combined volume discount theory.

Nor do the announced synergies become merger-specific based on Anthem's assertion that the combination will give it the opportunity to offer its customers the popular specialty services such as behavioral health, population health, disease management, and disability management that Cigna offers and it does not. *See* Israel Tr. 1840 (right now, customers who prefer Anthem discounts cannot contract for the full set of front-end services that Cigna offers); Israel Tr. 4371–73. There has been no

testimony that these are patented or proprietary concepts, and if the health benefits market is as easy to enter as Anthem says it is, it would not be very difficult for one of the biggest and most well-established carriers in the business to expand into related product areas, especially given the Anthem executives' confidence that it is Anthem that continues to lead the way in bringing innovative, value-based products to the market. *See, e.g.*, Drozdowski (Anthem) Tr. 1670; 1634–35; Swedish (Anthem) Tr. 295–96; Kendrick (Anthem) Tr. 1200–01. So the merger does not need to take place to enable Anthem to offer the programs that Cigna is selling that customers value – it just needs to develop and offer them. The failure to do so to date may relate more to corporate culture than to barriers in the marketplace, and any lack of cultural alignment around these issues makes the promised post-merger scenario somewhat less verifiable as well. Furthermore, the marketing of additional products would not represent an increase in value for the consumer dollar: the customers will of course have to pay extra for any "ancillary" programs they choose to add to their medical benefits contracts. *See* Gidley (defense counsel) Tr. 4793 (responding to question from the Court: "Sure they'll pay for it."). So the fact that the merger may afford Anthem access to a broader range of Cigna offerings is not an "efficiency" that offsets the competitive harm, even if it would be an attractive aspect of the combination for both the new firm and Anthem customers.

2. The claimed savings are not verifiable.

The evidence gives rise to a number of concerns about whether the projected medical cost

savings or the G&A efficiencies can actually be achieved. Putting aside the conspicuous chill in the relationship between the merging parties for a moment, there is much in the record to indicate that obtaining the proclaimed medical cost savings may be easier said than done. Anthem internal memoranda reflect concerns that providers may not accept the obligation to extend lower Anthem fee schedules to Cigna patients without a fight. *See* PX 89; *see also* PX 54 (email from Colin Drozdowski, stating, "In all circumstances, I would expect strong provider resistance, as they view this as an incremental discount with no corresponding incremental value (no new members)."). And physician contracts may be terminated by either party with only 90 days' notice, so the doctors could rebel and negotiate for more favorable terms. Drozdowski (Anthem) Tr. 1684; PX 296.

Cigna personnel recognize the problem as well. CEO David Cordani testified that Anthem's predicted cost savings are unreliable in part because they are based on an unproven assumption that providers will not react and renegotiate their fee schedules upwards. Cordani Tr. 443. Alan Muney, Cigna's Chief Medical Officer, expressed considerable skepticism about the reliability of the projections and characterized them as "nirvana." PX 716; *see also* PX 717 (email from Muney stating, "I think . . . the execution risk is high . . . large delivery systems . . . could push back hard."); PX 722 (email from Muney stating, "I would add the adjective 'potential' to any estimates of savings as obviously there are a lot of variables that play into whether it's achievable or not.").

Also, Anthem witnesses were not particularly reassuring about the time it would take to realize any medical cost savings. Anthem CEO Joe Swedish, who adamantly resisted the government's suggestions that Anthem would promptly "drop the hammer" on its providers and unilaterally enforce its contractual rights, warned that any reduction in provider costs will take years to come to fruition. Swedish Tr. 337–38 (closing the discount gap "would play out over a lengthy period of time because . . . our contracts with providers may span three years, and maybe in some cases five years. So a lot of these providers are not subject to renegotiated arrangements for a considerable period of time."); *see also* Drozdowski (Anthem) Tr. 1684 (facility agreements are on three year cycles and cannot be terminated); Matheis (Anthem) Tr. 1521 (discussing a document predicting a 4 year time frame post-merger: "from date of close to actually getting all of the products aligned for large group market is going to take us some time."). What's more, neither invoking the affiliate clause nor renegotiating provider contracts would do anything to enable Anthem to come into compliance with the best-efforts rules, Drozdowski (Anthem) Tr. 1678, so Anthem may be unable to rely on contractual approaches as a means of achieving savings to the extent originally predicted.

Finally, Cigna's David Cordani testified that Anthem's cost savings calculation is "narrow-minded" and "incomplete" since it is based solely on a comparison of discounted fees for services and does not factor in utilization – that is, the savings realized when clinical programs and accountable care relationships improve health and medical

management and reduce the need for services altogether. Cordani Tr. 442.[46] Dr. Dranove identified this and other flaws in the medical cost savings calculation, Dranove Tr. 2310–39, and plaintiffs' expert Ronald G. Quintero also identified several reasons why the estimates were unreliable, including the fact that they were based solely on invoices and not a comparison of the fee schedules themselves. Quintero Tr. 2529. According to Dr. Dranove, error problems with measuring discounts and assumptions underlying the calculations affect the totals significantly. *See, e.g.*, Dranove Tr. 2327–29.

Not only are there difficulties verifying the Anthem assumptions that Cigna customers will be able to utilize the Anthem rates, and that they will save money by doing so, but the record is devoid of plans specifying what method could be employed to enable existing Anthem members – or Cigna

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[46] Despite the fact that he was testifying as the defense expert, Dr. Israel was subjected to a not particularly friendly cross examination conducted by counsel for Cigna. Israel Tr. 2068–69 ("In this case, . . . you've been retained and are being paid exclusively by Anthem; is that correct? . . . And Cigna did not participate in the preparation of your report or your trial testimony?"). This unusual exercise underscored that the expert's analysis of Anthem's cost advantage was based strictly on Anthem's fee schedules and that it did not take into account any savings generated by the reductions in utilization that result from Cigna's collaborative approach. Rule (Cigna counsel) Tr. 2082–83 ("[W]ouldn't you say that in order to compare utilization, you have to adjust it for the different risks and features of the population that is being compared as Anthem versus Cigna at a particular provider?"); *see also id.* 2086 ("You can't determine whether Anthem programs versus the Cigna programs were more successful in lowering utilization, can you?").

members who rebrand as Blue members – to enjoy any existing superior Cigna discounts. Even if Cigna's provider contracts contain affiliate provisions, the Blue Cross Blue Shield Association rules would bar the merged company from invoking them. PX 721; Matheis (Anthem) Tr. 1608. Also, the record includes testimony that some providers have historically offered Cigna lower rates to help it sustain its collaborative model and compete against the more dominant Anthem and United. *See* [TEXT REDACTED BY THE COURT]. Nothing in the expert's negotiation model explains why providers would continue to be willing to provide that sort of support after a merger. So the $800 to 900 million in supposed savings on the Anthem side of the equation is largely unverified.

There is no question that the integration involved in this case would involve, as Anthem CEO Joe Swedish called it, a "[H]erculean effort." Swedish Tr. 359.[47] But, getting to the nub of the verification

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[47] Based on his many years of merger and acquisition experience working on "hundreds" of transactions at [TEXT REDACTED BY THE COURT] explained that "when you've got two really significant organizations looking to come together, it's hard work to sort out all of the efforts around integration and alignment and ownership and governance and process. And so that's challenging." [TEXT REDACTED BY THE COURT] Dep. 275. He predicted that the Anthem/Cigna transaction will be complicated by Anthem's membership in the Blue Cross Blue Shield Association: "you've got . . . somebody that is a Blues licensee and they participate in a subset of the states and you marry that with a company that's trying to serve a broader set of states . . . . How do you sort that out? What are the rules of being a Blues licensee . . . ? . . . [H]ow are the economics going to work?" *Id.* at 276–77. He added: "[I]t's hard work. And it takes time to bring together companies, to bring together

problem, while Anthem witnesses were confident that once the merger is approved, the suspended integration efforts will resume, the leadership team will step into place, and the synergies will be achievable, *see, e.g.*, Drozdowski (Anthem) Tr. 1673, Anthem's internal documents make it clear that the effort has not yet proceeded from general "high level" planning to the essential process of detailing actual strategies and "budget level" initiatives. *See* DX 712. That is because Cigna's input is required before the real work can be done, and the two parties have not been working together for some time. Swedish Tr. 359–60 ("There's still a lot of work to be done in terms of the integration process after day one go live."); Cordani Tr. 428 (parties have not resolved their differing views about the go-to-market strategy, and how the new company will sell its products and provide value to clients is "mission critical"); *see also* Drozdowski (Anthem) Tr. 1671–73; DX 712 (slides titled "Progress on integration planning impacted due to inconsistent Cigna engagement" contrasting "where we could be" with "where we are now;" and "Integration planning is at a point where further refinement of value capture requires

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cultures, to bring together people, to bring together management structures, to bring together governance structures. And then that doesn't say anything about the technology that underlies both businesses and how you bring those together, the data structures . . . and then you get into the relationships that exist in the market and how do you draw those together, whether it's with brokers or consultants or with care providers or with lab companies or medical device manufacturers or pharmacies . . . there's a lot." *Id.* at 277–78.

significant Cigna input.").[48] The record contains compelling evidence of the deterioration of the merging parties' relationship. On December 29, 2015, five months after the two firms publicly announced their plans to combine, Joe Swedish voiced a series of complaints to David Cordani at Cigna. *See* PX 1 ("With the passing of the fifth month since the announcement and reflecting on what has been accomplished and what requirements remain, I can only conclude that the implementation and execution of our integration plan has been unacceptable."). In an email in early March, he reiterated his concerns that the companies were not yet aligned. PX 3 ("Anthem believes that the work associated with Day 1 and synergy capture is not currently on track."). Cigna responded with its objections to Anthem's proposals for the new company's organization and management structure, PX 4, and by April 2016, Cigna's disengagement was so complete that Anthem established an independent team to proceed with integration planning on its own. PX 725. Meanwhile, the two companies, through counsel, began to exchange increasingly heated letters accusing the other of being the first to breach the terms of the

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[48] The PowerPoint presentation prepared for the July 11, 2016 Anthem Board meeting contains such dour pronouncements as: "Day 1 scope minimized due to delayed engagement model; 40% of minimized scope completed; remainder needs strong collaboration NOW." "Talent selection process not allowed to proceed." "Culture work stalled – Leadership team beginning with (L2) not named." "Focus limited to only High Level G&A; full scope G&A targets and plans limited to Anthem without full risk mitigation plan." DX 712.

merger agreement. PX 16; PX 17; PX 18; PX 19; PX 20.

All of these circumstances impair the Court's ability to credit the total estimated network cost savings and G&A efficiencies. Anthem's former CFO Wayne DeVeydt testified that having the leadership in place is fundamental to undertaking an integration, *see* DeVeydt Tr. 1695, 1701, but the two firms here have not yet agreed on the identity of a single member of the new company's management structure beyond naming the "NewCo" President (Anthem's Swedish) and CEO (Cigna's Cordani). Swedish Tr. 367–68; DX 712. And even that basic allocation of authority has not been fully negotiated; the parties have been at odds since March of 2016 over Swedish's proposed diminution of Cordani's span of control. PX 4.

What's more, Anthem's own leadership has predicted that given those circumstances, it may be extremely difficult to get back on track. In December of 2015, the Anthem CEO warned his counterpart at Cigna, "[h]ow we integrate our companies based on the pre-close efforts will dictate whether we can capture and realize the expected value for our members and shareholders." PX 1. He made the same point in a presentation to the Anthem Board seven months later pointing to notable large acquisitions that had failed in the past: "[i]nsufficient collaboration and misalignment between acquirers and targets have [been] shown to erode value." DX 712. So Anthem is hard pressed to argue that a green light from the Court will be sufficient to cure the problems caused by the disruption in the integration effort.

Anthem internal documents detail the highly unfinished nature of the planning to capture the G&A efficiencies in particular; the Board was told in July of 2016 that the focus is "limited to only high level G&A." DX 712. Meanwhile, the final quantification of the synergies, the development of detailed implementation plans, and the establishment of an organizational structure remain in abeyance. DX 712. Plaintiffs' economic expert, Dr. Dranove, found flaws in Anthem's methodology and set forth a number of reasons to be skeptical about the result of the calculations of the savings. Dranove Tr. 2324. But it is not necessary to delve into them in much detail since even under Dr. Israel's calculations, the claimed savings would not be sufficient to offset the anticompetitive effects if one does not include the medical cost savings in the total. Dranove Tr. 2285–86.

With respect to the projected medical cost savings, the numbers may be based on some actual claims data, but Anthem has yet to detail a plan for how to achieve those savings for Cigna customers. Matheis (Anthem) Tr. 1598–99; Drozdowski (Anthem) Tr. 1672–73; *see* DX 712 (firms still need to "[a]lign on provider contracting strategy and medical management policy"). Similarly, the company only has a "general plan" for coming into compliance with the best efforts rules; "it ultimately requires some input from Cigna and some confidential information from Cigna." Schlegel (Anthem) Tr. 1413. These obstacles leave the Cigna personnel, and even some Anthem executives, pessimistic about the outcome. PX 722; *see also* PX 75 (July 17, 2015 email from Anthem Senior Vice President Douglas Wemmers to Joe Swedish noting the conflict between Anthem's

stated plans to increase provider collaboration and to "drop the hammer" on providers with lower rates, and expressing concerns that NewCo "will not be as effective or fast moving" as originally envisioned).

This evidence also suggests that the "Cigna product at the Anthem price" or "best of both worlds" scenario touted by Anthem and Dr. Israel, *see, e.g.*, DeVeydt (Anthem) Tr. 1697–98, Israel Tr. 1946–48, is a dubious proposition.[49] Anthem's own witnesses recognized that there are reasons to doubt that providers will be willing to engage in the collaborative efforts embodied in their contracts with Cigna if they are forced to accept lower Anthem rates at the same time. Matheis (Anthem) Tr. 1602 (invoking the affiliate clause will cause "provider abrasion," making collaboration more difficult in the short run); *see also* Drozdowski Tr. 1666 (acknowledging the expected "enhanced tension with the provider"); PX 89. So this key tool of the integration strategy is inconsistent with the harmonious picture of the merged company's future that Anthem has endeavored to paint throughout the trial.

Anthem's planned rebranding efforts also run counter to its optimistic predictions. The testimony of the CEO of Cigna, David Cordani, inflicted

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[49] While Anthem's Schlegel described rebranding as "the opportunity to have a Blue-branded Cigna product," and he made the claim that Cigna customers would "enjoy the exact same benefits and services they're getting" today, he acknowledged that the customers would lose the Cigna provider network and cost structure, and that "you would have to meld some of that together . . . utilizing our contracts and utilizing our licenses." Schlegel (Anthem) Tr. 1430.

significant damage on the synergies defense when he advanced his opinion that both rebranding Cigna customers and imposing lower fee structures would unravel the collaborative relationships with providers that are essential to accountable care and better clinical outcomes. Cordani Tr. 492–93.

Cordani explained that given the rate and the amount that healthcare costs have been rising, the healthcare industry recognized that it had to change. In his view, the approach could not be limited to lowering the cost of care when a patient got sick – the effort had to be refocused on encouraging and sustaining health.

> We have essentially 17 percent of the GDP is being expended on health care, so we could either continue to just pay when people get sick or we could add to that and try to help people avoid being sick in the first place. We could try to optimize the outcomes when somebody's dealing with a chronic disease, to make it a more manageable, high-quality outcome. And that's both better quality of life for the person, but a lower cost event.

Cordani (Cigna) Tr. 393.[50] This shift is part of a growing trend in the industry, *see* Abbott (WTW)

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[50] This approach includes engaging with individual members so that they can become more actively aware of how their behavior and lifestyle can affect their health, and offering diagnostic screenings for free to an employer's entire workforce, as well as collaborating on the provider side of the relationship. Cordani explained that such an accountable care arrangement can include placing nurses in doctors' offices so that medical professionals can spend the necessary time with patients explaining their diagnoses and how to manage them, or notifying doctors when their patients are not refilling their prescriptions on schedule

Tr. 96–97, Swedish Tr. 283, and Cigna has endeavored to differentiate itself and become more competitive with a two-sided model that engages both the customer and the provider around these issues, with an emphasis on customer satisfaction and clinical program quality.[51] Cigna identifies its

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and are therefore at greater risk of experiencing complications. Cordani (Cigna) Tr. 393–97, 442–43 (reducing emergency room visits for asthma patients by ensuring they use controller therapies). Rachel Rowe of Granite Health testified that since 2012, her hospital consortium has had an ACO value-based overlay contract with Cigna aimed at population health. The collaboration involves care coordination and the sharing of raw patient data which can be analyzed to identify opportunities to reduce unexplained variations in medical practice. Cigna and Granite Health worked together to develop the shared services model and identify the particular metrics that would make the biggest difference in how patients are treated. Cigna pays a per-patient per-month care coordination fee separate and apart for any fees charged for specific services, and it funds a pool that the provider may share if it achieves its medical cost and quality goals. Rowe (Granite Health) Tr. 2807–15.

[51] There was certainly evidence adduced to show that Anthem is also very involved in the health insurance industry's transition from a pure fee-for-service model to a more value-based approach, and that its numbers of value based or ACO arrangements are growing. *See, e.g.*, Swedish (Anthem) Tr. 295–98; Drozdowski (Anthem) Tr. 1638; Dranove Tr. 975–77; Kehaly (Anthem) Dep. 113–16, 118–22. But the testimony revealed that at this time, that effort consists largely of incorporating incentive provisions in contracts with healthcare providers that enable the providers to earn financial rewards or kickers when their invoices fall below pre-established targets. *See, e.g.*, Berfiend (IU Health) Tr. 2875–76. This can be a mixed blessing when Anthem insists upon contracts that "rebase," and last year's successes thereby become next year's

accountable care relationships as the centerpiece of this growth strategy, and Cordani maintained that replacing an old structure of remuneration based on volume with a new structure of value based care requires working closely with providers to be sure that the risk is shared and both parties' incentives are aligned. Cordani (Cigna) Tr. 441–50. It also requires a consistent delivery of volume to those providers in order to be sustained.

Therefore, Cordani voiced concerns that a post-merger Blue Bias strategy to rebrand Cigna lives – especially if it included lives outside the fourteen states as part and parcel of the rebranding of their employers headquartered within the fourteen states – would reduce the volume Cigna could bring to its providers. Cordani (Cigna) Tr. 447. This would, according to Cordani, "dramatically unwind" Cigna's collaborative relationships, and rapidly destroy the Cigna value proposition, diminishing Cigna's prospects for growth in the non-Anthem states and weakening its offerings to its existing customers.

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targets. Berfiend Tr. 2876. The providers who testified in the second phase of the trial also described a very different attitude on the part of Anthem towards the data sharing necessary for collaborative care as well as a lack of meaningful consultation in establishing the operative medical cost and quality goals. Compared to Cigna's individually negotiated model, Anthem's value based program was depicted as more of a take it or leave it option. Berfiend (IU Health) Tr. 2877–89; *see also* Hurst (Piedmont) Dep. 39–41 (Cigna is the most collaborative of the commercial payers in terms of setting quality based targets).

Cordani Tr. 492–93.[52] It would also diminish Cigna's ability to innovate.

Even if one discounts the Cordani testimony in recognition of the fact that a certain amount of marketing, along with some positioning for potential breach litigation, was on display on the part of both companies in the courtroom, it becomes clear when one considers the entire record, including the testimony of consultants, customers, providers, and even Anthem's own experts, that people "like something Cigna offers." Israel Tr. 1842; *id.* at 1841 ("people have indicated today that they like that package of services that Cigna offers"); *see also* Goulet (Anthem) Dep. 87 ("Cigna has a much better clinical presence, a much better process of helping individuals get back to work."). The evidence shows that that the current trend to shift the focus to population health requires an initial investment of resources by the carrier, and providers have been quite clear that one cannot ask them to do more but pay them less at the same time. Therefore, the Anthem prediction that the merger will make the Cigna product available to more customers at a lower cost – "it's the opportunity to have a Blue-branded Cigna product, if you will, the customer may enjoy the exact same benefits and services they're getting currently today . . . it's just it would happen that their ID cards would be a Blue-branded ID card"

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[52] Ken Goulet, the former Anthem President of Commercial and Specialty Business, also predicted that Cigna provider discounts would deteriorate over time for any customers who chose to remain with the Cigna brand due to the migration of volume away from those providers. Goulet (Anthem) Dep. 138.

Schlegel (Anthem) Tr. 1430 – is an oversimplification that is not supported by the evidence. *See* Cordani (Cigna) Tr. 437 ("[C]ertain of the service offerings that we have for our clients are enabled on technologies that have been built over time. They just can't be plugged and played into a different technology."). So this aspect of the efficiencies defense remains unverified, because a Cigna product with a Blue label on it is not the Cigna product anymore.

3. It is questionable whether the medical cost savings can rebut the prima facie case since there is no evidence of "efficiencies" created in the relevant market.

The nature of the defense in this case has raised an additional question: what is an "efficiency," anyway?

The Merriam Webster dictionary defines efficiency (not "an" efficiency) as: "effective operation as measured by a comparison of production with cost (as in energy, time, and money)." The Merger Commentary describes a merger-specific efficiency as something "that enables the combined firm to achieve lower costs for a given quantity and quality of product." Merger Commentary § 4; *see also id.* ("Merging parties may reduce *their costs* by combining complementary assets, eliminating duplicate activities, or achieving scale economies. . . . [S]ufficiently large reductions in the marginal *costs of producing and selling the products of one or both of the merging firms* may eliminate the unilateral incentive to raise prices that the merger might otherwise have created.") (emphasis added). But the

medical cost savings that are being touted here do not relate to *the new company's* ability to produce anything, and they do not derive from a reduction of the new company's costs, or result in a reduction of the price of the new firm's products.

From the very start of the national accounts phase of the trial, Anthem emphasized that these defendants do not sell "health insurance" – they sell ASO. Under the circumstances that pertain to national accounts and ASO arrangements, the medical costs are not "costs" paid upstream by the insurers to "produce" anything that is sold downstream – the carriers do not pay them at all. They are paid directly out of the customers' bank accounts. This means that while the total healthcare cost that a national account customer will incur at the end of the day may be reduced if the network savings can actually be realized, there is no evidence that the merger will enable the combined firm to offer the only "product" it sells in the relevant market – that is, claims administration, claims adjudication, etc. – at a lower price because its own "costs" are going to be reduced. The "product" being sold is not the employer's entire healthcare spend – ASO is only one portion of that expenditure – and Anthem is not arguing that either its costs of production or the price of what *it* is selling will go down.[53]

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[53] Certainly, *access* to a network that offers the customer's desired attributes is something that insurers are selling. But that "product" – the network access, combined with the claims administration – is factored into and paid for by the ASO fees; the fees paid to the providers are not part of the insurers' "costs" that get factored into their "product," *i.e.*,

The Court is not aware of any reported case in which any court has found that the anticompetitive effects of a merger were outweighed by the combined firm's ability to buy supplies more cheaply due to its size (and therefore to produce or sell something at a lower cost), although there are hints in the Horizontal Merger Guidelines and the case law that those circumstances could qualify as an efficiency under some circumstances. *See* Guidelines §12; *see also Staples I*, 970 F. Supp. at 1089–90.

In the 1997 Staples and Office Depot merger case, the defendants argued that as their suppliers grew more efficient due to the increased sales volume attributable to the merged retailers, they would be able to lower prices, and the combined company would pass these savings on to its customers. *Staples I*, 970 F. Supp. at 1089. The court rejected this and other claimed efficiencies because it did not find the defendants' methodology to be reliable, or the evidence concerning the amount of the savings or the pass through rate to be credible. *Id.* at 1089–90.[54] But it appeared to accept the proposition that some verifiable savings based on obtaining better prices from vendors could be considered to be merger-specific.

Even if increased purchasing power on the supply side can be viewed as an efficiency in some

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the medical coverage. They are simply part of the *customers'* costs – their total healthcare spend.

[54] The *Staples* court also objected to the fact that the parties had included in their calculation price reductions that they would have received from suppliers separately and therefore, were not merger-specific. *Staples I*, 970 F. Supp. at 1090.

scenarios, the facts of this case do not fit the paradigm. The defendants are not making the argument advanced in *Staples*; they are not saying the providers themselves will become more efficient by virtue of the new combined volume – the calculations are based on the volume the providers already serve. And the claimed savings are not attributed to production by healthcare providers at a lower cost either. It will still take the same amount of energy, time, or money for providers to treat the patients. *See* Berfiend (IU Health) Tr. 2873; Atwood (Stanford Health) Dep. 25–26 (stating that "there is no difference in the cost that it takes the physician or the provider to provide services to the same patients" whether they are covered by Anthem or Cigna). And at most, there will only be small transactional savings realized when a provider contracts with one carrier instead of two. Brendt (Sutter Health Plus) Dep. 120.

So while the Court has ruled that the claimed efficiencies fail as a defense because they are not merger-specific and a substantial portion are not verifiable, it also has serious doubts about whether they fall within the category of efficiencies at all. The promised reduction in customers' total medical costs does not result from either company doing anything better, or from the elimination of duplication or the creation of new demand. It does not result from the carriers' or the providers' operating more efficiently, and there has been no showing that the merger will result in increased output or enhanced quality at the same cost. There is also reason to question whether the combined firm will be producing "a given quality and quantity" at a lower cost as the Merger Commentary specifies, or whether the quality of the

Cigna offering will in fact degrade. *See* Cordani (Cigna) Tr. 448. There is evidence that suggests that customers and providers are likely to lose the opportunity to choose between contracts that emphasize cost as the number one factor and those that are more focused on the nature of the collaborative offering, and that testimony supplies another reason to reject the defense. *See* Guidelines § 10 ("[P]urported efficiency claims based on lower prices can be undermined if they rest on reductions in product quality or variety that customers value.")

For all of these reasons, the situation here cannot be compared to the "reduction in costs and increase in productivity" that was found to have some limited significance in *Arch Coal*, 329 F. Supp. 2d at 153.

D. The potential buy-side savings do not change the analysis of the merger's competitive effects.

Anthem maintains that the Court should view the evidence of reduced medical costs as a factor to be considered in assessing the overall competitive effect of the merger even if it does not rise to the level of an offsetting efficiency. *See Arch Coal*, 329 F. Supp. 2d at 151. But this does not change the outcome.

First of all, there is reason to doubt that the claimed savings will be entirely passed on to consumers as Anthem has repeatedly ensured the Court that they would. *See* Curran (Def. Counsel) Tr. 40 (opening statement) ("As to the medical cost savings, those are guaranteed to flow through to the ASO customers."). Anthem's internal documents reflect that the company has been actively

considering multiple scenarios for capturing any medical cost savings for itself, and the corporate executives responsible for that exercise listed "pass all savings through to customers" as the last of seven potential options. PX 727; *see also* PX 214; King (Anthem) Tr. 3071–76 (now that Anthem has created value for its ASO customers with its Enhanced Personal Healthcare Program, it can seek to capture some of the savings by raising its ASO fees).

Dr. Israel posited that an insurance company could raise its ASO fees to capture some of the savings, Israel Tr. 4360, and his network savings estimate was calculated based on a 98%, not 100%, pass through. This may be a very small percentage, but it assumes that $48 million of the projected difference will end up in the coffers of the new firm. Since the integration planning is not yet complete, there isno evidentiary basis to draw a conclusion one way or the other about how the merged company will ultimately proceed.

Counsel for Anthem argued at the closing of Phase II that the defining characteristic of an efficiency is "consumer welfare," pointing to that portion of the *Heinz* opinion that cites *University Health*, 938 F. 2d 1206 (1991). Curran (Def. Counsel) Tr. 4888. He stated that the D.C. Circuit's citation of *University Health* "is interesting because *University Health* says when we're analyzing efficiencies, the touchstone is consumer welfare," and he characterized the citation in *Heinz* as an "endorsement" of the consumer welfare test for efficiency. Curran Tr. 4888. But the *University Health* opinion did not say that; the court held that a defendant seeking to overcome the presumption "must demonstrate that the intended acquisition

would result in significant economies and that these economies ultimately would benefit *competition*, and, hence, consumers." 938 F. 2d at 1223 (emphasis added). And *Heinz* quoted that sentence as support for its admonition that "high market concentration levels . . . require, in rebuttal, proof of extraordinary efficiencies," 246 F.3d at 720; it did not mention consumer welfare at all.

There has been no showing made here that the claimed medical cost economies would enhance competition, so *University Health* is inapposite. Moreover, no court has held that a potential general benefit to consumers at the end of the day can negate competitive harm; what precedent there is states precisely the opposite.[55] As the Supreme Court stated in *Philadelphia National Bank*, 374 U.S. at 371, a merger that may substantially lessen competition is not saved because "on some ultimate reckoning of social or economic debits and credits, it may be deemed beneficial." Nor may one justify the loss of competition in one market with an argument that it would countervail market power in another. *Id.* at 370.

That admonition is of particular importance here where there is no evidence that the rates charged by the thousands of providers in Anthem's network – which range from individual family doctors, to sophisticated physician groups and urgent care facilities, and from non-profit, rural, or community hospitals to advanced tertiary care centers and large for-profit hospital "systems" – are inflated due to the providers' market power. There

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[55] *See Knevelbaard Dairies v. Kraft Foods, Inc.*, 232 F.3d 979, 985 (9th Cir. 2000).

was certainly testimony from all sides that medical costs are high and increasing and that the situation is unsustainable, but this trial did not venture into uncovering the causes or cause. Anthem claims that the customer's pocketbook is its number one concern, and it urges the Court to embrace the merger as a means to bring down the rising cost of healthcare in America. That exhortation does not necessarily square with the evidence that Cigna's efforts to reduce utilization are reducing its customers' medical cost trends right now notwithstanding the company's discount disadvantage. And Anthem is not exactly an unbiased observer – the large insurer comes to healthcare economics from the perspective of its own profit-maximizing interest and the interests of its shareholders. What the defense is asking the Court to do is to elevate Anthem's ability to sustain its margins over the need or ability of physicians and hospitals to do the same, and Supreme Court precedent indicates that courts should not be in the business of making policy determinations about the appropriate allocation of healthcare dollars; those are value judgments that are better directed to the legislature. *See Arizona v. Maricopa Cnty Med. Soc.*, 457 U.S. 332, 354–55 (1982).[56] Moreover, these choices certainly cannot be

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[56] Even in *Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922 (1st Cir. 1984), where a court declined to strike down an insurer's restrictions on provider billing practices, in part because it expressed the view that antitrust law is aimed at high prices, not low ones, one circumstance found to "militate strongly . . . against any effort by an antitrust court to supervise the Blue Shield/physician price bargain" was that the cost of medical care "is an area of great complexity where more than solely economic values are at stake." 749 F.2d at 930–31.

made based on this record, which does not begin to supply the evidentiary basis needed to determine whether any, much less all, of the providers are operating so far above their costs that Anthem's hard bargaining can be viewed as a public service. Nor is there sufficient evidence in the record to reach a determination on whether the buying power that would accompany the proposed merger would result in a reduction in the availability or quality of service as plaintiffs have suggested. *See* Pls.' Proposed Findings of Fact: Phase I ¶¶ 399, 401.

Finally, if consumer benefit is indeed the touchstone, there is ample evidence in the record that the merger would harm consumers by reducing or weakening the Cigna value based offerings which aim to reduce medical costs by reducing utilization and by engaging with, rather than simply reducing the fees paid to, providers. For instance, for instance, Rachel Rowe, the President and CEO of New Hampshire's hospital consortium, Granite Health, agreed that the Cigna value-based program has working well for the Cigna patients and "achieving savings." Rowe Tr. 2827. "The Cigna Collaborative Accountable Care Agreement that we've had in place for four, almost five years is important to us. It's been important to our providers; important for our patients; important for Granite Health. . . . [It] has really been foundational to our population health management program." Rowe Tr. 2827–28. She added that losing it "would be a problem for our chief medical officer group in understanding, really, how we care for the majority of our commercial patients across Granite Health." Rowe Tr. 2828.

Since the Court has determined that the claimed medical cost efficiencies are not sufficiently

merger-specific or verifiable to offset the anticompetitive effects of the merger, and that the government has carried its burden to demonstrate that there is a substantial likelihood of an effect on competition if the merger proceeds, it need not reach the third question posed by the complaint: whether the merger should be enjoined on the grounds that it would create a monopsony on the buying side of the equation. But since the efficiencies defense is based not on any economies of scale, reduced transaction costs, or production efficiencies that will be achieved by either the carriers or the providers due to the combination of the two enterprises, but rather on Anthem's ability to exercise the muscle it has already obtained by virtue of its size, with no corresponding increase in value or output, the scenario seems better characterized as an application of market power rather than a cognizable beneficial effect of the merger. As Dr. Israel candidly put it, his calculations "quantify the benefit of being a larger insurer." Israel Tr. 1880–81.[57]

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[57] *See also* Israel Tr. 4413 (the implication of the economic model is that "bigger players get better prices."). Here there can be no argument that when the expert talks about "bigger," he means greater market share: he was talking about the ability to deliver more patient volume to providers, and increased patient volume is exactly the same thing as increased market share since the denominator of the market share fraction is the number of insured lives. The total number of patients to be covered in the marketplace is fixed, and there will not be increased demand.

V. The merger is also likely to cause anticompetitive harm in the market for the sale of medical insurance coverage to large group employers.

Plaintiffs' second claim is that the market for the sale of commercial insurance to large group employers in thirty-five local markets will be harmed by the merger. Compl. ¶¶ 38–50. Phase two of the trial addressed this claim, and plaintiffs focused their presentation in the courtroom on five of those local markets: Portland, Maine; the New Hampshire markets; Richmond, Virginia; Indianapolis, Indiana; and northern California. The Court concludes that the merger is likely to lessen competition substantially in Richmond, Virginia at least, and it does not reach any of the other markets.

A. Plaintiffs have met their initial burden to show that the merger is presumptively anticompetitive in the Richmond, Virginia market.

1. Relevant market

Product Market: Plaintiffs allege a product market of health insurance sold to large group employers. Compl. ¶¶ 39–40. State statutes distinguish between "small group" and "large group" employers. In forty-six states, a small group employer is defined as an employer with two to fifty employees. Bailey Dep. 59–60; Goulet (Anthem) Dep. 15. In California, Colorado, New York, and Vermont, a small group employer is defined as an employer having between two and 100 employees. Bailey Dep. 59. Employers with more than fifty or 100 employees, respectively, are considered "large group" employers. Goulet (Anthem) Dep. 16.

The defense asserts that this product market is improper because it includes the national accounts that are at issue in plaintiffs' first claim. *See* Defs.' Pretrial Brief [Dkt. 324] at 6.[58] But the industry recognizes a clear distinction between small group and all large group insurance since small group insurance is defined by state regulation and subject to state and federal statutes. *See, e.g.*, Bailey Dep. 59; King Tr. 3040. The fact that the Court found insurance sold to national accounts to be a valid product market in the first part of the case does not preclude it from finding insurance sold to the entire set of large groups to be a separate valid product market. *See Brown Shoe*, 370 U.S. at 325 (within a product market, "well-defined submarkets may exist which, in themselves, constitute product markets for antitrust purposes"), citing *E.I. du Pont de Nemours & Co.,* 353 U.S. at 593–95. Accordingly, the Court finds that the relevant product market is appropriate.

Geographic Market: The defense also challenges the delineation of the thirty-five geographic markets. There is no dispute that, as it was often stated in this case, "healthcare is local." *See, e.g.*, Dranove Tr. 3785. Employers purchase coverage with access to providers where their employees live and work. *See, e.g.*, Guertin (Anthem) Tr. 3582–83; Rothermel (Anthem) Tr. 4150–51;

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[58] The defense also argues that combining both fully-insured and ASO plans in the product market is invalid. *See* Defs.' Pretrial Brief at 6; Israel Tr. 4444. As set forth below, however, plaintiffs presented market share and concentration calculations for Anthem and ASO business separately.

Kendrick (Anthem) Tr. 1181–82. But the defense insists that plaintiffs' local markets were too tightly drawn, and it maintains that they do not properly account for patient travel patterns. Fowdur Tr. 4202–06.

Plaintiffs used Core-Based Statistical Areas or "CBSAs" to define their thirty-five local geographic markets. Dranove Tr. 4754. CBSAs, which are "aggregations of zipcodes," Willig Tr. 3710, were developed by the Office of Management and Budget and are geographic areas that the federal government uses for a variety of purposes. *See Bellevue Hosp. Ctr. v. Leavitt*, 443 F.3d 163, 167 (2d Cir. 2006) (upholding the use of MSAs by the Department of Health and Human Services in calculating Medicare payments to hospitals); *Miss. Comm'n on Envtl. Quality v. EPA*, 790 F.3d 138, 147–48 (D.C. Cir. 2015) (EPA guidance recommending CBSAs as an option for geographic boundaries used in regulating certain air quality standards). CBSA replaced MSAs after the 2000 census and "are roughly equivalent to the previous groupings." *Lawrence & Mem'l Hosp. v. Sebelius*, 986 F. Supp. 2d 124, 128 (D. Conn. 2013). Both groupings "are based on census data and use counties as building blocks to roughly approximate the local labor market." *Id.* at 127–28.

In the healthcare insurance industry, MSAs are "an agreed-upon geographic basis that is well defined both for employers, [consultants], and for the health plans." Abbott (WTW) Tr. 107. The industry uses them in the ordinary course of business when examining local markets. For example, consultants use them when analyzing provider discounts, *id.* at 107–08, and Anthem and Cigna use them to analyze

where members live and work to understand their access to healthcare. Weber Dep. 27–28; Thackeray (Cigna) Tr. 722; *see also* Cordani Tr. 409–12 (Cigna evaluates MSAs, "which are essentially cities," to identify where to place more resources).

The defendants argues that the geographic markets in Phase II are too small, but these complaints ring somewhat hollow in light of their insistence that the geographic market in Phase I was too big because it did not accord sufficient attention to firms that might be of significance on a regional or local basis. Dr. Fowdur testified that Dr. Dranove did not conduct a proper SSNIP test for each geographic market to determine if a price increase by the hypothetical monopolist could be "defeated by substitution, for example, by customers in the region traveling outside of that region to purchase the relevant product." Fowdur Tr. 4211–12. She provided data in connection with the New Hampshire markets identified in the complaint that patients often travelled within the small state to larger cities nearby for visits to physicians or access to hospital services. Fowdur Tr. 4205; DDX 493 at 12. But the patients are not the "customers;" their employers are. So it is the response of employers, not patient travel patterns, that is relevant here. *See Penn State Hershey Med. Ctr.*, 838 F.3d at 338–46 (geographic market based on a patient flow data in a hospital merger case failed to "account for the likely response of insurers in the face of a SSNIP").[59]

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[59] Furthermore, Dr. Fowdur did not even attempt to present evidence that enough people would brave the traffic between Richmond and Washington, DC to make northern Virginia providers a real part of the competitive picture,

The Court finds that plaintiffs' use of CBSAs to outline their thirty-five relevant geographic markets is "economically significant" and corresponds to "commercial realities." *Brown Shoe*, 370 U.S. at 336–37. Dr. Dranove testified that he defined the relevant market for large groups in the same manner that he did for the national accounts market, to include all types of commercial health insurance plans, products, and funding arrangements. Dranove Tr. 3695. He further testified that large group employers faced with an SSNIP could respond by forgoing the purchase of group health insurance altogether, directly contracting with providers, or shrinking their employee base so they become eligible to purchase small group coverage. *Id.* He testified these options are not viable. *See* Dranove Tr. 861, 3695. Moreover, there is no evidence that a large group would reduce its employee base in response to an SSNIP.[60]

The Court holds that the thirty-five geographic markets approximate the geographic

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and the providers she mentioned in Lynchburg and the Tidewater area are also too far to the east or the west of Richmond's central location to make a difference either.

[60] To confirm his conclusion, he utilized a critical elasticity approach and calculated the critical elasticity to be 1.18, which means that a 5% price increase by a hypothetical monopolist would become unprofitable if it resulted the loss of 6% of its business or more. Dranove Tr. 3695–97. Relying on the same academic literature he used in his analysis of national accounts, Dr. Dranove found that employers do not drop their coverage, and the estimated actual elasticity is much lower than the critical elasticity – "implying, as our intuition would tell us, that in response to a 5 percent increase in insurance premiums, these employers are not going to stop purchasing insurance." Dranove Tr. 3697.

areas the industry uses when analyzing local markets for medical services and were drawn in a way that does not diminish the role of regional and local players that could serve as reasonable options. Accordingly, they are valid relevant geographic markets.

2. Market share and concentration establish the presumption.

Dr. Dranove measured shares in the large group segment using the number of enrollees residing within each CBSA, Dranove Tr. 3709–10, which is how insurers typically measure their own large group market shares. *See, e.g.*, PX 603; Tallman (Centene) Dep. 31. For each CBSA, the numerator in Dr. Dranove's calculation is the number of a particular insurer's large group enrollees in the CBSA, and the denominator is an estimate of the total number of large group enrollees who reside in the CBSA. Dranove Tr. 3710, 3712. As he did for national accounts, Dr. Dranove used both a census and a build-up and approach to calculate this number and then used the larger in his market share denominator. Dranove Tr. 3710.[61]

Combining Anthem with the other Blues and combining ASO with fully-insured products, Dr. Dranove calculated Anthem's market share in Richmond to be 65% and Cigna's 13%, for a combined share of 78%. PX 751. The pre-merger HHI for

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[61] The Court notes that in the ordinary course of business, Anthem calculates market share similarly to the census approach. *See* PX 567 (calculating state commercial market share by dividing group membership resident in the state by the census's estimate of the number of individuals insured on an employer sponsored basis in the state).

Richmond is already quite high – 4594 – and after the merger, it would reach level of 6277, reflecting a change of 1683, both of which are well in excess of what the Guidelines would deem to be presumptively unlawful. PX 751; *see also* App. A to Pls.' Proposed Findings of Fact: Phase II [Dkt. 483] (depicting the market shares and HHI data appearing in PX 751 as bar graphs) ("Phase 2 App. A").

Dr. Dranove also anticipated some of Anthem's objections, and he calculated what Anthem's share would be alone, without including any lives covered by the rest of the Blues. When both ASO and fully-insured products are combined, the results of a combination are still presumptively anticompetitive: Anthem's market share in Richmond is 53%, Cigna's is 13%, and their combined share is 66%. The pre-merger HHI is 3190, and the post-merger HHI will be 4561, with a change of 1371. PX 751; Phase 2 App. A.

What if you take fully insured plans out of the picture? This is not necessary since they become more prevalent at the smaller end of the large group spectrum and represent part of the Phase II product market, but calculating market shares in that manner would not save the day in any event. Combining the Blues as a single competitor and looking at ASO only, the market shares in Richmond are 61% for Anthem and 16% for Cigna, leading to a combined share of 77%. The pre-merger HHI is 4227, and the post-merger HHI would be 6145, with a difference of 1918. PX 751; Phase 2 App. A.

Finally, calculating Anthem's share separately from the rest of the Blues and looking at only the ASO market, Anthem's market share in Richmond

remains substantial, at 48%, Cigna's is 16%, and their combined share would be 64%. The pre-merger HHI is 2840, and the post-merger HHI increases to 4350, with a change of 1511. PX 751; Phase 2 App. A.

The defense criticizes these calculations because the data the expert used did not extend beyond January 2015, and because he supplemented the CID data obtained directly from the carriers with data from industry sources – HealthLeaders and Mark Farrah – that defendants claim is deficient in various ways.[62] But the Court notes that the defense itself cites HealthLeaders data. Willig Tr. 4566–70 (using HealthLeaders data to identify entrants in the market). Also, Dr. Dranove turned to the Mark Farrah database for only 3% of his enrollment numbers. Dranove Tr. 704. Finally, the shares Dr. Dranove calculated are consistent with testimony from industry participants that Anthem has the largest share of the market in Richmond. *See, e.g.*, Hilbert (Optima) Dep. 83 (Anthem has more than 50% share in Richmond); *see also* Hawthorne (Scott Insurance) Tr. 2989 (stating that he has more clients with Anthem and Cigna than any other insurer); PX 424.

Even if the data Dr. Dranove used for his calculations was not perfect, the resulting market share and concentration figures were sufficiently large in the Richmond CBSA to be unaffected by

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[62] The defense also criticizes the numbers because Dr. Dranove's build-up approach did not include other carriers or any TPAs and because he combined the market shares of the other Blues for some of the calculations. But the Court rejects these arguments for the same reasons it gave when they were made with respect to the national accounts claim. *See* section I.B. above.

minor discrepancies. Since the expert's determinations comport with the other evidence describing the market and appear to closely approximate market conditions as required by law, the Court finds that plaintiffs have established their prima facie case for the Richmond market.

B. Defendants' rebuttal evidence

In Phase II, the defense presented some evidence related to each of the 35 markets, including evidence showing that there are new entrants in New Hampshire and Indiana positioned to be successful, *see* Rowe (Granite Health) Tr. 2852; Berfiend (IU Health) Tr. 2860, and that the market is somewhat less concentrated in those states and in California, where there is a more active presence of another Blue licenses, along with TPAs, and Kaiser. PX 751. With respect to Richmond in particular, defendants presented evidence to show that Dr. Dranove's calculations overstate Anthem's market share because Anthem participates in the Federal Employee Program, which accounts for about 20% of Anthem's total commercial enrollment in Richmond. PX 419; *see also* Dranove Tr. 3840. It also presented evidence about other competitors in the state that may be able to serve customers in Richmond, pointing to carriers and other alternative sellers of group insurance in Lynchburg, the Virginia Beach/Tidewater area, and northern Virginia.

Because only an evidentiary "showing" is necessary to shift the burden back to plaintiffs, *Marine Bancorporation,* 418 U.S. at 631, the Court must go on to consider whether plaintiffs have met their ultimate burden of persuasion.

C. Plaintiffs have carried their burden to establish that the merger is likely to harm competition in the Richmond market.

Plaintiffs have presented sufficient evidence to show anticompetitive harm from the merger in the Richmond, Virginia market for large group insurance. The Richmond market topped or came in second on the list of thirty-five markets on every measure of market share or concentration, whether calculated with or without the other Blues, and whether calculated including both ASO and fully insured plans or only ASO. PX 751; Phase 2 App. A.

Anthem witnesses did little to refute these undeniable statistics. Burke King, the President of Anthem Virginia, testified that Anthem is the largest health insurer in Virginia across individual, small group, and large group segments, and that it has the highest market share. Burke (Anthem) Tr. 3041. He admitted that Anthem competes head-to-head with Cigna in Richmond, and that Cigna is the second strongest player in that market. Burke Tr. 3043–44. King also worked to advance what appeared to be a well-rehearsed Anthem motif that the company does not view Cigna as a strong competitive threat, King Tr. 3042–43, *see also, e.g.*, Rothermel (Anthem California) Tr. 4091, 4092–93, 4107; Guertin (Anthem New Hampshire) Tr. 3485–87, 3512, but this testimony was not credible, as it was contradicted by numerous Anthem documents referring to Cigna as one of Anthem's closest competitors. *See* King Tr. 3046 (discussing PX 579),

Rothermel Tr. 4125–29 (discussing PX 737); Guertin Tr. 3484 (discussing PX 734).[63]

Further, the defense evidence did not do much to show that other players in and around the Richmond market will provide the necessary competition to overcome the anticompetitive effects of the merger in that market. First, the Court finds unpersuasive the defense's arguments that competitors outside the Richmond market will affect competition in the market. As one Virginia-based broker testified, his Richmond-based clients want a network with providers conveniently located near where their employees live, and they would not find a network with providers only in northern Virginia to be attractive. Hawthorne (Scott Insurance) Tr. 2982–3.

Further, the firms that the defense identified do not appear interested in entering the Richmond market or able to compete at a level that could dull the merger's anticompetitive effects. Piedmont Community Health Care is a small health plan owned by a Lynchburg-based provider Centra that does not compete or have members in Richmond, and is not looking to expand into Richmond. Adams (Centra) Dep. 11–12, 29, 72–73; Hilbert (Optima) Dep. 89; PX 419. [TEXT REDACTED BY THE COURT] is an insurer [TEXT REDACTED BY THE

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[63] King tried to dull the impact of the expert testimony and described the tracking of market share to be "an inexact science." King Tr. 3014. Other Anthem witnesses went further but did not advance the cause when they professed – somewhat incredibly and contrary to their ordinary course records – that they do not pay much attention to market shares at all. Rothermel (Anthem) Tr. 4111–14; Guertin (Anthem) Tr. 3486–87.

COURT] Dep. 11–12. Although [TEXT REDACTED BY THE COURT] has membership in Richmond, it does not appear able to compete on the same field as the merged company. *See* [TEXT REDACTED BY THE COURT] Dep. 79–80, 91–92, 98. Wheeler (Bon Secours) Tr. 3398 ([TEXT REDACTED BY THE COURT] has "struggled in the Richmond marketplace relative to their home base"). Bon Secours, a large health system in Richmond, does not sell insurance and its executive explained that it does not have a provider-sponsored plan. Wheeler (Bon Secours) Tr. 3404–06. Innovation Health and Gateway Health are insurers that operate elsewhere in Virginia, but not in Richmond. Henderson (Innovation Health) Dep. 52, 157; Jackson (Gateway) Dep. 50–51, 61. Although [TEXT REDACTED BY THE COURT], has approached [TEXT REDACTED BY THE COURT] about expanding [TEXT REDACTED BY THE COURT] into the [TEXT REDACTED BY THE COURT] market, there is no evidence that [TEXT REDACTED BY THE COURT], much less that the entry would be sufficiently imminent to counteract the effects of the merger in a timely manner. Further, Gateway Health has no plans to enter the Richmond market. Jackson (Gateway) Dep. 28, 50–52, 61–62, 66, 76–77.

Finally, using the same types of merger simulation and UPP models that he used to analyze the national accounts market, Dranove Tr. 3734, Dr. Dranove calculated the static harm for the large group market and found that the merger would result in aggregate harm for all thirty-five local markets and in the Richmond market alone. Dranove Tr. 3734–39, PX 752. Significantly, he testified that even if he factored 100% of Dr. Israel's claimed

efficiencies into his analysis, the merger would still have an anticompetitive effect in the Richmond market. Dranove Tr. 4736–38 (discussing PX 760).

In light of this evidence, the Court holds that plaintiffs have met their burden to prove by a preponderance of the evidence that the merger will have anticompetitive effects on the Richmond, Virginia market for the sale of large group health insurance.

CONCLUSION

Because the effect of Anthem's acquisition of Cigna may be substantially to lessen competition in the market for the sale of medical health insurance to national accounts in the fourteen Anthem states and the sale of medical insurance to large group employers in the Richmond, Virginia CBSA, the Court will enjoin the merger.

A separate order will issue.

/s/ Amy B. Jackson
AMY BERMAN JACKSON
United States District Judge

DATE: February 8, 2017

APPENDIX D

§ 18. Acquisition by one corporation of stock of another

No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

No person shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of one or more persons engaged in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition, of such stocks or assets, or of the use of such stock by the voting or granting of proxies or otherwise, may be substantially to lessen competition, or to tend to create a monopoly.

This section shall not apply to persons purchasing such stock solely for investment and not using the same by voting or otherwise to bring about, or in attempting to bring about, the substantial lessening of competition. Nor shall anything contained in this

section prevent a corporation engaged in commerce or in any activity affecting commerce from causing the formation of subsidiary corporations for the actual carrying on of their immediate lawful business, or the natural and legitimate branches or extensions thereof, or from owning and holding all or a part of the stock of such subsidiary corporations, when the effect of such formation is not to substantially lessen competition.

Nor shall anything herein contained be construed to prohibit any common carrier subject to the laws to regulate commerce from aiding in the construction of branches or short lines so located as to become feeders to the main line of the company so aiding in such construction or from acquiring or owning all or any part of the stock of such branch lines, nor to prevent any such common carrier from acquiring and owning all or any part of the stock of a branch or short line constructed by an independent company where there is no substantial competition between the company owning the branch line so constructed and the company owning the main line acquiring the property or an interest therein, nor to prevent such common carrier from extending any of its lines through the medium of the acquisition of stock or otherwise of any other common carrier where there is no substantial competition between the company extending its lines and the company whose stock, property, or an interest therein is so acquired.

Nothing contained in this section shall be held to affect or impair any right heretofore legally acquired: *Provided*, That nothing in this section shall be held or construed to authorize or make lawful anything heretofore prohibited or made illegal by the antitrust laws, nor to exempt any person from the penal

provisions thereof or the civil remedies therein provided.

Nothing contained in this section shall apply to transactions duly consummated pursuant to authority given by the Secretary of Transportation, Federal Power Commission, Surface Transportation Board, the Securities and Exchange Commission in the exercise of its jurisdiction under section 79j of this title, the United States Maritime Commission, or the Secretary of Agriculture under any statutory provision vesting such power in such Commission, Board, or Secretary.

APPENDIX E

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA
450 5th Street, NW, Suite 4100
Washington, DC 20530

STATE OF CALIFORNIA
300 South Spring Street, Suite 1720
Los Angeles, CA 90013

STATE OF COLORADO
1300 Broadway, 7th Floor
Denver, CO 80203

STATE OF CONNECTICUT
55 Elm Street, P.O. Box 120
Hartford, CT 06141-0120

DISTRICT OF COLUMBIA
441 4th Street, NW
Washington, DC 20001

STATE OF GEORGIA
40 Capitol Square, SW
Atlanta, GA 30334-1300

STATE OF IOWA
1305 East Walnut Street, 2nd Floor
Des Moines, IA 50319

STATE OF MAINE
6 State House Station

Augusta, ME 04333-0006

STATE OF MARYLAND
200 Saint Paul Place
Baltimore, MD 21202

STATE OF NEW HAMPSHIRE
33 Capitol Street
Concord, NH 03301

STATE OF NEW YORK
120 Broadway
New York, NY 10271-0332
STATE OF TENNESSEE
500 Charlotte Avenue
Nashville, TN 37202

and

COMMONWEALTH OF VIRGINIA
202 North 9th Street
Richmond, VA 23219

Plaintiffs,

v.

ANTHEM, INC.
120 Monument Circle
Indianapolis, IN 46204

and

CIGNA CORP.
900 Cottage Grove Road
Bloomfield, CT 06002

Defendants.

COMPLAINT

The United States of America, acting under the direction of the Attorney General of the United States, and the States of California, Colorado, Connecticut, Georgia, Iowa, Maine, Maryland, New Hampshire, New York, and Tennessee, the Commonwealth of Virginia, and the District of Columbia ("Plaintiff States"), acting by and through their respective Attorneys General, bring this civil antitrust action to prevent Anthem, Inc. from acquiring Cigna Corp.

I. INTRODUCTION

1. Anthem's proposed $54 billion acquisition of Cigna would be the largest merger in the history of the health-insurance industry. It would combine two of the few remaining commercial health-insurance options for businesses and individuals in markets throughout the country. And in doing so, it would substantially lessen competition, harming millions of American consumers, as well as doctors and hospitals

2. The U.S. healthcare system—including commercial health insurance—affects the lives and pocketbooks of virtually every citizen. Each year, Americans visit the doctor or hospital more than a billion times and spend more than $3 trillion on healthcare. Half of all Americans obtain healthcare through their employers, which purchase plans from insurance companies such as Anthem and Cigna. Millions more citizens purchase health insurance on public exchanges established by the Affordable Care Act.

3. Competition among insurance companies like Anthem and Cigna ensures that employers and individuals can purchase high-quality policies at affordable prices. Employers seek competitive bids when selecting plans to offer their employees. Individuals choose among competing insurers when purchasing policies on the public exchanges. And competition is critical for doctors and hospitals who obtain access to most of their commercial health-insurance patients by contracting with insurers to be "in-network" providers.

4. This competition is now at risk. Today, the industry is dominated by five large insurers commonly referred to as "the big five." In a scramble to become even bigger, four of the big five now propose to merge: Anthem seeks to buy Cigna for $54 billion, and Aetna seeks to acquire Humana for $37 billion. These mergers would reshape the industry, eliminating two innovative competitors—Cigna and Humana—at a time when the industry is experimenting with new ways to lower healthcare costs. Other insurers lack the scope and scale to fill this competitive void. As one Anthem executive vice president explained in 2015, this "very consolidated" industry is "really down to a big five and then, it gets much more smaller in terms of players that are available after that." After the mergers, the big five would become the big three, each of which would have almost twice the revenue of the next largest insurer.

5. Today, the United States and a number of states have filed lawsuits in this Court to enjoin both mergers. This complaint seeks to block Anthem's attempt to buy Cigna. If allowed to proceed, this merger would enhance Anthem's power to profit at

the expense of both consumers and the doctors and hospitals providing their medical care.

6. Anthem is the largest member of the Blue Cross and Blue Shield Association. It competes in 14 states as the Blue licensee and partners with other Blue plans to compete throughout the country. Anthem admits in business documents that its share is already "dominant in most of [its] markets," a position that gives it "a clear advantage and provides opportunities to drive margin growth." But Anthem has also earned a reputation in many markets for having poor customer service, being slow to innovate, and being difficult to work with for doctors and hospitals. The president of Anthem's Indiana business conceded, "There are some customers, some prospects who loathe us."

7. Cigna increasingly competes head to head with Anthem by finding innovative ways to lower its customers' medical costs. Cigna offers sophisticated wellness programs that improve the health of its members, provides highly-regarded customer service, and works closely with doctors and hospitals to improve the quality and lower the cost of care. These efforts have been well received by consumers and healthcare providers, pressuring Anthem to respond. Without the merger, Cigna expects to double in size in the next seven to eight years.

8. Anthem's purchase of Cigna would eliminate it as a competitive threat and substantially lessen competition in numerous markets around the country. The harm to competition in any one of these markets is sufficient to enjoin the transaction.

(a) ***National accounts.*** Of the big five, only four insurers offer a nationwide

commercial network sufficient to serve the country's largest employers, known as "national accounts." Anthem, working together with its fellow Blues, is one; Cigna is another. Anthem and Cigna view each other as close competitors for these accounts and have adopted strategies for winning national business from each other.

(b) ***Local commercial markets.*** Anthem and Cigna are often two of few remaining options for large-group employers in at least 35 metropolitan areas, including New York, Los Angeles, San Francisco, Atlanta, and Indianapolis. In some of these areas, Cigna has won most of its new accounts from Anthem, and Anthem has described Cigna as "aggressive" and "our number one competitor."

(c) ***Individual exchanges.*** In at least two metropolitan areas—St. Louis and Denver—Anthem and Cigna are key competitors selling policies to individuals and families on the public exchanges. Cigna has grown rapidly in these markets. For example, in the two years Cigna has participated on the exchange in St. Louis, it has captured nearly 25 percent of the market—with much of that growth coming at Anthem's expense. Without the merger, Cigna plans to continue to expand on the exchanges.

(d) ***Purchase of healthcare services by commercial health insurers.*** Anthem's high market shares already give it significant bargaining leverage with doctors and hospitals. In the same 35 metropolitan areas referenced above, this merger would substantially increase Anthem's ability to dictate the reimbursement rates it pays providers, threatening the availability and quality of medical care. The merger also would deprive both providers and consumers of Cigna's innovative efforts to work cooperatively with providers and enter into "value-based" contracts that reward them for improving patient health and lowering cost.

9. If permitted to proceed, Anthem's purchase of Cigna likely would lead to higher prices and reduced benefits, and would deprive consumers and healthcare providers of the innovation and collaboration necessary to improve care outcomes. Because this merger threatens to reduce competition across the country, it violates Section 7 of the Clayton Act. To prevent this unlawful harm, the Court should enjoin this merger.

II. THE DEFENDANTS AND THE MERGER

10. Anthem competes in all 50 states and the District of Columbia either directly or through the Blue Cross and Blue Shield Association, a joint venture of insurance companies that partner to offer their members access to a nationwide network of healthcare providers. Anthem controls the Blue

license in all or part of 14 states, covering 39 percent of the U.S. population: California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, most of Missouri, Nevada, New Hampshire, parts of New York, Ohio, Virginia (except the DC suburbs), and Wisconsin. In all these states but California and New York, Anthem has the exclusive right to bid for new business under both the Blue Cross and Blue Shield brands. In 2015, Anthem had approximately 39 million members nationwide and earned $78 billion in revenue.

11. Cigna also competes in all 50 states and the District of Columbia. In 2015, it had approximately 13 million U.S. members and earned $38 billion in revenue. Cigna has earned a reputation as an innovator in the industry by developing wellness programs to improve the health of its members and by collaborating with healthcare providers to improve patient health and lower the overall cost of medical care. Cigna has enjoyed compound revenue growth of 13 percent annually over the last six years.

12. 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." Soon after, Anthem began talks to acquire Cigna. The companies were well aware of the competitive problems the deal would create: In October 2014, Cigna's chief financial officer warned the CEO to stop using words like "dominant" and "market share" when analyzing the potential deal because they are "both sensitive words from a post deal review perspective." Anthem and Cigna also realized that the value of their combined company would be limited by the Blue Cross and Blue Shield

Association's "best-efforts" rules, which cap the proportion of revenue that Anthem can earn from brands not affiliated with the Blue network, including Cigna. In February 2015, Anthem's board of directors called off the deal.

13. But just a few months later, Anthem's interest in acquiring Cigna was renewed when Humana began seeking a buyer. This sparked a bidding frenzy in the industry. In a two-month period, Anthem made several bids for Cigna; Cigna made two bids for Humana; UnitedHealthcare made bids for Aetna and Cigna; and Aetna made a bid for Humana, which after only weeks of negotiation resulted in an agreement on July 2, 2015. Just a few weeks later, on July 23, 2015, Anthem agreed to acquire Cigna for $54 billion.

14. Anthem's acquisition of Cigna was contentious from the start. In mid-June 2015, Cigna's board of directors rejected an offer from Anthem in a letter pointing to "a number of major issues," including complications relating to Anthem's membership in the Blue Cross and Blue Shield Association. The insurers also fought publicly about which CEO would lead the combined company. In the months since the agreement was signed, Anthem and Cigna have continued to quarrel over how they should integrate their two companies.

15. Anthem has also been unable to explain how the combined company would address problems created by Anthem's membership in the Blue Cross and Blue Shield Association. For example, Anthem calls other Blue plans "comrades in arms" and works closely with them to win national accounts from Cigna and other insurers. But after this merger,

Anthem would also own Cigna. Anthem would thus be competing with—and against—its fellow "Blues brethren" for the same national accounts. Anthem's CEO testified that he did not know how the company would resolve this conflict of interest.

III. BACKGROUND ON COMMERCIAL HEALTH INSURANCE

16. Anthem and Cigna compete vigorously in the sale of both "large group" and "individual" commercial health insurance. Group insurance sold to employers with more than 50 employees (or in four states, more than 100 employees) is called "large group" insurance. Within large groups, the industry recognizes a subset of the largest employers with employees in more than one state called "national accounts." Most large employers buy self-insured plans (also known as administrative-services-only or "ASO" contracts), under which the employer retains most of the risk of its employees' healthcare costs and pays the insurer an administrative fee for access to the insurer's network of doctors and hospitals and for processing medical claims. For employers of any size, health-insurance costs are a significant expense, and even large employers are increasingly shifting more of the costs of healthcare to their employees. Anthem and Cigna also sell "individual" insurance, which individuals and their families most commonly purchase on the public exchanges.

17. To sell plans to employers and individuals, commercial health insurers compete on price, customer service, care management, wellness programs, and reputation. Insurers also compete on the breadth of their network of healthcare providers,

including doctors and hospitals, as most people seek medical care close to where they live or work.

18. Traditionally, insurance companies reimburse providers on a "fee-for-service" basis whereby providers receive compensation for all, or almost all, services provided. But insurers are increasingly experimenting with—and competing with each other to create—contractual arrangements that reward doctors and hospitals for better health outcomes and lower total costs. Instead of reimbursing providers based solely on the quantity of services they perform, this value-focused movement gives providers incentives to improve their patients' overall health and perform fewer, but more effective, services. Industry participants call these arrangements "provider collaborations" or "value-based arrangements," and refer to this shift in approach as the "volume-to-value" movement. Competition is a key ingredient to the volume-to-value movement's continued success, and Cigna has been particularly innovative in advancing these provider collaborations.

IV. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF HEALTH INSURANCE TO NATIONAL ACCOUNTS

19. Anthem and Cigna vigorously compete against each other to sell commercial health insurance to national accounts. The proposed merger would eliminate that competition and leave national accounts with only three meaningful options.

A. The sale of health insurance to national accounts is a relevant product market.

20. The typical starting point for merger analysis is defining the relevant market. Courts define relevant product markets to help determine which customers are most likely to be affected by the merger. The sale of commercial health insurance to national accounts is one such relevant product market and line of commerce under Section 7 of the Clayton Act.

21. National accounts are distinct customers with unique characteristics. They typically require a provider network covering multiple states; undergo a lengthier, more resource-intensive purchasing process involving requests for proposals; are more likely to hire a large consulting firm to aid them in evaluating and selecting an insurer or insurers; and are more likely to want flexible and customized benefit designs. Anthem and Cigna have dedicated business units focused on selling and marketing to national accounts, and each insurer is able to charge those accounts different prices and offer different plan benefits than they do for other types of accounts.

22. The sale of commercial health insurance to national accounts satisfies the well-accepted "hypothetical monopolist" test set forth in the U.S. Department of Justice and Federal Trade Commission 2010 Horizontal Merger Guidelines. Under the Guidelines, relevant markets may be defined as a group of customers that could be profitably targeted for price increases. A hypothetical monopolist of commercial health

insurance sold to national accounts likely would impose a small but significant and non-transitory price increase because an insufficient number of national accounts would stop purchasing commercial health insurance to make that price increase unprofitable. Because health insurance is a significant employment benefit, and national accounts offer it to recruit and retain highly qualified employees, very few national accounts will stop buying health insurance for their employees in the event of a small but significant price increase. Nor are a sufficient number of national accounts likely to build their own provider networks by contracting directly with doctors and hospitals or attempt to process all of their employees' healthcare claims themselves. And arbitrage (the reselling of a product from one customer to another) is impossible, so national employers could not avoid a price increase by buying health insurance from other employers.

B. This merger would harm national accounts in two relevant geographic markets.

23. The proposed merger would harm national accounts in (1) the parts of the 14 states where Anthem sells under a Blue license; and (2) the United States generally.

(1) The 14 Anthem states are a relevant geographic market.

24. Anthem and Cigna compete directly for national accounts headquartered in the Anthem states, and national accounts headquartered in those states have similar options for health insurance. Therefore, it is appropriate to consider these 14

states together as a single relevant geographic market and section of the country under Section 7 of the Clayton Act.

25. This geographic market satisfies the hypothetical monopolist test. National accounts headquartered in the Anthem states do not have reasonable substitutes to purchasing commercial health insurance from insurers doing business in these states. National accounts would not close their headquarters and move them to different states in response to a small but significant and non-transitory price increase.

(2) The United States is a relevant geographic market.

26. It is also appropriate to consider the United States as a single relevant geographic market and section of the country under Section 7 of the Clayton Act. National accounts headquartered throughout the United States have similar options for health insurance. And, in addition to competing in the 14 Anthem states, Anthem and Cigna compete for national accounts headquartered throughout the rest of the country. Cigna has a nationwide provider network and competes throughout the United States, and Anthem competes for national accounts headquartered in the 36 states in which it does not have a Blue license in at least two ways.

27. First, Anthem bids directly for national accounts headquartered outside its 14 states when other Blue plans "cede" that right to Anthem. The Association's rules generally permit only one Blue plan to bid on an account—the plan holding the license in the territory where the national account is headquartered. For example, only BlueCross

BlueShield of Tennessee can submit a bid for a national account based in Tennessee. But Blue plans can cede that right to each other on an account-by-account basis. Anthem has received hundreds of cedes from its fellow Blue plans.

28. Second, even when Anthem is not ceded an account, it competes indirectly as part of the bid submitted by the local Blue plan. For example, when BlueCross BlueShield of Tennessee bids for a national account based in Nashville, that account evaluates the strength of the Blues' provider network in other states where it has employees, including the 14 states that Anthem's network covers. And Anthem profits when the Tennessee Blue wins the account because Anthem receives "BlueCard fees" when any of that account's employees obtain medical care in Anthem's territories. Because almost 40 percent of the U.S. population lives in the 14 Anthem states, Anthem earns significant BlueCard revenue—$450 million in 2014 alone, much of it from national accounts.

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

C. This merger is presumptively unlawful in both the 14 Anthem states and across the entire United States.

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

31. For national accounts headquartered in the 14 Anthem states, Anthem and Cigna have a combined market share of at least 40 percent. For national accounts in the United States as a whole, Anthem (together with the other Blues) and Cigna have a combined market share of at least 30 percent. In these markets, the merger is presumptively unlawful under Supreme Court precedent and the Merger Guidelines.

32. These measures of market concentration understate the competitive harm likely to result from the proposed merger, in part, because they include so-called "slice" insurers—local insurers that compete for only a portion of a national account's business. Such "slice" insurers cannot compete to fully replace Anthem, Cigna, Aetna, or United Healthcare nationwide. Among national accounts in the 14 Anthem states seeking to buy a nationwide

plan from one of these four insurers, Anthem and Cigna would have a combined market share of at least 50 percent. Among national accounts across the country seeking a nationwide plan from one of these four insurers, Anthem (together with the other Blues) and Cigna would similarly have a combined market share of at least 50 percent.

D. This merger likely would harm national accounts in the Anthem states and throughout the country.

33. In the 14 Anthem states, the proposed merger would combine Anthem and Cigna and thus eliminate Cigna as a competitor for national accounts. Anthem and Cigna have frequently been the two finalists when these national accounts seek competitive bids for commercial health insurance, and those accounts have been able to use the competition between Anthem and Cigna to obtain lower prices and better terms. This merger would end that competition.

34. For example, in a 2013 bid, Anthem feared that Cigna would aggressively market the benefits of its clinical programs, and Anthem ended up lowering its fees to the customer to ward off a competitive bid. In another bid that year, Cigna won what its executives called a "dogfight with Anthem" by offering better overall value to the customer. In 2014, Anthem targeted a longtime Cigna customer as a "good opportunity to continue to pick off Cigna accounts." Anthem made a competitive offer and won the account.

35. Anthem has introduced strategies specifically designed to win national accounts from

Cigna and Aetna, another national rival. For example, Anthem has offered flexible renewal pricing, which allows its sales teams to adjust pricing for accounts in which "Aetna or Cigna is an incumbent for at least one-third of the [account]"; trend guarantees, which cap the rate of increase of medical costs for national customers "where Aetna or Cigna is the alternate carrier and/or the account is significantly increasing [its] clinical offering"; and a "bounty" program that compensated Anthem sales agents who won new accounts from Cigna or Aetna. These and other initiatives reflect Anthem's view that Cigna and Aetna "should not exist."

36. In the 36 non-Anthem states, the proposed merger would also substantially harm competition in at least three ways. First, as explained above, Anthem often competes directly with Cigna for national accounts that other Blue plans have ceded to Anthem. That competition would be lost. Second, after the merger, Cigna would not compete as hard against other Blue plans for national accounts because Cigna (through its owner, Anthem) would likely receive significant BlueCard fees if a Blue plan won the account. Third, Anthem would have a reduced incentive to compete aggressively with the Cigna brand because the Blue Cross and Blue Shield Association's best-efforts rules would limit Cigna's growth relative to Anthem's. Anthem has already conceded that it would violate one of the best-efforts rules if it acquires Cigna's substantial commercial membership, meaning Anthem may have to limit Cigna's competitiveness throughout the country.

37. In both the Anthem states and in the United States as a whole, the merger also would enhance coordination among insurers competing for national

accounts. For example, after the merger, Anthem, the biggest of the Blue plans, would also own Cigna—one of the Blues' most formidable competitors—making coordination among the Blue plans and Cigna significantly more likely.

V. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF HEALTH INSURANCE TO LARGE-GROUP EMPLOYERS

38. In local markets throughout the country, head-to-head competition between Anthem and Cigna has created substantial benefits for large-group employers. In many of these markets, Anthem and Cigna are two of very few competitive options. The proposed merger would eliminate the valuable benefits of this competition and leave large groups with even fewer options.

A. The sale of health insurance to large groups is a relevant product market.

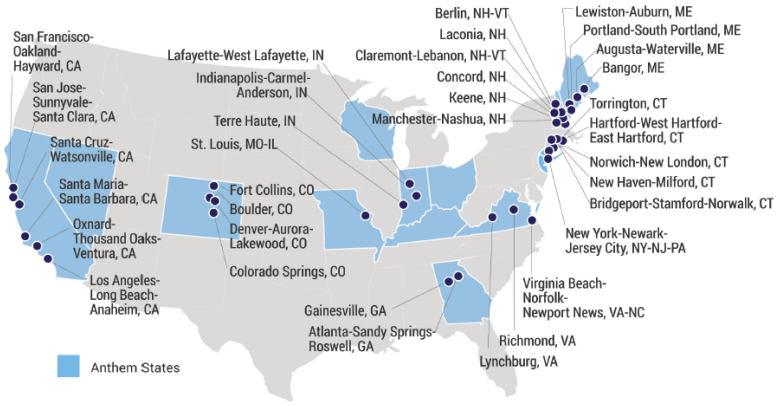
39. The sale of commercial health insurance to large groups (employers with more than 50 employees or, in four states, more than 100 employees) is a relevant product market and line of commerce under Section 7 of the Clayton Act. Large-group employers are distinct customers, and insurers that sell to them do not need to follow various regulatory requirements applicable to small groups, including limitations on the factors that can be used in determining rates and other licensing and rate-filing requirements. Anthem, Cigna, and other

insurers have dedicated business units focused on selling and marketing to large groups, charge those accounts different prices, and offer them different plan benefits than they do for other types of accounts.

40. Large-group employers are a relevant market for assessing the competitive effects of this merger because an insufficient number of large groups would stop buying commercial health insurance to make a small but significant and non-transitory price increase unprofitable. Nor are large groups likely to build their own provider networks and administer their health plans themselves. And, as with national accounts, large-group employers cannot avoid a price increase by purchasing commercial health insurance from other employers.

B. This merger would harm large groups in 35 relevant geographic markets.

41. The proposed merger would harm large-group employers in at least the 35 metropolitan areas listed on the map below. More than 65 million people live in these areas. Each area is a relevant geographic market and section of the country under Section 7 of the Clayton Act.



42. Patients typically seek medical care close to where they live or work, so they strongly prefer health plans offering a network of doctors and hospitals in those same areas. Thus, when purchasing commercial health insurance, large-group employers want insurers to provide access to healthcare provider networks in the areas where their employees are located. In each of the 35 metropolitan areas listed above, large groups do not view insurance companies that lack a meaningful provider network in that area as reasonable substitutes for those that offer such a network.

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

C. This merger is presumptively unlawful in most of the relevant geographic markets.

44. Anthem already has a large share in many of these local markets, which would increase further if it acquired Cigna. Even when treating each Blue plan as a separate competitor and including all other insurers in these markets, the proposed merger is presumptively unlawful under Supreme Court precedent and the Merger Guidelines in at least 20 of the relevant markets. But that understates the merger's effect on concentration for two reasons. First, the Blue plans effectively compete as a single entity; with very few exceptions, only one Blue plan at a time competes for an employer's business. When accounting for this market reality, the merger is presumptively unlawful in nearly all of the 35 markets listed above. Second, some insurers included in these market-share calculations are not close competitors to Anthem and Cigna. For example, in California, Kaiser's share is significant but its integrated business model and its "closed network" of providers is very different from Anthem's and Cigna's. One Cigna executive in California testified that he did not believe Cigna had "ever lost an ASO customer to Kaiser."

D. This merger likely would harm large-group employers by eliminating competition between Anthem and Cigna.

45. For some large groups in local markets, Anthem and Cigna are the only two competitive options. For many others, Anthem and Cigna are two of very few competitive options. In each of the 35 relevant markets, Anthem and Cigna are close

competitors. In each market, Anthem has a substantial market share and competes using its well-known Blue brand and low provider reimbursement rates. Cigna is able in some of these markets to compete with Anthem on the basis of reimbursement rates. But even where its reimbursement rates are not as attractive, Cigna competes vigorously with Anthem for large groups by offering exceptional customer service, innovative wellness programs that lower its members' utilization of healthcare, and provider-collaboration programs with hospitals and doctors. By contrast, many large-group employers believe that Anthem provides poor customer service and is far less innovative. Soon after the merger was announced, two prospective customers complained to Cigna: "We hate Anthem and you guys are about to become them."

46. In company documents, Anthem has frequently viewed Cigna as a close competitor in these 35 markets:

- In 2015, Anthem's Georgia sales force described Cigna as "aggressive" and "our toughest competition in a number of situations."
- In 2014, an Anthem sales executive wrote, "Cigna continues to present a very strong clinical/care management story, coupled with a great deal of financial flexibility. They remain our number one competitor in the 1,000+ arena."
- In a 2015 strategy document for its New Hampshire business, Anthem stated that it "remains the dominant carrier in New

Hampshire, with among the highest total market shares [of any region] in the company." Despite that dominance, one of its points of strategic focus for the large-group business was to "focus on Cigna groups."

- A 2014 presentation to investors noted that in Indiana, Anthem held "a 42% to 12% [market-share] advantage over our closest competitor (FYI—Cigna)."

47. Cigna has similar views of Anthem in these same markets:

- In 2015, a Cigna executive referring to Maine, New Hampshire, and Connecticut wrote, "we have Anthem in 3 of the New England states. Over the past 4 years 40% of our new business growth has come from these Anthem plans. Those companies primarily chose Cigna, to move away from the Anthem service model, to reduce plan spend and to become more engaged consumers."
- In 2015, a Cigna executive in California estimated that "60% of our 1/1/16 regional pre sale opportunities are coming from Anthem."

48. Cigna has been particularly effective in using its innovative wellness programs to compete with Anthem. For example, in September 2015, an Anthem sales account executive noted that Cigna was offering a large municipal account in New Hampshire up to $70,000 in wellness dollars, compared to Anthem's $6,000. In response, his boss replied, "What? That's absurd. What are their

current admin rates?" Around that same time, Anthem learned that Cigna was competing hard for a bid in California by selling its care management and wellness programs. An Anthem executive complained to the broker handling the bid, asking: "Does [the client] realize we are going to own Cigna in about a year anyways?"

49. Competition between Anthem and Cigna has also spurred innovation and led both companies to develop new products for large-group employers. For example, Cigna has expanded its popular "level funded" product. This product allows smaller large-group employers to pay fixed monthly installments with a chance to get money back at the end of year if claims costs fall below the anticipated level. A survey of brokers conducted by Anthem confirmed that "Cigna is the strongest competitor in this space" with "the most robust alternative funding options." Anthem further noted that, in California, Cigna was "[d]ominating the down-market ASO product sales, taking 31 clients from Anthem." To respond to Cigna, Anthem introduced its own similar product, which it made a strategic priority in California. In 2015, as Anthem rolled out several enhancements to that product, Cigna recognized that Anthem had "created a product that is a much greater threat."

50. Anthem and Cigna also compete to offer customers value-based programs and provider collaborations. An Anthem executive explained that "since we tend to have the best overall discount position in the market…our competitors have a strong incentive to be more aggressive and flexible with their [value-based] programs than Anthem." Indeed, Cigna has been particularly focused on investing time and resources in value-based

arrangements as a way to gain share against Anthem and other larger competitors. Cigna's internal plans show that absent the merger it would continue to aggressively develop its provider collaborations. The proposed merger, however, would eliminate Cigna as a competitor against Anthem and significantly reduce the incentives of the combined Anthem–Cigna to develop these innovative and beneficial programs.

VI. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION IN THE SALE OF HEALTH INSURANCE ON THE PUBLIC EXCHANGES

51. Anthem and Cigna compete head to head in the sale of individual health insurance on the public exchanges. Anthem's CEO has testified that the company is "committed to expanding our presence in the exchange marketplace." Likewise, Cigna's CEO has testified that the company is "committed to the public exchanges" and is expanding into at least three new states next year. Anthem and Cigna are close competitors on the exchange in local areas in Colorado and Missouri. The proposed merger would eliminate that competition and the important benefits it offers for individuals and families seeking affordable health insurance.

A. The sale of health insurance on the public exchanges is a relevant product market.

52. The sale of commercial health insurance on the public exchanges is a relevant product market and line of commerce under Section 7 of the Clayton Act. The majority of consumers who purchase individual health-insurance plans purchase them through the public exchanges. Through these exchanges, consumers can learn about their coverage options, compare health plans, and enroll in one. Financial assistance in the form of tax credits and cost-sharing reductions is available for many individuals and families who purchase through the public exchanges.

53. Anthem, Cigna, and other insurers recognize individuals purchasing health insurance on the public exchanges as a separate group of customers. These customers have distinct characteristics, and insurers may offer them different provider networks and different sets of benefits than other customers. Insurers consider different factors when setting prices for the public exchanges, both because most consumers receive financial assistance and because insurers selling on public exchanges incur additional fees and costs, such as user fees and the cost of technology required to connect with the exchange platform.

54. The sale of health insurance on the public exchanges satisfies the hypothetical monopolist test because consumers who use the exchanges have no reasonable substitutes that they could turn to in response to a small but significant and non-transitory increase in price. Individuals below

certain income thresholds are eligible for tax credits and cost-sharing reductions, but only if they purchase their health insurance through a public exchange. Approximately 85 percent of consumers who purchase health insurance on the public exchanges receive some financial assistance. And purchasing healthcare directly from doctors and hospitals is prohibitively expensive for individuals and their families.

B. This merger would harm individuals and families in 22 relevant geographic markets.

55. Individuals may only enroll in exchange plans that have been approved for sale in their county. Therefore, competition in each county is limited to the insurers that have been approved to operate in that county, and individuals cannot practicably switch to a plan offered in another county. Likewise, the amount of any financial assistance is calculated based on the plans available to a consumer in their county. Each of the following counties is a relevant geographic market and section of the country under Section 7 of the Clayton Act:

(a) ***Colorado:*** Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Eagle, Jefferson, La Plata, Lake, Montezuma, and Summit counties; and

(b) ***Missouri:*** Franklin, Jefferson, Lincoln, Saint Charles, Saint Francois, Saint Louis, Saint Louis City, Sainte Genevieve, Warren, and Washington counties.

C. This merger is presumptively unlawful in each of the relevant geographic markets.

(1) Colorado

56. Anthem and Cigna are the second- and third-largest insurers on the Colorado public exchange. Combined, they insure almost 55,000 lives—more than one-third of all enrollees on the exchange.

57. In 12 counties in Colorado, in which more than 95,000 people rely on the public exchange for health insurance, the proposed merger is presumptively unlawful under Supreme Court precedent and the Merger Guidelines. Notably, current market concentration levels understate the competitive harm likely to result from the proposed merger because both Humana and UnitedHealthcare—the fourth- and fifth-largest insurers in the Denver area—have announced that they will not offer individual health-insurance plans in Colorado in 2017, leaving Kaiser as Anthem and Cigna's only significant competitor.

(2) Missouri

58. In the counties surrounding St. Louis, Cigna and Anthem are the second- and third-largest insurers on the public exchange. Combined, they insure over 81,000 lives on the Missouri public exchange—over 25 percent of all enrollees on the exchange.

59. In 10 counties in Missouri, in which more than 112,000 people rely on the public exchanges for health insurance, the proposed merger is presumptively unlawful. As in Colorado, current market concentration levels understate the competitive harm likely to result from the proposed

merger because UnitedHealthcare—the fourth-largest insurer on the exchange in the St. Louis area—has announced that it will withdraw from the Missouri public exchange next year, leaving Aetna as Anthem and Cigna's only significant competitor.

D. This merger would harm individuals and families who buy health insurance on the public exchanges.

60. Anthem and Cigna compete head to head to sell insurance to individuals and families who use public exchanges. Anthem competes on public exchanges in all 14 states where it controls the Blue license. Cigna has begun expanding its sale of individual insurance by focusing first on certain markets, including the relevant counties. More than 200,000 people buy their health insurance on the public exchanges in these 22 counties. These consumers have benefited from Cigna's efforts to compete with Anthem; consumers in other markets would similarly benefit as Cigna follows through on its plans to aggressively expand in the next few years. The proposed merger harms these individuals and families who depend on competition to keep the price of their health insurance affordable.

61. As with other types of commercial health insurance, Cigna competes effectively for enrollment from individuals and families through its innovative products and customer service, helping to offset Anthem's bargaining leverage with providers. For example, Cigna's approach in Colorado has been to "leverage the strength of its provider relationships" to "drive superior products & manage risk." In 2016, Cigna introduced two new provider networks in the

Denver area that built on its relationships with doctors and hospitals to provide prices competitive with Anthem's. As a result, Cigna's market share increased substantially.

62. In Missouri, Anthem planned to "dominate the [exchange] marketplace for a long time" by creating "a competitive advantage around network, pricing, marketing, and distribution." But since entering the Missouri public exchange in 2015, Cigna has been an important competitive constraint on Anthem's dominance. Cigna considers its success in St. Louis a "success recipe" for future growth in other public-exchange markets across the country.

63. Anthem and Cigna are likely to be even stronger competitors on the public exchanges in the future. Absent the merger, both companies would continue to compete on the public exchanges in Colorado and Missouri, as well as to grow their business on the public exchanges in other states. The proposed merger would eliminate that competition, to the detriment of individuals and their families that rely on health insurance purchased on the public exchanges. It likely would also lead to increases in the amount of financial assistance offered through the public exchanges, harming taxpayers as well.

VII. THIS MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE PURCHASE OF HEALTHCARE SERVICES

64. Anthem and Cigna, like other commercial health insurers, compete to sign up doctors, hospitals, and other healthcare providers for their networks. Competition in this market is the mirror image of competition in the markets discussed above. Insurers compete by offering healthcare providers access to greater numbers of patients, more generous reimbursement terms, better service, and more innovative collaborations. The proposed merger will eliminate this competition between Anthem and Cigna and likely lead to lower reimbursement rates, less access to medical care, reduced quality, and fewer value-based provider collaborations.

A. The purchase of healthcare services by commercial health insurers is a relevant product market.

65. The purchase of healthcare services by commercial health insurers is a relevant product market and line of commerce under Section 7 of the Clayton Act. Because healthcare providers in each relevant market face similar competitive conditions when selling services to commercial insurers, it is appropriate to aggregate these services into a single relevant product market for analytical convenience.

66. Anthem, Cigna, and other insurers view the purchase of healthcare services for commercial patients as a distinct line of business. They have separate business units for negotiating such purchases, employ staff dedicated to those

negotiations, and develop provider-specific reimbursement strategies.

67. This market satisfies the hypothetical monopsonist test (a "monopsonist" is a buyer that controls the purchases in a given market), the buyer-side counterpart to the hypothetical monopolist test. For doctors, hospitals, and other healthcare providers, there are no reasonable substitutes for the sale of their services to commercial health insurers. In response to a reduction in reimbursement rates from those insurers, few providers would be able to compensate for the loss of revenue by selling more services to government programs such as Medicare Advantage, Medicare, or Medicaid. Those government programs generally reimburse providers at far lower rates than do commercial health insurers, and it is difficult for providers to greatly increase the number of their Medicare Advantage, Medicare, or Medicaid patients because the total number of enrollees in those programs is relatively fixed. Most people also cannot afford to pay for many healthcare services directly, making direct sales to patients a poor substitute for sales to commercial health insurers. In response to a small but significant and nontransitory reduction in reimbursement rates, an insufficient number of providers would start selling their services to other purchasers to make that rate reduction unprofitable.

B. The relevant geographic markets for identifying harm to competition for the purchase of healthcare services are the same 35 markets in which large groups would be harmed.

68. The purchase of healthcare services by commercial health insurers in each of the 35 metropolitan areas identified in the map in paragraph 41 above satisfies the hypothetical monopsonist test and constitutes a relevant geographic market and section of the country under Section 7 of the Clayton Act. The markets for the purchase of these services are local because in the vast majority of cases patients seek care from doctors and hospitals in the same area where they live and work. In response to lower reimbursement rates by local insurers, very few healthcare providers would move their practice or facilities to a different metropolitan area.

C. This merger is presumptively unlawful in most of the relevant geographic markets.

69. The proposed merger would substantially increase concentration for the purchase of healthcare services by commercial health insurers in each of the relevant markets. In at least 25 of these markets, the merger is presumptively unlawful under Supreme Court precedent and the Merger Guidelines.

D. This merger would harm doctors, hospitals, and their patients by eliminating competition between Anthem and Cigna.

70. Anthem already has substantial bargaining leverage when negotiating with doctors and hospitals because it represents a large share of their commercial patients and revenue. As one Anthem executive put it: "[T]he more patients doctors and hospitals see from [an insurance] carrier, the more leverage that carrier has to negotiate the best arrangements in the market." Noting that in California more than half of consumers "have an Anthem logo on their ID card," the executive added: "I hope this data helps support the argument about the leverage we have in the market."

71. The proposed merger would enhance Anthem's leverage—both over physician practices that receive "take-it-or-leave-it" terms (without any negotiation) and over hospitals and physician groups that individually negotiate their contracts and rates with Anthem. As a result of the merger, Anthem likely would reduce the rates that both types of providers earn by providing medical care to their patients.

72. This reduction in reimbursement rates likely would lead to a reduction in consumers' access to medical care. For example, lower reimbursement rates likely would cause some physician practices to limit their hours of operation or reduce their staff. It may become more difficult to recruit new physicians to many of these markets. Other more experienced doctors may decide to retire early. This would exacerbate the shortage of certain doctors—such as

those providing primary care—that plagues many of these markets.

73. As Anthem has recognized, these rate reductions would not result from any additional efficiencies or potentially procompetitive volume discounts. Rather, as noted by Anthem's head of provider contracting, the rate reductions from this merger would be perceived by many providers as "an incremental discount with no corresponding incremental value (no new members)."

74. The merger also likely would slow down the much-needed transition to value-based contracting. Historically, with its larger market share and lower reimbursement rates, Anthem has had fewer incentives to collaborate with providers. In many markets, it has acknowledged that it has lagged behind its competition—particularly Cigna, which it identified as "our closest competitor" for value-based contracts—and that providers view it as being "slow to respond, cumbersome, and not nimble." The merger would make that situation worse, eliminating Cigna and further reducing Anthem's incentives to enter into value-based contracts.

75. The merger would also jeopardize Cigna's existing provider collaborations. Anthem plans to lower reimbursement rates by applying its generally lower rates to the Cigna membership it acquires, which would threaten Cigna's value-based contracts with doctors and hospitals. As Cigna's executive in charge of provider contracting testified, "if you're going to have mostly a discount-based discussion with the hospital, you're not going to have [] provider collaboration coming out of that discussion." Even Anthem recognizes this tension. One of its top

executives alerted Anthem's CEO that the company may "have two, conflicting strategies— collaborate in new models on the one hand, and 'drop the hammer' on the other."

VIII. ABSENCE OF COUNTERVAILING FACTORS

76. Entry of new commercial health insurers or expansion of existing commercial health insurers is unlikely to prevent or remedy the proposed merger's likely anticompetitive effects.

77. The proposed merger would be unlikely to generate verifiable, merger-specific efficiencies sufficient to reverse or outweigh the anticompetitive effects that are likely to occur. To the extent the merging parties anticipate cutting the reimbursement rates paid to doctors and hospitals for their services as a result of the merger, these reductions stem from a reduction in competition and may not be treated as efficiencies.

IX. THE DEFENDANTS HAVE NOT PROPOSED A REMEDY THAT WOULD FIX THE MERGER'S ANTICOMPETITIVE EFFECTS

78. Restoring competition is the key to any effective antitrust remedy. The only acceptable remedy for an anticompetitive merger is one that completely resolves the competitive problems created by the merger. Proposed remedies including divestitures must give the buyer both the means and the incentive to effectively compete. Defendants bear the burden of showing that any remedy they propose

meets these standards. The Defendants have not proposed any remedy that would negate the anticompetitive effects of this merger.

X. VIOLATION ALLEGED

79. The United States brings this action, and this Court has subject-matter jurisdiction over this action, under Section 15 of the Clayton Act, 15 U.S.C. § 25, to prevent and restrain the Defendants from violating Section 7 of the Clayton Act, 15 U.S.C. § 18.

80. The Plaintiff States bring this action under Section 16 of the Clayton Act, 15 U.S.C. § 26, to prevent and restrain the Defendants from violating Section 7 of the Clayton Act, 15 U.S.C. § 18. The Plaintiff States, by and through their respective Attorneys General, bring this action as *parens patriae* on behalf of and to protect the health and welfare of their citizens and the general economy of each of their states.

81. The Defendants are engaged in, and their activities substantially affect, interstate commerce. Anthem and Cigna sell commercial health insurance to national accounts with a substantial number of employees located in several different states, and that insurance covers enrollees when they travel across state lines. Anthem and Cigna also purchase healthcare services in several different states, as well as healthcare products and services (such as pharmaceuticals) in interstate commerce.

82. This Court has personal jurisdiction over each Defendant under Section 12 of the Clayton Act,

15 U.S.C. § 22. Anthem and Cigna both transact business in this district.

83. Venue is proper under Section 12 of the Clayton Act, 15 U.S.C. § 22, and under 28 U.S.C. §§ 1391(b) and (c).

84. The effect of the proposed merger, if approved, likely would be to lessen competition substantially, and to tend to create monopoly, in interstate trade and commerce in each of the relevant markets, in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18.

85. Among other things, the transaction would likely have the following effects:

(a) eliminating significant present and future head-to-head competition between Anthem and Cigna in the relevant markets;

(b) reducing competition generally in the relevant markets;

(c) causing prices to rise for customers in the relevant markets;

(d) causing reimbursements to drop for healthcare providers in the relevant markets;

(e) causing a reduction in quality in the relevant markets; and

(f) reducing competition over innovation and new product development.

XI. REQUEST FOR RELIEF

86. Plaintiffs request:

(a) that Anthem's proposed acquisition of Cigna be adjudged to violate Section 7 of the Clayton Act, 15 U.S.C. § 18;

(b) that the Defendants be permanently enjoined and restrained from carrying out the planned acquisition or any other transaction that would combine the two companies;

(c) that Plaintiffs be awarded their costs of this action, including attorneys' fees to Plaintiff States; and

(d) that Plaintiffs be awarded such other relief as the Court may deem just and proper.

Dated: July 21, 2016

Respectfully submitted,

FOR PLAINTIFF UNITED STATES OF AMERICA:

SCOTT I. FITZGERALD,
JESÚS M. ALVARADO-RIVERA,
BRYSON L. BACHMAN,
SHOBITHA BHAT,
DANDO CELLINI,
AARON COMENETZ,
ALVIN H. CHU,
BARRY L. CREECH,
JENNIFER HANE,
HENRY J. HAUSER,
JON B. JACOBS,
KATHLEEN KIERNAN,
LAUREN G.S. RIKER,
NATALIE ROSENFELT,
DEBORAH A. ROY,
PETER SCHWINGLER,
ADAM T. SEVERT,
DAVID L. SNYDER,
JULIE A. TENNEY,
U.S. Department of Justice, Antitrust Division
Litigation I Section
Attorneys for the United States

SONIA K. PFAFFENROTH,
Deputy Assistant Attorney General

PATRICIA A. BRINK,
Director of Civil Enforcement
ERIC MAHR,
Director of Litigation
PETER J. MUCCHETTI,
Chief, Litigation I
RYAN M. KANTOR,
Assistant Chief, Litigation I

FOR PLAINTIFF STATE OF CALIFORNIA:
KAMALA D. HARRIS,
Attorney General
KATHLEEN E. FOOTE,
Senior Assistant Attorney General
NATALIE S. MANZO,
Supervising Deputy Attorney General
PAULA LAUREN GIBSON,
PATRICIA L. NAGLER,
Deputy Attorneys General

FOR PLAINTIFF STATE OF COLORADO:
CYNTHIA H. COFFMAN,
Attorney General
DEVIN LAIHO,
Senior Assistant Attorney General, Colorado Department of Law Consumer Protection Section

FOR PLAINTIFF STATE OF CONNECTICUT:
GEORGE JEPSEN,
Attorney General
MICHAEL E. COLE,
Chief, Antitrust and Government,
Program Fraud Department
RACHEL O. DAVIS,
CHRISTOPHER M. HADDAD,
Assistant Attorneys General

FOR PLAINTIFF DISTRICT OF COLUMBIA:
KARL A. RACINE,
Attorney General for the District of
Columbia
ELIZABETH SARAH GERE,
Deputy Attorney General,
Public Interest Division
CATHERINE A. JACKSON,
Assistant Attorney General

FOR PLAINTIFF STATE OF GEORGIA:
SAMUEL S. OLENS,
Attorney General
DANIEL WALSH,
Senior Assistant Attorney General,
Office of the Attorney General

FOR PLAINTIFF STATE OF IOWA:
THOMAS J. MILLER,
Attorney General
LAYNE M. LINDEBAK,
Assistant Attorney-General,
Iowa Department of Justice,
Special Litigation Division

FOR PLAINTIFF STATE OF MAINE:
JANET T. MILLS,
Attorney General
CHRISTINA M. MOYLAN,
Assistant Attorney General,
Office of Maine Attorney General,
Consumer Protection Division

FOR PLAINTIFF STATE OF MARYLAND:
BRIAN E. FROSH,
Attorney General
ELLEN S. COOPER,
Assistant Attorney General
Chief, Antitrust Division

FOR PLAINTIFF STATE OF NEW HAMPSHIRE:
JOSEPH A. FOSTER,
Attorney General
ANN RICE,
Deputy Attorney General,
New Hampshire Department of Justice

FOR PLAINTIFF STATE OF NEW YORK:
ERIC T. SCHNEIDERMAN,
Attorney General
MANISHA M. SHETH,
Executive Deputy Attorney General,
Division of Economic Justice
ELINOR R. HOFFMANN,
Deputy Chief, Antitrust Bureau
IRINA C. RODRIGUEZ,

Assistant Attorney General,
Antitrust Bureau,
Office of the New York State
Attorney General

FOR PLAINTIFF STATE OF TENNESSEE:
HERBERT H. SLATERY III,
Attorney General and
Reporter
CYNTHIA KINSER,
Deputy Attorney General
VICTOR J. DOMEN, JR.,
Senior Counsel
ERIN MERRICK,
Assistant Attorney General
Tennessee Attorney General's
Office

FOR PLAINTIFF COMMONWEALTH OF VIRGINIA:
MARK R. HERRING,
Attorney General
CYNTHIA E. HUDSON,
Chief Deputy Attorney General
RHODES B. RITENOUR,
Deputy Attorney General,
Civil Litigation Division
RICHARD S. SCHWEIKER, JR.,
Senior Assistant Attorney General and Chief
SARAH OXENHAM ALLEN,
Senior Assistant Attorney General and Unit Manager

TYLER T. HENRY,
Assistant Attorney General,
Antitrust Unit,
Consumer Protection Section

APPENDIX F

Horizontal Merger Guidelines

U.S. Department of Justice
and the
Federal Trade Commission

Issued: August 19, 2010

* * *

10. Efficiencies

Competition usually spurs firms to achieve efficiencies internally. Nevertheless, a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products. For example, merger-generated efficiencies may enhance competition by permitting two ineffective competitors to form a more effective competitor, e.g., by combining complementary assets. In a unilateral effects context, incremental cost reductions may reduce or reverse any increases in the merged firm's incentive to elevate price. Efficiencies also may lead to new or improved products, even if they do not immediately and directly affect price. In a coordinated effects context, incremental cost reductions may make coordination less likely or effective by enhancing the incentive of a maverick to lower price or by creating a new maverick firm. Even when efficiencies generated through a merger enhance a firm's ability to compete, however, a merger may have other effects that may lessen competition and make the merger anticompetitive.

The Agencies credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. These are

termed merger-specific efficiencies.[13] Only alternatives that are practical in the business situation faced by the merging firms are considered in making this determination. The Agencies do not insist upon a less restrictive alternative that is merely theoretical.

Efficiencies are difficult to verify and quantify, in part because much of the information relating to efficiencies is uniquely in the possession of the merging firms. Moreover, efficiencies projected reasonably and in good faith by the merging firms may not be realized. Therefore, it is incumbent upon the merging firms to substantiate efficiency claims so that the Agencies can verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific.

Efficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means. Projections of efficiencies may be viewed with skepticism, particularly when generated outside of the usual business planning process. By contrast, efficiency claims substantiated by analogous past experience are those most likely to be credited.

Cognizable efficiencies are merger-specific efficiencies that have been verified and do not arise from

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[13] The Agencies will not deem efficiencies to be merger-specific if they could be attained by practical alternatives that mitigate competitive concerns, such as divestiture or licensing. If a merger affects not whether but only when an efficiency would be achieved, only the timing advantage is a merger-specific efficiency.

anticompetitive reductions in output or service. Cognizable efficiencies are assessed net of costs produced by the merger or incurred in achieving those efficiencies.

The Agencies will not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market.[14] To make the requisite determination, the Agencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger's potential to harm customers in the relevant market, e.g., by preventing price increases in that market.[15] In conducting this

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[14] The Agencies normally assess competition in each relevant market affected by a merger independently and normally will challenge the merger if it is likely to be anticompetitive in any relevant market. In some cases, however, the Agencies in their prosecutorial discretion will consider efficiencies not strictly in the relevant market, but so inextricably linked with it that a partial divestiture or other remedy could not feasibly eliminate the anticompetitive effect in the relevant market without sacrificing the efficiencies in the other market(s). Inextricably linked efficiencies are most likely to make a difference when they are great and the likely anticompetitive effect in the relevant market(s) is small so the merger is likely to benefit customers overall.

[15] The Agencies normally give the most weight to the results of this analysis over the short term. The Agencies also may consider the effects of cognizable efficiencies with no short-term, direct effect on prices in the relevant market. Delayed benefits from efficiencies (due to delay in the achievement of, or the realization of customer benefits from, the efficiencies) will be given less weight because they are less proximate and more difficult to predict. Efficiencies relating to costs that are fixed in the short term are unlikely to benefit customers in the short term, but can benefit

analysis, the Agencies will not simply compare the magnitude of the cognizable efficiencies with the magnitude of the likely harm to competition absent the efficiencies. The greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to customers, for the Agencies to conclude that the merger will not have an anticompetitive effect in the relevant market. When the potential adverse competitive effect of a merger is likely to be particularly substantial, extraordinarily great cognizable efficiencies would be necessary to prevent the merger from being anticompetitive. In adhering to this approach, the Agencies are mindful that the antitrust laws give competition, not internal operational efficiency, primacy in protecting customers.

In the Agencies' experience, efficiencies are most likely to make a difference in merger analysis when the likely adverse competitive effects, absent the efficiencies, are not great. Efficiencies almost never justify a merger to monopoly or near-monopoly. Just as adverse competitive effects can arise along multiple dimensions of conduct, such as pricing and new product development, so too can efficiencies operate along multiple dimensions. Similarly, purported efficiency claims based on lower prices can be undermined if they rest on reductions in product quality or variety that customers value.

The Agencies have found that certain types of efficiencies are more likely to be cognizable and substantial than others. For example, efficiencies

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customers in the longer run, e.g., if they make new product introduction less expensive.

resulting from shifting production among facilities formerly owned separately, which enable the merging firms to reduce the incremental cost of production, are more likely to be susceptible to verification and are less likely to result from anticompetitive reductions in output. Other efficiencies, such as those relating to research and development, are potentially substantial but are generally less susceptible to verification and may be the result of anticompetitive output reductions. Yet others, such as those relating to procurement, management, or capital cost, are less likely to be merger-specific or substantial, or may not be cognizable for other reasons.

When evaluating the effects of a merger on innovation, the Agencies consider the ability of the merged firm to conduct research or development more effectively. Such efficiencies may spur innovation but not affect short-term pricing. The Agencies also consider the ability of the merged firm to appropriate a greater fraction of the benefits resulting from its innovations. Licensing and intellectual property conditions may be important to this enquiry, as they affect the ability of a firm to appropriate the benefits of its innovation. Research and development cost savings may be substantial and yet not be cognizable efficiencies because they are difficult to verify or result from anticompetitive reductions in innovative activities.

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