UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, et al.,

Plaintiffs,

v.

ANTHEM, INC. and CIGNA CORP.,

Defendants.

Case No. 1:16-cv-01493 (ABJ)

(Redacted, Public Version)

PLAINTIFFS' PROPOSED FINDINGS OF FACT: PHASE II

TABLE OF CONTENTS

I. THE MERGER IS LIKELY TO SUBSTANTIALLY LESSEN COMPETITION IN 35 LOCAL MARKETS FOR THE SALE OF COMMERCIAL HEALTH INSURANCE TO LARGE-GROUP EMPLOYERS.

A. The sale of commercial health insurance to large-group employers is a relevant product market.

1. The sale of commercial health insurance to large-group employers is a relevant product market. Trial Tr. 12/20/16, 3689:22–3690:5 (Dranove). Because pricing for large-group products is determined on a customer-by-customer basis and arbitrage is impossible, insurers can profitably target large groups with price increases. Trial Tr. 12/20/16, 3694:17–3695:6 (Dranove); *infra* Section I.A.ii.

(i) Small-group products are not a substitute for large-group products.

a. The Affordable Care Act and state regulations clearly define whether an employer is a large or small group.

2. The ACA defines large groups as employers with more than 50 employees and small groups as employers with up to 50 employees. 42 U.S.C. § 18024(b)(1)–(2). While it allows states to extend the definition of small groups to those employers with up to 100 employees, 42 U.S.C. § 18024(b)(3), only four states—including three states at issue in this litigation, California, Colorado, and New York—have done so. *See* Cal. Health & Safety Code § 1357.500(k); C.R.S.A. § 10-16-102(61)(b)(II); N.Y. Ins. Law § 4317(a)(1).

b. Large groups are subject to less stringent regulations than small groups.

3. Sales to large groups are not subject to the same regulations as those to small groups, which are subject to much greater oversight and restrictions. *See, e.g.*, Trial Tr. 12/15/16, 3040:16–3041:1 (King); [redacted] Tallman (Centene) 10/14/16 Dep. 156:14–157:1 (large-group segment "least affected" by the ACA).

4. Under the relevant statutes, insurers have less control over small group pricing than

for large groups. They must consolidate plans into a single community-rated risk pool and develop prices based on that aggregated pool of small groups, preventing price discrimination between accounts. 42 U.S.C. § 18032(c)(2); Bailey 4/12/16 Dep. 59:7–60:1; Fetherston 5/6/16 Dep. 21:23–22:1; Corcoran 3/9/16 Dep. 60:18–61:10; Brown (Arthur J. Gallagher) 10/14/16 Dep. 15:13–16:9; Kehaly 4/28/16 Dep. 36:9–37:5; Trial Tr. 12/15/16, 3040:16–3041:1 (King). They may also only consider a specific set of demographic and risk factors when setting small-group prices. *See, e.g.*, Cal. Health & Safety Code § 1357(k). Finally, they must have their proposed rates approved by state departments of insurance and maintain a special state license. *See, e.g.*, Conn. Gen. Stat. Ann. § 38a-564(7)(B)(iii); N.Y. Ins. Law § 4317(c)(1); Trial Tr. 12/16/16, 3224:6–25 (Mifsud/Melita); Trial Tr. 12/19/16, 3560:18–3561:4 (Guertin).

5. Small-group insurers also have less freedom to pick and choose the benefits and people they cover. They must cover certain benefits and fit into certain actuarial tiers that benchmark the average level of benefit to each enrollee, and small-group products are more "canned" as a result. Brown (Arthur J. Gallagher) 10/14/16 Dep. 16:20–24; 42 U.S.C. § 300gg-6(a); 42 U.S.C. § 18022(a)–(d). They also may not turn away applicants, *see, e.g.*, Cal. Health & Safety Code § 1357.503(e), and must guarantee renewals. 45 C.F.R. § 146.152(a).

6. By contrast, insurers set large-group prices individually, on an employer-specific basis, and may consider a variety of risk factors. *See, e.g.*, Trial Tr. 12/15/16, 3040:16–3041:1 (King); Trial Tr. 12/20/16, 3686:15–24 (Dranove); Trial Tr. 12/19/16, 3560:18–3561:4 (Guertin); Kehaly 4/28/16 Dep. 36:13–37:11; Trial Tr. 12/16/16, 3224:6–25 (Mifsud/Melita). Large-group insurers are not required to provide specific benefits, resulting in more customization and differentiation, and may freely deny employers coverage. *See, e.g.*, 42 U.S.C. § 300gg-6(a); 42 U.S.C. § 18022(a); Cal. Health & Safety Code § 1357.503(e).

c. Large groups have other distinct characteristics that distinguish them from small groups.

7. The difference in regulations for large and small groups has, over time, caused the two groups to develop distinct characteristics. *See* Brown (Arthur J. Gallagher) 10/14/16 Dep. 15:5–12 (stating that California's small-group regulations have caused the segment to "evolve[] into a specialty market as distinct from the larger group market").

8. Unlike small groups, large groups tend to place more emphasis on "best value" than price. PX0686 at -825-5, -825-15; *see also* [redacted] In addition to price, large groups select insurers based on factors like the breadth and quality of the insurer's provider network; the insurer's wellness offerings and clinical programs; and the insurer's administrative services and support capabilities. Williams 3/24/16 Dep. 72:4–73:21; Martie 4/28/16 Dep. 119:25–120:10; [redacted]

(ii) Large groups are subject to price discrimination.

9. Insurers can profitably target large groups—in other words, engage in price discrimination—because they can easily identify large groups; prices for large-group products are negotiated individually; and arbitrage is impossible. Trial Tr. 12/20/16, 3686:15–3687:5, 3694:17–3695:6 (Dranove); Kehaly 4/28/16 Dep. 36:9–37:13. Indeed, during the bidding process, insurers obtain information about the customer relevant to pricing, including the size of the account, where members reside, and whether any members have chronic conditions. *See* Trial Tr. 11/23/16, 720:19–722:14 (Thackeray); Kehaly 4/28/16 Dep. 40:18–41:16 (stating that Anthem identifies a

large group "when it comes in the door" and that this delineation "happens through the submission process"); Trial Tr. 12/15/16, 3040:16–3041:1 (King) (stating that "[i]n the large group market, [Anthem] sets prices on an employer-specific basis"). By contrast, insurers cannot individually price small groups. *See supra* I.A.i.b.

(iii) The fact that industry participants segment employers in additional ways does not mean that large group is not a relevant market.

10. Large groups are not all the same; they exist on a continuum in terms of size and needs. Trial Tr. 12/20/16, 3688:5–3689:5 (Dranove); Trial Tr. 12/19/16, 3559:17–3560:17 (Guertin) ("[T]hey're defined by regulation in terms of what is a large group and what is a small group. . . . But in other ways, I think it's more of a continuum in terms of the products."); Manders 6/2/16 Dep. 96:22–97:8.

11. To account for this, industry participants sometimes divide large groups into additional sub-segments. See Trial Tr. 12/19/16, 3559:10–3560:17 (Guertin). For example, a broker in Richmond, Virginia, divides his large-group clients into three sub-segments. Trial Tr. 12/15/15, 2984:23–2985:11 (Hawthorne/Scott Insurance); PX0424. Cigna segments its large group into select (51–249 employees), regional or middle market (250–4,999 employees), and national accounts (5,000 plus multi–state employees). PX0284 at 8 (Cigna form 10–K).

12. Even where industry participants use additional sub-segments, however, they typically draw a bright line between small groups and large groups based on the regulatory definition. Butler 4/29/16 Dep. 34:5–14; Augur 5/25/16 Dep. 19:16–20:6; *see also* Tallman (Centene) 10/14/16 Dep. 127:14–128:6; Trial Tr. 12/20/16, 3652:10–17 (Mahoney/SML). National accounts are large groups under the definitions of the ACA and applicable state statutes and subject to the same regulation as other large groups. *See infra* Section I.A.i.

13. In addition, it is appropriate to aggregate large-group segments because this is a

price-discrimination market. Trial Tr. 11/20/16, 3686:15–3687:5 (Dranove); *see also* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact) at ¶ 70. While price-discrimination markets could be defined around individual employers, it is appropriate to look at large groups together because they have similar needs and can be served by a common set of suppliers. Trial Tr. 12/20/16, 3686:15–3687:5 (Dranove); Trial Tr. 12/2/16, 2239:5–17 (Dranove).

14. Contrary to Dr. Fowdur's criticism, Dr. Dranove did not err in including national accounts along with other large-group employers into a single antitrust market. National accounts, like smaller large-group accounts, need local coverage and thus can be aggregated with smaller large groups when analyzing the merger's effect on local competition. Trial Tr. 1/3/17, 4689:15–4690:3 (Dranove). Further, overlapping markets are not only logically consistent but also compatible with the Guidelines, which permit more than one relevant product market. Trial Tr. 1/3/17, 4690:4–11 (Dranove).

(iv) Fully-insured, self-insured, and other funding arrangements and health insurance products are properly included in the relevant product market.

15. It is appropriate to include fully-insured, self-insured and other healthcare products, as well as alternative funding arrangements in the definition of large group. Trial Tr. 12/20/16, 3687:14–22, 3688:6–3689:5, 3689:22–3690:8, 4007:7–19 (Dranove). Fully-insured plans are properly included in the relevant product market because smaller large groups prefer fully-insured products. *See, e.g.*, PX0515 at -593 [redacted] Caldwell (Alliant) 10/17/16 Dep. 22:2–18; Trial Tr. 12/20/16, 3691:4–19 (Dranove); Trial Tr. 12/22/16, 4436:23–4438:5 (Israel); Hummel 10/18/16 Dep. 16:13–19.

16. Alternative funding arrangements like level-funded plans are also properly included in the relevant product market because some large groups view them as attractive options. Trial Tr. 12/20/16, 3687:14–25, 3689:19–3690:5, 4007:7–19 (Dranove). Level-funding

products create a spectrum between fully-insured and self-insured plans. *See* Trial Tr. 12/20/16, 3658:9–16 (Mahoney/SML) (stating that level-funding helps the customer "bridge the gap from fully insured to a possible move to self-funding").

17. Anthem's criticism that Dr. Dranove failed to adhere to the "smallest market principle" is misplaced. Trial Tr. 12/20/16, 3691:20–3694:15 (Dranove). The merger guidelines are clear that there can be more than one relevant market. Trial Tr. 12/20/16, 3692:1–14 (Dranove). Moreover, when defining a market, the primary concern is to avoid a market defined too narrowly, which could overstate the effects of a merger. Trial Tr. 12/20/16, 3692:1–3693:11 (Dranove).

(v) Large groups have no reasonably interchangeable alternatives to purchasing commercial health insurance and therefore pass the SSNIP test.

18. A hypothetical monopolist could profitably impose a small but significant, non-transitory increase in price, or SSNIP, on large groups.

19. Because the relevant market for large groups includes all types of commercial health insurance plans, products, and funding arrangements, large-group employers faced with a SSNIP could potentially respond in only three ways: (1) forgo the purchase of group health insurance for their employees; or (2) self-supply by directly contracting with doctors and hospitals; or (3) somehow morph into small groups. Trial Tr. 12/20/16, 3695:7–23 (Dranove).

20. Forgoing health coverage is not a reasonable substitute because virtually all large employers offer health coverage to their employees. Trial Tr. 11/28/16, 861:9–23 (Dranove). Dr. Dranove confirmed this conclusion by performing a "critical elasticity test." Trial Tr. 12/20/16, 3695:24–3697:4 (Dranove). Elasticity of demand measures the responsiveness of unit sales to changes in price. The more elastic the demand, the greater the loss in unit sales for a given price

increase. The hypothetical monopolist test is satisfied if actual elasticity is a small fraction of the critical elasticity. Trial Tr. 12/20/16, 3695:24–3697:4 (Dranove). *See also* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact), Section II.F.i.

21. Dr. Dranove calculated critical loss based on margins and found a critical elasticity of 1.18, which means that a five percent price increase by a hypothetical monopolist would be unprofitable if it resulted in large-group employers representing about six percent of enrollment dropping their coverage. Trial Tr. 12/20/16, 3695:24–3697:4 (Dranove). Based on the same peer-reviewed academic literature he used in national accounts, Dr. Dranove found that the estimated actual elasticity is much lower than the critical elasticity. Trial Tr. 12/20/16, 3695:24–3697:4 (Dranove).

22. The merging firms earn [redacted] on the sale of commercial health insurance to large-group employers. [redacted] Dr. Dranove's estimates are only "slightly different" than Defendants'. Trial Tr. 12/22/16, 4266:17–18 (Fowdur).

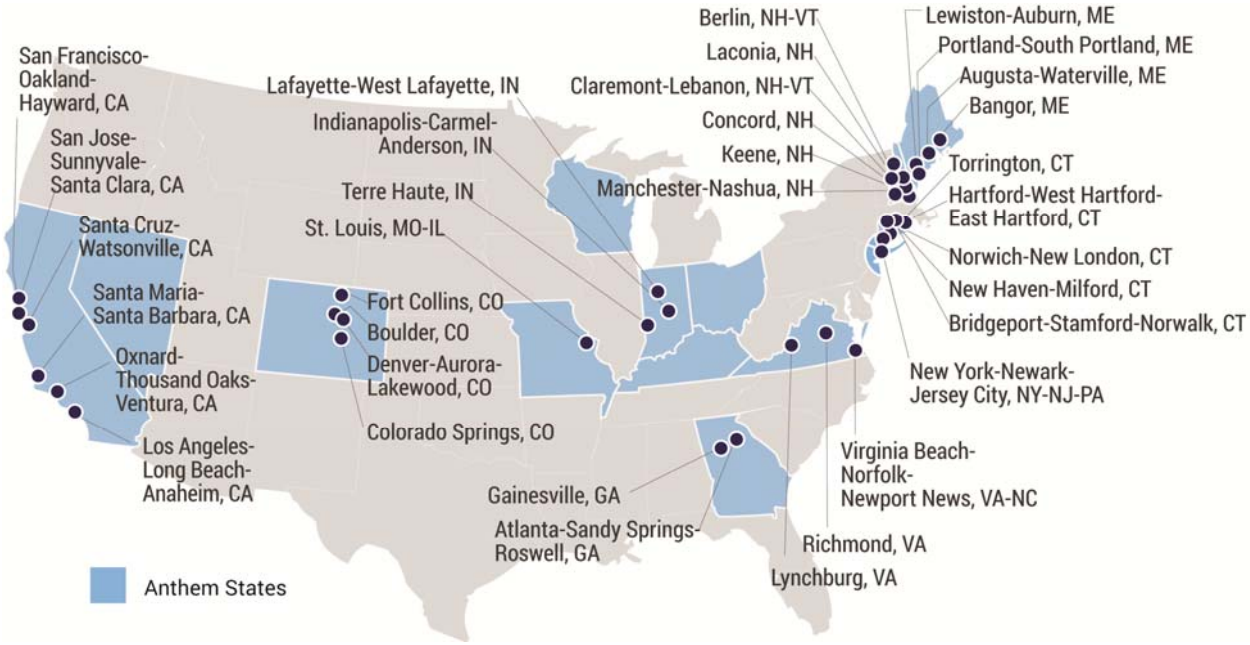
23. Self-supply is also not a reasonably interchangeable substitute. Trial Tr. 12/20/16, 3695:7–23 (Dranove). Contracting directly with a large number of doctors and hospitals requires a critical mass and density of members in a specific market. Trial Tr. 11/21/16, 121:25–122:9 (Abbott/Willis Towers Watson). Because of their size, smaller employers are less likely to have the critical mass and density of members necessary to be successful. *See* Trial Tr. 12/20/16, 3695:7–23 (Dranove); ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact), Section II.F.ii.

24. Morphing from large group to small group is also not a viable alternative. A large-group employer wishing to do so would need to reduce the number of benefits-eligible employees to the state-specific threshold to qualify as a small group. *See supra* Section I.A.i; Wise

(ConnectiCare) 9/19/16 Dep. 44:3–11; Goulet 9/29/16 Dep. 15:7–16:20; Mascolo (Wells Fargo) 10/20/16 Dep. 154:13–155:10. There is no evidence in the record of a large group responding to a price increase by becoming a small group.

B. The 35 metropolitan areas are relevant geographic markets.

25. There are 35 relevant geographic markets, each defined by the sale of commercial health insurance to large group employers located in the relevant area. The geographic markets consist of the 35 core-based statistical areas ("CBSA") presented below:



(i) Customers want access to local healthcare provider networks.

26. Like in Phase 1, here, a hypothetical monopolist could price discriminate based on customer location, and so it is important to define the market around customers in a common geographic area who share common needs. Trial Tr. 12/20/16, 3698:3–20 (Dranove). Supplier location is irrelevant; the only relevant question is whether the supplier can reach the targeted customers. Trial Tr. 12/20/16, 3698:3–20 (Dranove).

27. Anthem executives recognize the importance of offering employers access to

networks where their employees live and work. *See, e.g.*, Trial Tr. 12/19/16, 3582:5–3583:8 (Guertin); Trial Tr. 12/21/16, 4150:22–4151:3 (Rothermel); Trial Tr. 11/29/16, 1181:13–1182:8 (Kendrick) [redacted] Weber 10/18/16 Dep. 27:3–28:21.

28. Likewise, Cigna views markets as local. Huggins 5/13/16 Dep. 16:10–19; *see also* Morris 4/8/16 Dep. 43:15–45:9. [redacted] Like Anthem, Cigna analyzes whether a potential customer's employees will have sufficient network access based on whether enough providers are within a certain radius of the employees' locations. Trial Tr. 11/23/16, 722:7–723:16 (Thackeray); Williams 3/24/16 Dep. 39:21–40:1.

29. Employers have testified that they want networks where their employees live and work. *E.g.*, [redacted] Parker (PrimeLine) 10/7/16 Dep. 33:9–34:24; Little (Post Holdings) 10/20/16 Dep. 56:20–57:2, 57:16–25; McKean (Town of Salem) 10/4/16 Dep. 89:5–20. And other industry participants agreed. *See* Trial Tr. 12/15/16, 2982:19–25 (Hawthorne/Scott Insurance); Trial Tr. 12/16/16, 3258:8–17 (Mifsud/Melita); Trial Tr. 12/19/16, 3392:16–23 (Wheeler/Bon Secours); Batniji (Collective Health) 10/20/16 Dep. 107:3–7.

30. CBSAs are defined around commuting patterns; that is, CBSAs define where large-group employees live and work. Trial Tr. 12/21/16, 4008:6–7 (Dranove). Thus, employees who live and work in a common CBSA share the common need of access to health insurance in that CBSA. Trial Tr. 12/20/16, 3683:20–3684:10, 3699:5–3700:6 (Dranove). This common

characteristic, coupled with price discrimination, allows Dr. Dranove to aggregate customers in a CBSA into one geographic market. Trial Tr. 12/20/16, 3683:20–3684:10, 3699:5–3700:6 (Dranove). Thus, these geographic markets are defined around customer location. Trial Tr. 12/20/16, 3703:7–11 (Dranove).

(ii) Industry participants recognize view local areas as distinct markets.

31. In part, because in many states competitive conditions vary from one metropolitan area to another, it is appropriate to analyze competition on a CBSA level. For example, in California, Anthem views Los Angeles, Sacramento, and San Francisco as unique geographic areas, with distinct competitive conditions. *See* Trial Tr. 12/21/16, 4150:5–4151:3 (Rothermel).

32. Industry participants testified that Richmond, Virginia is a separate market from Fredericksburg, Trial Tr. 12/19/16, 3393:4–6 (Wheeler/Bon Secours), Hampton Roads (Norfolk-Newport News-Virginia Beach MSA), Trial Tr. 12/16/16, 3142:23–3143:18 (Gorse/Patient First); Trial Tr. 12/19/16, 3393:4–8 (Wheeler/Bon Secours), and the rest of Virginia. *See* Trial Tr. 12/15/16, 3015:24–3016:11 (Hawthorne/Scott Insurance); Trial Tr. 12/19/16, 3358:14–19, 3359:8–10 (Harlin/Wells Fargo); [redacted] Trial Tr. 12/20/16, 3703:12–24 (Dranove).

33. The same is true in other states. In Georgia, for example, the Atlanta area is viewed as a distinct market from other parts of Georgia. *See* Caldwell (Alliant) 10/17/16 Dep. 30:15–31:9, 62:19–22; [redacted]

(iii) To analyze competition at the local level, the industry regularly uses MSAs (or MiSAs) to classify geographic markets.

34. MSAs are "an agreed-upon geographic basis that is well defined both for employers, for [the brokers/consultants], and for the health plans." Trial Tr. 11/21/16, 107:16–23 (Abbott/Willis Towers Watson); *see also* [redacted]

As Professor Dranove testified, a CBSA is a useful aggregation because employers need to

provide insurance to employees in the CBSA, and thus the employer will be affected by competitive conditions within the CBSA. Trial Tr. 12/20/16, 3706:17–22 (Dranove).

35. Anthem uses MSAs to classify local markets. For example, at trial, one of its executives repeatedly referred to the "Richmond MSA" as a distinct local market. Trial Tr. 12/15/16, 3055:15–3056:4, 3082:18–3083:24 (King). Another Anthem executive noted that employers are increasingly focusing on MSA-level solutions when seeking health insurance. Trial Tr. 11/29/16, 1181:13–1182:8 (Kendrick).

36. Likewise, Cigna's CEO testified that the company's "Go Deep" strategy uses MSAs to identify target markets. Trial Tr. 11/22/16, 409:3–16 (Cordani). [redacted]

37. [redacted] Similarly, when Willis Towers Watson evaluates provider discounts, it typically focuses on MSAs, not states. Trial Tr. 11/21/16, 106:24–107:23 (Abbott/Willis Towers Watson); PX0310 at -826.

(iv) The fact that some industry participants do not use the technical term "MSA" or "CBSA" is irrelevant.

38. The Census Bureau defines the term "CBSA" to refer to both MSAs and Micropolitan Statistical Areas (or MiSAs). *See* https://www.census.gov/geo/reference/gtc/gtc_cbsa.html. Most of the industry participants unfamiliar with this term still discuss competition at a local level in a way that is *equivalent* to

CBSAs. For example, Cigna's CEO testified that he views MSAs as essentially synonymous with "cities." Trial Tr. 11/22/16, 411:20–24 (Cordani). Anthem's former CFO did not use the term "MSA," but testified that he viewed Marion County, Indiana, a part of the "Greater Indianapolis" area, as a separate market from Fort Wayne, Indiana. DeVeydt 10/14/16 Dep. 69:21–70:12.

[redacted] A Bon Secours executive repeatedly referred to the "Richmond marketplace." Trial Tr. 12/19/16, 3398:8–3399:17 (Wheeler/Bon Secours).

(v) The 35 geographic markets easily satisfy the hypothetical monopolist test.

39. Each of the 35 CBSAs passes the hypothetical monopolist test. Trial Tr. 12/20/16, 3700:7–3701:2 (Dranove). In response to a SSNIP, a large-group employer would not move its business out of any of these CBSAs, stop purchasing health insurance, or self-supply. Trial Tr. 12/20/16, 3700:7–3701:2, 3707:11–3708:11 (Dranove); Trial Tr. 1/3/17, 4693:9–24 (Dranove). Consequently, a hypothetical firm controlling all present and future sales of health insurance to large group customers would impose at least a SSNIP in each CBSA. Trial Tr. 12/20/16, 3700:7–3701:2 (Dranove).

(vi) Anthem's arguments that the geographic market should be broader are flawed.

40. Anthem's experts' arguments that the geographic markets should be broader—even as broad as entire states—are flawed for several reasons.

41. Initially, Dr. Fowdur's criticisms relating to patients' travel patterns are misleading and irrelevant. Dr. Fowdur mischaracterizes the geographic markets when she claims that enrollees could defeat a SSNIP by traveling beyond their local area for healthcare. Trial Tr. 1/3/17, 4690:23–4692:2 (Dranove). Again, the relevant geographic markets are defined around *customer*

location, not *provider* (or even supplier) location. Trial Tr. 12/20/16, 3698:3–20 (Dranove); Trial Tr. 1/3/17, 4690:23–4692:2 (Dranove). Thus, no matter how often enrollees travel to providers beyond their CBSA, the customers (i.e., the employers) would still be part of the relevant geographic market and their insurer would still be part of the hypothetical monopolist because the consumers continue to be located within the same CBSA. In other words, Dr. Fowdur's arguments about patient flow are misleading and wholly irrelevant to the hypothetical monopolist analysis. Trial Tr. 1/3/17, 4690:23–4692:2 (Dranove).

42. Dr. Fowdur noted that industry participants sometimes analyze competition and compute market shares on a statewide, and not on a CBSA-specific, level. Trial Tr. 12/22/16, 4234:12–4235:8 (Fowdur). But sometimes the only available data is aggregated at a state level. Trial Tr. 12/20/16, 3708:13–23, 3842:3–10 (Dranove) (explaining why certain state-level data was used). In some states, statewide market shares are consistent with local shares, so statewide shares are a convenient proxy for local conditions. Trial Tr. 12/20/16, 3706:23–3707:10 (Dranove); *see also* Trial Tr. 12/14/16, 2862:5–2862:12 (Berfiend/IU Health) (discussing [redacted]). Some of the same individuals who use statewide data also analyze markets on a more local basis. Trial Tr. 12/15/16, 3061:20–3062:14; 3076:25–3077:13 (King); Trial Tr. 12/21/16, 4079:8–21, 4121:1–20 (Rothermel); *see generally* Trial Tr. 1/3/17, 4701:4–12 (Dranove). And statewide competitiveness is itself a relevant consideration for some customers, even if it is simply an aggregation of local competitiveness across the state. *See* Trial Tr. 12/21/16, 4025:8-15 (Burke/Maine Education Association Benefits Trust); [redacted]

43. Dr. Fowdur also argues that the entire New England region could be defined as a geographic market because the Aon private exchange groups all six New England states into a single zone. Trial Tr. 12/22/16, 4277:1–14 (Fowdur). However, an Aon executive testified that

competition is "really in an individual geography where an employee sits." Sharp (Aon) 10/6/16 Dep. 11:4–21. The employee is able to choose insurers based on "network availability, based on whether their doctors are in the network." Sharp (Aon) 10/6/16 Dep. 11:4–21. As explained above, employees desire health care that is local to their home and work.

44. Regardless of whether larger geographic markets would also pass the hypothetical monopolist test, local markets are appropriate here because competition tends to be local. *See infra* Section IV. Provider network strength can vary metro area to metro area, so a given insurer's competitive strength can vary even within a state. *See* Trial Tr. 12/20/16, 3700:7–25, 3706:4–22 (Dranove).

45. Even if Defendants' experts were correct that the geographic markets are statewide, Dr. Dranove found that the broader market would not have a significant effect on the results: he still found that the market shares, HHIs, and the presumption of harm are reasonably close to the conclusions reached when assessing CBSAs. Trial Tr. 12/20/16, 3706:23–3707:10 (Dranove); *see* [redacted]

C. The merger is presumptively unlawful in most of the relevant markets.

46. Market shares help assess the likely effects of a merger because they reflect the relative importance of firms in the market and the extent to which customers have alternatives. Trial Tr. 11/28/16, 874:9–16 (Dranove).

(i) It is appropriate to combine the Blues when calculating market shares.

47. As with national accounts, it is appropriate to combine the Blue plans when calculating market shares for large groups, since only one Blue can bid for an account. Trial Tr. 12/20/16, 3710:18–24 (Dranove). Anthem often includes other Blues when evaluating its market share and competitive position. ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact) at ¶

131; PX0191 at -336-5; *see also* PX0564; PX0518 at -676, -679–680; PX0215 at -043, -048–049; PX0562 at -420, -425–426; PX0494 at -294–297; Pogar 3/30/16 Dep. 298:8–21; PX0167 at -768.

48. Including BlueCard lives is also appropriate because they contribute to Anthem's ability to negotiate with providers. *See* Trial Tr. 12/20/16, 3710:18–24 (Dranove). Providers value Anthem's membership in the Blue Cross Blue Shield Association, Pogar 3/30/16 Dep. 300:5–8, and Anthem counts all local BlueCard lives in negotiations with providers. Pogar 3/30/16 Dep. 111:11–112:2, 299:14–300:4.

49. Finally, BlueCard lives are no different than United lives within the Anthem territory who work for an employer based outside of the Anthem territory. Trial Tr. 12/20/16, 3710:25–3712:1 (Dranove). Excluding BlueCard lives while counting the United lives would distort market shares and understate Anthem's competitive significance. Trial Tr. 12/20/16, 3710:25–3712:1 (Dranove).

(ii) Market-share methodology

50. Insurers typically measure large-group market shares in terms of insured lives ("enrollment"). *See, e.g.*, PX0603 at -292; Tallman (Centene) 10/14/16 Dep. 31:15–18. Likewise, Dr. Dranove measured large-group shares based on enrollment residing within each CBSA. Trial Tr. 12/20/16, 3709:8–3710:15 (Dranove). This approach reflects the local strength of each insurer, enables use of the census-based denominator as a benchmark, and is consistent with industry practice. Trial Tr. 12/20/16, 3709:8–3710:15 (Dranove).

51. Dr. Dranove calculated market share numerators and denominators using the same approach as with national accounts. For each CBSA, the numerator is the number of an insurer's large-group enrollees in the CBSA. Trial Tr. 12/20/16, 3712:2–8 (Dranove).

52. The denominator is an estimate of the total number of large-group enrollees who

reside in the CBSA. Dr. Dranove applied two alternative approaches for calculating the denominator—the build-up and Census approaches—and for each market, chose the larger of the two. Trial Tr. 12/20/16, 3710:6–12 (Dranove). As discussed in Phase 1, Dr. Dranove's two approaches include all competitively significant firms and yield shares that, if anything, understate the significance of Anthem and Cigna for the same reason as in Phase 1.Trial Tr. 12/20/16, 3708:12–3709:7, 3714:1–3715:18, 3718:18–3734:5 (Dranove). Anthem's own approach to calculating market share is very similar to the Census approach. Trial Tr. 11/28/16, 890:15–23 (Dranove); *see also* PX0567 at -206; PX0567 at -204.

53. Plaintiffs incorporate by reference their Phase 1 Proposed Findings of Fact on measuring market concentration under the *Horizontal Merger Guidelines* using HHIs. ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact) at ¶ 140.

(iii) Market shares and concentration in the 35 large-group markets

54. Dr. Dranove's market share calculations are presented in the following summary exhibit: [redacted] *see also* Trial Tr. 12/20/16, 3716:3–3718:16 (Dranove).

55. Dr. Dranove calculated market shares with the Blues combined as a single competitor, with ASO and full insurance combined. Trial Tr. 12/20/16, 3717:17–22 (Dranove); [redacted] The market shares and resulting concentration in 33 of the 35 large group markets are presumptively anticompetitive under the *Horizontal Merger Guidelines*. [redacted] The four CBSAs with the lowest cumulative Anthem-Cigna market share all have one thing in common: "they're all in markets where Kaiser has a big presence." Trial Tr. 12/20/16, 3716:13–21 (Dranove).

56. Dr. Dranove also calculated market shares for ASO products with the Blues combined as a single competitor, which essentially means excluding Kaiser from market shares.

Trial Tr. 12/20/16, 3717:23–3718:5 (Dranove); [redacted] With Kaiser's fully-insured product removed, all remaining insurer's shares increased. Trial Tr. 12/20/16, 3717:23–3718:5 (Dranove); [redacted] Even in the most competitive CBSA, the combined Anthem–Cigna ASO-only share is over 35percent. Trial Tr. 12/20/16, 3717:23–3718:5 (Dranove).

57. Even if the Blues' shares are not aggregated, with ASO and full insurance combined the merger is still presumptively unlawful in 19 of the 35 large group markets. [redacted] Likewise, if Blues are separated and fully-insured accounts are excluded, the merger is presumptively unlawful in 26 of the large-group markets. Trial Tr. 12/20/16, 3718:6–11 (Dranove); [redacted]

58. Graphs presenting market shares and HHIs for the 35 large group CBSAs appear in Appendix A.

59. Although many CBSAs are already highly concentrated pre-merger, the merger can still have a substantial competitive effect in those markets. Trial Tr. 12/20/16, 3774:8–21 (Dranove). Indeed, that is the purpose of focusing on the delta HHI. And as Professor Dranove explained, "you're simply going from bad to worse. . . . Consumers are harmed even more than they would have been before." Trial Tr. 12/20/16, 3774:8–18 (Dranove).

D. The merger would substantially lessen competition for the sale of commercial health insurance to large-group employers in the 35 relevant markets.

60. As discussed in general terms in this Section, the merger would substantially lessen competition for large groups in each of the relevant local markets. Additional market-specific evidence of competitive effects is presented below in Section IV.

(i) Anthem already is the dominant firm in most of its markets, many of which already are highly concentrated.

61. Anthem's market share already is "dominant" in most of its markets. PX0494

at -295; *see also, e.g.*, PX0734 at -375, Trial Tr. 12/19/16, 3482:21–24 (Guertin) (Anthem has by far the largest market share in New Hampshire); Hillman 5/5/16 Dep. 207:17–208:4, 225:2–14 [redacted] PX0514 at -741; Trial Tr. 12/15/16, 3041:2–11 (King) (Anthem is the largest health insurer in Virginia, including for large groups).

62. In some of these highly concentrated markets, and for certain customers, Anthem and Cigna are the two best options. *See, e.g.*, Parker (PrimeLine) 10/7/16 Dep. 82:24–83:11; [redacted] McKean (Town of Salem) 10/4/16 Dep. 119:2–18. For one broker in Richmond, Virginia, in each of her last four RPFs for Richmond clients, the two finalists were Anthem and Cigna. Trial Tr. 12/19/16, 3359:11–21 (Harlin/Wells Fargo); [redacted]

63. By contrast, in markets where Anthem is less dominant, and has less of a discount advantage, it competes more creatively. Anthem's Colorado market shares and discounts are just on par with those of Cigna and others. *See infra* Section IV.D.i. [redacted]

Kehaly 4/28/16 Dep. 81:19–24, 82:4–83:20. [redacted]

PX0554 at -573.

(ii) Cigna challenges Anthem's dominance with innovative solutions.

64. In most markets, Anthem competes primarily by emphasizing its unit-cost advantage, touting that its discount position is "#1 in 93 of 129 markets." PX0494 at -298; *see also* Goulet 9/29/16 Dep. 110:13–111:21. By contrast, Cigna rarely has the best unit-cost position and therefore competes using a different value proposition, one focused on innovating to reduce the total cost of care. *See* ECF #416 (Plaintiffs' Phase 1 Proposed Findings of Fact), Section V.D.i (describing Cigna's emphasis on innovation to overcome its typically lower reimbursement rates).

65. As a result, Cigna often is recognized as a leader in wellness and disease management. Eddy (Tolman & Wiker) 10/14/16 Dep. 95:3–20; 101:8–24; Trial Tr. 12/20/16, 3656:25–3657:22 (Mahoney/SML). Cigna offers "wellness dollars" that an employer can spend on wellness activities; other insurers have followed Cigna. Trial Tr. 12/20/16, 3657:23–3658:8 (Mahoney/SML). [redacted] Kehaly 4/28/16 Dep. 84:22–85:4, 86:18–87:1 [redacted] Kehaly 4/28/16 Dep. 88:1–13.

66. Cigna's need to be "the most innovative company" also leads it to continually "introduce unique product/plan designs that no other carrier offers." PX0686 at -825-7. In particular, Cigna has developed alternative funding strategies for large group employers. [redacted] PX0559 at -176–177; Goulet 9/29/16 Dep. 372:9–377:11, 380:13–20 (discussing PX0559).

67. [redacted] PX0559 at -176. [redacted] Hillman 5/5/16 Dep. 181:8–182:1.

68. [redacted]

[redacted] PX0537 at -423. [redacted] PX0537 at -424-17. [redacted] PX0537 at -423.

69. Altogether, Cigna has used these strategies to compete and grow in specific local markets. Since 2009, Cigna has targeted "Go Deep" markets where it places more resources—including sales, clinical, and management resources—to achieve higher than average growth. Trial Tr. 11/22/16, 408:24–410:9 (Cordani). Cigna's Go Deep strategy has been successful, enabling it to achieve industry-leading top-line growth. Trial Tr. 11/22/16, 410:1–411:5 (Cordani); [redacted] Absent the proposed merger with Anthem, Cigna will continue to invest and introduce new innovations in local markets. Trial Tr. 11/22/16, 444:16–447:13 (Cordani) (describing Cigna's planned expansion of customized networks).

(iii) Dr. Dranove's economic analysis shows that Anthem and Cigna are closer competitors than market shares predict.

70. Dr. Dranove evaluated whether market shares accurately reflect the impact of the merger by looking at closeness of competition—in particular, whether customers tend to prefer Anthem and Cigna more often than their shares would imply. Trial Tr. 12/20/16, 3724:2–14 (Dranove). He began by noting the many customer-specific examples where Anthem and Cigna competed head-to-head for a given account. Trial Tr. 12/20/16, 3724:15–3725:14 (Dranove).

71. Dr. Dranove then examined win/loss data across the 35 CBSAs and on a state-by-

state basis. Trial Tr. 12/20/16, 3728:14–3729:13 (Dranove). He aggregated the data because the parties' win/loss data contained too few observations at the CBSA level for robust analysis, and he examined the data at the state level to see if aggregation could overstate or understate the merger's effects. Trial Tr. 12/20/16, 3726:3–22 (Dranove). This is despite the fact that ASO customers, like those for whom Cigna most often competes, likely go out to bid less frequently than fully insured accounts. Trial Tr. 12/21/16, 4095:12-4098:17 (Rothermel). Dr. Dranove found that Anthem and Cigna tend to be closer competitors than market shares predict. Trial Tr. 12/20/16, 3728:14–3729:13 (Dranove); *see* PDX033 at 38–39 (in three of the four aggregate win/loss studies presented by Dr. Dranove, diversion implied by win/loss was greater than diversion implied by market shares).

72. Using the state-by-state data, Dr. Dranove found that in most instances (e.g., Connecticut, California, New York) the data showed higher diversions between Anthem and Cigna than shares would predict. Trial Tr. 12/20/16, 3729:14–3730:3 (Dranove); [redacted] In some states (e.g., New Hampshire, Maine) the data showed lower diversions between Anthem and Cigna than shares would predict. Trial Tr. 12/20/16, 3729:14–3730:3 (Dranove); [redacted] In markets in some of these states, however, the combined shares are as high as 60 or 70 percent, making the win/loss data less relevant. Trial Tr. 12/20/16, 3719:9–19 (Dranove). Dr. Dranove noted that the data for New Hampshire and Maine included very few observations and thus does not permit a statistical inference about Anthem's and Cigna's closeness of competition in those states. Trial Tr. 12/20/16, 3729:14–3731:20 (Dranove).

73. In contrast to Dr. Dranove's analysis, Dr. Willig's attempted win/loss analysis suffers from three critical flaws. First, Dr. Willig tried to perform a matching analysis to confirm wins and losses in both Anthem's and Cigna's data, but the data does not allow for such an

analysis and produced implausible results. Trial Tr. 12/20/16, 3732:10–3733:18 (Dranove). Indeed, the analysis was so incompatible with the data that it mathematically prevented Dr. Willig's Cigna-to-Anthem diversion ratio from ever exceeding 11.6%. Trial Tr. 1/3/17, 4657:11–4664:10 (Willig). Second, although Dr. Willig excluded any win/loss data where the same result could not be confirmed in both Anthem's and Cigna's data, he did not look for the same matching when assessing win/loss data involving other insurers. Trial Tr. 12/20/16, 3733:19–3734:5 (Dranove). Third, Dr. Willig's diversion calculations were not limited to the 35 CBSAs; they were calculated based on Anthem's entire 14-state footprint, which included many states and CBSAs for which the government alleged no harm. Trial Tr. 1/3/17, 4673:25–4674:7 (Willig). Thus, Dr. Willig's analysis tends to understate the extent to which Anthem and Cigna compete with each other, and tends to overstate the extent to which they both compete with other insurers. Trial Tr. 12/20/16, 3733:19–3734:5 (Dranove). Finally, even if Dr. Willig's UPP analysis were accurate, it would fail to establish net benefit in each CBSA because it analyzes the CBSAs as an aggregated whole. Trial Tr. 1/3/17, 4674:6–4675:9 (Willig). In other words, net upward pricing pressure in any individual CBSA would be obscured in Dr. Willig's analysis by data from other markets. Trial Tr. 1/3/17, 4674:6–4675:9 (Willig).

(iv) Dr. Dranove's merger simulation and UPP models both show substantial static harm from the merger.

74. Under the various simulation models, and assuming no efficiencies, Dr. Dranove found that the aggregate harm is likely to be somewhere between $531 and $884 million per year in the 35 CBSAs. PX0752 at 1–4; Trial Tr. 12/20/16, 3737:16–3738:11 (Dranove). If all $515 million in claimed G&A efficiencies are achieved, the aggregate harm would range from $449 million to $803 million. PX0752 at 5–7; Trial Tr. 12/20/16, 3734:19–3739:9 (Dranove). To

quantify the static price effects, Dr. Dranove used the same merger simulation and UPP models that he used in Phase 1. Trial Tr. 12/20/16, 3734:6–18 (Dranove).

75. Even Dr. Israel predicts the merger will produce static harm in the absence of efficiencies. Trial Tr. 12/22/16, 4409:17–21 (Israel).

(v) Dr. Fowdur's critical loss analysis is not appropriately applied in a market where sales are made by RFP and prices individually negotiated.

76. Dr. Fowdur's critical loss analysis is misguided. Critical loss analysis evaluates what would happen if the hypothetical monopolist raised all prices by X percent and then calculates how much business the monopolist would have to lose for such a price increase to be unprofitable. Trial Tr. 1/3/17, 4704:15–4706:1 (Dranove). Critical loss is unhelpful in this case, because there is no evidence that Anthem would uniformly raise its prices after the merger. Trial Tr. 1/3/17, 4704:15–4706:1 (Dranove). Instead, the unilateral price effects would follow from customer-specific RFPs and would be felt most acutely by customers that rank Anthem and Cigna highly. Trial Tr. 1/3/17, 4704:15–4706:1 (Dranove).

E. Competitive harm will not be prevented by entry, expansion, or existing competitors.

(i) Provider-sponsored plans and other regional players

77. At trial, Anthem's witnesses have argued that provider-sponsored entry is sufficient to counteract the merger's likely effects on competition, particularly at the local level. In particular, Anthem has cited several examples, including Kaiser, Sutter, Bon Secours, Optima, and Innovation Health. *See* [redacted] Trial Tr. 12/15/16, 3042:22–24, 3054:19–3056:4 (King). With the exception of Kaiser, however, which has spent decades building its business model, even Anthem's carefully chosen provider-sponsored plans have struggled to expand. *See, e.g.*, Trial Tr. 12/20/16, 3741:1–3742:4, 3744:18–3746:8 (Dranove); [redacted]

[redacted] Trial Tr. 12/19/16, 3406:5–16 (Wheeler/Bon Secours) (Bon Secours does not have the capital necessary to expand into new markets); *see also* Caldwell (Alliant) 10/17/16 Dep. 10:13–24, 27:2–28:5 (observing that Alliant is the only provider-sponsored plan left in Northern Georgia after others exited); [redacted]

78. In California, for example, Anthem testified that Sutter Health is "making a competitive impact in California for large group." *See* Trial Tr. 12/21/16, 4084:11–15 (Rothermel). [redacted] Many other examples of provider-sponsored plans struggling to compete in local markets are discussed in the market-specific sections below. *See infra* Section IV.

79. Even Kaiser, while successful in its own niche, is unlikely to constrain Anthem or Cigna in the local markets where it competes. Anthem executives have testified that Kaiser is not

a good option for most large-group employers in California who want an ASO or PPO product. *E.g.*, Kehaly 4/28/16 Dep. 67:11–68:13. [redacted]

80. And brokers have confirmed Kaiser's limitations. For example, a broker from California testified that Anthem and Cigna do not respond to Kaiser's pricing of medical products because Anthem and Cigna have "different delivery model[s], different economics . . . ; they're different animals." Brown (Arthur J. Gallagher) 10/14/16 Dep. 57:20–59:1. Thus, brokers are "almost never" able to leverage a bid from Kaiser to extract more favorable pricing from Anthem or Cigna. Brown (Arthur J. Gallagher) 10/14/16 Dep. 57:20–59:1. Brokers from other areas have echoed these sentiments. *See, e.g.*, Trial Tr. 12/15/16, 2982:7–9 (Hawthorne/Scott Insurance) (broker has not placed any clients with Kaiser in the Richmond, Virginia area); [redacted] *see also* PX0629 at -027-53 (same).

81. [redacted] *see also infra* Section IV.C.iii.c.

82. Like entry by other fully-insured regional HMO players, entry by provider-sponsored plans will not provide a new competitive option for many customers of Anthem and Cigna. Trial Tr. 12/20/16, 3741:5–3742:4 (Dranove).

(ii) Third-party administrators

83. As in the market for national accounts, TPAs are unlikely to counteract the merger's anticompetitive effects at a local level in the relevant geographic markets. TPAs in the relevant local markets face many of the same challenges that were discussed in Phase 1. TPAs generally have higher costs than large-group insurers with their own networks. *See* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact) at ¶¶ 330–33; *see also, e.g.*, Corcoran 3/9/16 Dep. 183:23–25; Phillips 4/14/16 Dep. 321:16–322:11; [redacted] Most TPAs rely on networks rented from national insurers. *See* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact) at ¶¶ 313–14; *see also, e.g.*, [redacted] And TPAs have little recourse when their network supplier raises their rates. *E.g.*, [redacted] Gray (Key Benefit Admin.) 9/28/16 Dep. 84:6–20.

84. In addition, TPA arrangements typically contain non-compete clauses with the national insurers. *See* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact) at ¶¶ 320–24; *see also, e.g.*, Trial Tr. 12/21/16, 4140:2–3, 4140:12–4141:14, 4143:11–14, 4147:5–17 (Rothermel); PX0740 at -213–214, -219 (discussing Anthem policy, incorporated in most of its TPA contracts, that prohibits TPA partners from quoting against Anthem); PX0741 at -029; [redacted]

85. As just one example, Anthem identified Collective Health, a TPA in California, as one of its top competitors for large-group business. Trial Tr. 12/21/16, 4131:14 –4132:1 (Rothermel). But Anthem also partners with Collective—a partnership that Anthem executives internally touted in May 2016 as "creating competition," which "is a good thing in the near-term as we are looking to acquire CIGNA." PX0745 at -373; Trial Tr. 12/21/16, 4164:4–7 (Rothermel).

Indeed, they concluded that if Collective "ever truly become[s] a threat, we can mirror much of their experience/technology, *and further we hold all the cards because we have the network which we can pull*." PX0745 at -373 (emphasis added); Trial Tr. 12/21/16, 4164:8–13 (Rothermel).

86. [redacted]. Two other TPAs in the relevant markets similarly testified that they do not have plans to expand. [redacted]

(iii) Private exchanges have not facilitated entry or enhanced competition in the large-group segment

87. Private exchanges are unlikely to constrain large group pricing post-merger. Much of the evidence relating private exchanges from Phase 1 applies with equal force to the large-group market. *See* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact), Section VI.F. Anthem has offered no evidence demonstrating that the private exchange distribution platform has facilitated entry or increased the number of competitors vying for large-group commercial business in any relevant geographic area. And private exchanges have not gained traction at nearly the rate that what was predicted a few years ago. *See, e.g.*, Mascolo (Wells Fargo) 10/20/16 Dep. 148:3–18; Sharp (Aon) 10/6/16 Dep. 30:16–23; Soumakis 4/13/16 Dep. 104:15–105:4; 179:5–18; [redacted] PX0675 at -417-23; [redacted]

(iv) There are significant entry barriers to serving large groups.

88. Entry, expansion, or repositioning into the large-group segment would not be timely, likely or sufficient enough to prevent post-merger competitive harm.

89. Many of the barriers to serving national accounts are also barriers to serving local large groups. *See* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact), Section VI.E. First, an entrant would need to develop a provider network with sufficient geographic scope to serve large-group customers and their employees. [redacted]

90. [redacted]—which already markets commercial, Medicaid, and Medicare products in multiple states—[redacted] Health insurers (or other entrants) looking to expand must "file the products, build the products, negotiate the contracts with providers, [and] build relationships with the distribution systems in other states, all of [which] is extremely time consuming, expensive, and for large group, the time frames are very extended." [redacted]

91. Second, an entrant would need to offer competitive unit costs. *See* [redacted] This requires sufficient membership. That is, an entrant must have sufficient patient volume with a particular provider to receive discounts from that provider comparable to those received by other insurers. [redacted] Caldwell (Alliant) 10/17/16 Dep. 62:19–63:7, 64:14–25, 67:7–68:10 (it would take Alliant "over five years" and "approximately $20 million" to obtain the

necessary membership to successfully compete in Atlanta); Trial Tr. 12/21/16, 4028:6–10 (Burke/Maine Education Association Benefits Trust) (in Maine, health insurers need about 250,000 lives to profitably sell medical products); *see also* PX0378 at -704 ("[T]he more patients doctors and hospitals see from a carrier, the more leverage that carrier has to negotiate the best arrangements in the market."); [redacted]

92. Even providers, which may have access to their employees as a way to build membership, have been unable to to develop health plans with sufficient membership to compete effectively for large-group business. *See supra* Section I.E.ii; Trial Tr. 12/20/16, 3741:1 –16 (Dranove) ("it takes time and is difficult to expand beyond" the provider's own employees).

93. Third, an entrant would need to offer the necessary administrative services and a competitive ASO fee or premium. *See, e.g.*, [redacted]

94. Fourth, because major large group competitors like Anthem "sell 99 percent of [their] services through brokers and consultants," Trial Tr. 12/21/16, 4087:12–13 (Rothermel), an entrant would need to build relationships with those influencers. Doing so is a "long and arduous task." Tallman (Centene) 10/14/16 Dep. 123:21–124:1, 148:11–25.

95. For the foregoing reasons, [redacted]

[redacted]

96. Entry, expansion, or repositioning is made even more unlikely by the fact that opportunities in the large-group segment arise relatively infrequently. *See, e.g.*, [redacted] Tallman (Centene) 10/14/16 Dep. 67:19–21 (Centene has not seen any new entry in large group). This, of course, likely diminishes a would-be entrant's incentive to undertake the extensive efforts required to compete for large-group business.

97. For entry to sufficiently "offset the harm that results . . . from removing Cigna from the market," an entrant must replace Cigna's "competitive impact on the market." Trial Tr. 12/20/17, 3739:10–3740:3 (Dranove). Even if an entrant overcomes the barrier of assembling an attractive provider networks within a local market, it may *still* not be competitive for geographically dispersed large groups based in that very same market. *See* Trial Tr. 1/3/17, 4699:13–4700:4 (Dranove). For example, Harvard Pilgrim, one of the largest regional insurers in the country, is rarely competitive for accounts with employees outside of its footprint despite having a provider network that spans several states. Trial Tr. 1/3/17, 4697:9–12, 4698:18–4699:11 (Dranove); *see also* Trial Tr. 1/3/17 4696:15–4700:4 (Dranove) (discussing [redacted] Dr. Dranove demonstrated that Harvard Pilgram's market share is "essentially zero" unless at least 40 percent of a large group's employees reside within its four-state footprint. Trial Tr. 1/3/17, 4698:18-4699:11 (Dranove).

98. Dr. Willig erroneously claimed that entry and expansion could defeat any attempted price increase if the merged entity lost just 2.4 percent of sales as a result of the price increase. Trial Tr. 1/3/17, 4551:20–4852:8 (Willig). Anthem derives this figure by misapplying a six percent critical loss to an assumed Anthem 40 percent market share. Trial Tr. 1/3/17, 4551:9–4852:8 (Willig); Trial Tr. 12/22/16, 4212:7–4213:4 (Fowdur) (calculating critical loss of 9.2 percent). Anthem's critical loss analysis is flawed because, as Dr. Dranove explained, its application of a critical loss test is based on the erroneous assumption that the merged firm will somehow enact a uniform across-the-board price increase to all of its customers. Trial Tr. 1/3/17, 4704:15–4706:1 (Dranove). Both this assumption and the subsequent application of critical loss are inappropriate to assess the effects of this merger because they are at odds with the institutional realities of health insurance purchasing. Trial Tr. 1/3/17, 4704:15–4706:1 (Dranove). "[T]he critical loss experiment that [Anthem is] running . . . , [t]hat's what you do in a posted price market. But this is not a posted price market. We have to remember that this is a price discrimination market where the insurers can tailor their bids to the demands of each of their individual[] customers." Trial Tr. 1/3/17, 4705:3–11. (Dranove). For this reason, harm from the merger will occur on a customer-by-customer basis through an RFP process, not through an across-the-board increase in posted prices as Anthem assumes. Trial Tr. 1/3/17, 4704:15–4706:1 (Dranove).

II. THE MERGER WOULD SUBSTANTIALLY LESSEN COMPETITION IN 35 LOCAL MARKETS FOR THE PURCHASE OF HEALTHCARE SERVICES BY COMMERCIAL INSURERS.

A. The purchase of healthcare services by commercial insurers is a relevant product market.

99. The purchase of healthcare services by commercial insurers is a relevant product market. Trial Tr. 12/20/16, 3777:8–21 (Dranove). This definition includes healthcare services

purchased for all types of commercial insurance plans, such that the only alternative for a provider to avoid a small but significant and nontransitory reduction in price ("SSNRP") would be forgoing commercial insurance revenue altogether and expanding its revenue from non-commercial sources. Trial Tr. 12/20/16, 3777:8–3779:8 (Dranove).

(i) Plaintiffs' market definition is consistent with industry practice.

100. Commercial health insurers have separate business units dedicated to negotiating the purchase of healthcare services from providers. Leopold 3/29/16 Dep. 34:11–23; [redacted] Muney 4/6/16 Dep. 19:15–20:4; Van Etten (Kaiser) 10/13/16 Dep. 12:8–19; Cheslock 10/12/16 Dep. 19:9–20:4. Both defendants "employ[] staff responsible for provider contracting and relations." ECF #15 (Anthem's Answer) at ¶ 66; ECF #144 (Cigna's Answer) at ¶ 66.

101. Commercial health insurers typically negotiate a single rate for all types of commercial plans. [redacted]

102. Insurers also negotiate commercial discounts distinct from non-commercial ones. Leopold 3/29/16 Dep. 108:17–109:19, 110:23–111:7 [redacted] Pogar 3/30/16 Dep. 93:25–94:18. Anthem, which sells both commercial and Medicare Advantage products, has separate contracting teams dedicated to negotiating commercial rates. Ramseier 4/22/16 Dep. 10:8–20. In fact, providers who participate in both Anthem products typically have two rate contracts, one for each product. PX0407 at -540 [redacted]

[redacted]

103. As part of their effort to build a competitive provider network, these provider-contracting teams regularly formulate their own business plans and develop provider-specific reimbursement strategies. *See, e.g.*, [redacted] PX0558 at 663-1–42 [redacted] DX0592 [redacted] PX0394 at -086-1–129-29 [redacted]

104. Insurers focus on provider contracting for good reason: building provider networks in the buy-side market is part of how they compete in the sell-side market. Trial Tr. 12/20/16, 3785:4–3787:8 (Dranove). Commercial insurers try to contract with as many providers as necessary and negotiate discounts to make their network attractive to employers. Trial Tr. 12/20/16, 3785:18–3786:7 (Dranove); Drozdowski 5/4/16 Dep. 82:5–83:22; Trial Tr. 11/30/16, 1652:11–1653:1 (Drozdowski).

105. But insurers also compete to form integrated collaborations with providers. Increasingly, commercial health insurers vie to be the one partner to collaborate deeply with key providers in a market, thereby precluding other insurers from doing so. *See* Leopold 3/29/16 Dep. 273:4–15, 274:13–275:10, 276:8–277:4, 279:23–280:2; Muney 4/6/16 Dep. 88:8–89:14; Golias 6/3/16 Dep. 101:10–102:13.

(ii) The purchase of healthcare services by commercial insurers satisfies the hypothetical monopsonist test.

106. A firm that is the only present and future purchaser of healthcare services provided to commercially insured patients likely would impose at least a SSNRP. Trial Tr. 12/20/16,

3775:21–3776:7 (Dranove).

107. Providers earn revenue by treating commercially-insured and non-commercially insured patients. Non-commercially insured patients include those who pay entirely out-of-pocket and those who are covered by Medicare, Medicare Advantage, and Medicaid. Trial Tr. 12/20/16, 3777:22–3779:8 (Dranove).

108. Healthcare providers would be forced to accept a SSNRP because they have no reasonable substitutes to serving commercially insured patients. Trial Tr. 12/20/16, 3774:22–3783:12 (Dranove). Providers cannot reject a SSNRP, and thereby lose all of their commercially insured patients, by replacing commercial patients with government-insured patients because (1) government programs have lower reimbursement rates than commercial insurers, and (2) there is a fixed number of government-insured patients. Trial Tr. 12/20/16, 3777:22–3784:12 (Dranove). Similarly, providers cannot reject a SSNRP by replacing commercial patients with uninsured patients because relatively few patients are uninsured and providers generally serve such patients at a loss. Trial Tr. 12/19/16, 3416:6–17 (Wheeler/Bon Secours); Carley (Centura Health) 10/7/16 Dep. 67:22–68:16; McCreary (UC Health) 10/6/16 Dep. 85:6–21; *see also* Trial Tr. 11/28/16, 1016:22–1017:19 (Dranove); Trial Tr. 12/20/16, 3777:22–3778:18 (Dranove).

109. Government programs typically reimburse providers for healthcare services at far lower rates than commercial health insurers. ECF #15 (Anthem's Answer) at ¶ 67; ECF #144 (Cigna's Answer) at ¶ 67; Trial Tr. 12/16/16, 3146:12–14 (Gorse/Patient First); Butler 4/29/16 Dep. 115:23–116:6. Commercial reimbursement rates are generally paid in multiples of Medicare rates. Pogar 3/30/16 Dep. 96:17–97:4 (describing commercial rates as "flexed up" compared to Medicare rates); [redacted] Medicare Advantage rates are nearly identical to Medicare. PX0403 at -999; Morris 4/8/16 Dep. 88:25–91:3, 153:17–154:2.

110. Indeed, many providers rely on commercial reimbursement to subsidize losses from treating government patients. Trial Tr. 12/19/16, 3416:6–17 (Wheeler/Bon Secours); Trial Tr. 12/14/16, 2860:25–2861:6 (Berfiend/IU Health); Trial Tr. 12/16/16, 3146:15–18 (Gorse/Patient First); Trial Tr. 12/16/16, 3270:19–22 (Lipman/LRGHealthcare); [redacted] PX0397 at -066, -078 [redacted] PX0726 at -606-19–20 [redacted] Wilhelmsen (Southern NH) 10/14/16 Dep. 55:1–23; [redacted] Pogar 3/30/16 Dep. 107:21–108:7. As Anthem's CEO testified, these are "the rules of engagement in the industry." Trial Tr. 11/21/16, 281:22–282:6 (Swedish). Thus, in terms of covering their total costs, providers cannot make up for losses in commercial patients by substituting Medicare and Medicaid patients, because they lose money on Medicare and Medicaid patients. Trial Tr. 12/20/16, 3777:22–3783:12 (Dranove).

111. Dr. Dranove confirmed this testimony by calculating the number of government-insured patients it would take to offset the loss of a single commercially insured patient. Trial Tr. 12/20/16, 3779:9–3783:4 (Dranove). Using payment-to-cost ratios from the American Hospital Association, Dr. Dranove found that providers would need to treat "roughly three new Medicare or Medicaid patients to offset each commercially insured patient that they lost." Trial Tr. 12/20/16,

3782:13–3783:4 (Dranove).

112. But even if treating government patients were profitable, it would be difficult for providers to attract more of these patients. Government insured patients are a fixed population and attracting more of these patients is a zero-sum game for providers. Trial Tr. 12/20/16, 3777:22–3779:8 (Dranove); Trial Tr. 12/16/16, 3146:19–3147:1 (Gorse/Patient First) ("[T]here's no untapped pool of governmental program patients . . . that would just magically be brought into our medical centers."). Moreover, reimbursement rates for government patients are non-negotiable, meaning providers could not lower their Medicare or Medicaid rates in the hopes of attracting more patients to their facilities. Trial Tr. 12/20/16, 3777:22–3779:8 (Dranove); Drozdowski 5/4/16 Dep. 29:24–30:13; *see also* ECF #200 (joint stipulations) at 3–5. A similar problem exists for Medicare Advantage, which allows only a limited range of negotiation over rates. Morris 4/8/16 Dep. 88:25–91:3, 153:17–154:2; Drozdowski 5/4/16 Dep. 29:24–30:16.

113. Like government-insured patients, providers typically treat uninsured patients at a loss. Trial Tr. 12/19/16, 3416:6–17 (Wheeler/Bon Secours); Carley (Centura Health) 10/7/16 Dep. 67:22–68:16; McCreary (UC Health) 10/6/16 Dep. 85:6–21. Patients who are uninsured generally cannot pay for healthcare out-of-pocket. Even so, patients who do pay out-of-pocket—i.e., self-paying—account for a minimal source of patients for providers, particularly relative to commercially insured patients. E.g., PX0542 at -748-2 [redacted] Trial Tr. 12/16/16, 3144:5–12 (Gorse/Patient First) [redacted]

114. Insured patients for whom a provider is out-of-network are also generally

unwilling to pay entirely out-of-pocket for care. The list or "chargemaster" price for any particular service is typically substantially higher than an agreed-upon charge negotiated by a patient's insurer. *See* Archer (HealthSmart) 10/20/16 Dep. 95:25–96:20 ("[W]ithout a network, they're paying billed charged, which is kind of like the sticker price on a car. Right? I mean nobody wants to pay that."); *cf.* Trial Tr. 11/28/16, 796:17–797:5 (Bierbower/Humana) (stating that when a patient "go[es] out of network," "the costs [are] higher"). Subscribers typically pay a higher share of the cost of out-of-network care. As a result, only a small minority of insured individuals would be willing to pay for out-of-network care. *See* Archer (HealthSmart) 10/20/16 Dep. 95:25–96:20; *cf.* Martenet 10/19/16 Dep. 130:5–12.

115. For these reasons, this market satisfies the hypothetical monopsonist test. Because the relevant market includes all forms of commercial insurance, a healthcare provider faced with a small but significant, non-transitory reduction in price, or SSNRP, has only one alternative: sufficiently expand its revenue from non-commercial sources. Trial Tr. 12/20/16, 3777:22–3779:8 (Dranove). But "there's really no feasible way to make up the losses that would be incurred" by forgoing all revenue from commercial insurers because neither of providers' non-commercial sources of revenue—non-commercial insurers or self-pay—are substitutes for treating commercially insured patients. Trial Tr. 12/20/16, 3777:22–3779:8 (Dranove).

B. The same 35 metropolitan areas are also relevant geographic markets on the buy-side.

116. Each of the 35 CBSAs alleged in the Complaint is a relevant geographic market for the purchase of healthcare services by commercial health insurers. Defining markets around metropolitan areas is consistent with industry practice, each CBSA passes the hypothetical monopsonist test.

(i) Local markets are consistent with industry practice

117. As with the sale of commercial health insurance to large groups, the geographic markets for the purchase of healthcare services are appropriately defined as local. Because individuals want access to local healthcare networks, insurers compete to assemble local networks that are attractive to employers purchasing insurance on their employees' behalf. *See supra* Section I.B.i; *see* Trial Tr. 12/20/16, 3784:15–3785:3 (Dranove).

118. Providers also view the markets as local and often define their primary service areas based on where the majority of their patients live or work. *See* Benton (New West) 10/20/16 Dep. 77:10–12, 77:14–78:3; [redacted] Wilhelmsen (Southern NH) 10/14/16 Dep. 16:24–17:14, 17:21–23, 18:3–11; [redacted] Trial Tr. 12/19/16, 3392:16–23 (Wheeler/Bon Secours).

119. Consistent with this practice, providers regularly use MSAs or MiSAs to classify geographic markets. [redacted] Trial Tr. 12/16/16, 3143:7–18 (Gorse/First Patient) (Patient First's Richmond offices treat patients from the Richmond metropolitan area and its Virginia Beach offices treat "99 percent . . . local people"); Trial Tr. 12/16/16, 3268:25–3270:4, 3292:19–3295:4, 3296:14–3298:7 (Lipman/LRGHealthcare) (Most LRG patients, about 75 percent, come from Belknap County, which is part of the Laconia MiSA. The majority of LRG patients are from the CBSA that contains Laconia and nearby towns and includes Belknap County); Trial Tr. 12/19/16, 3392:7–23, 3393:4–3394:9, 3394:15–3395:9, 3398:8–16 (Wheeler/Bon Secours) (explaining that

Bon Secours views Richmond as a market); [redacted]

120. Even when providers are not familiar with the term CBSA or MSA/MiSA, they describe their geographic markets as being metropolitan areas that are essentially the same as CBSAs or MSAs. *See* [redacted] Trial Tr. 12/19/16, 3434:5–9, 3390:24–3391:3, 3398:8–14, 3398:25–3399:6, 3399:12–20 (Wheeler/Bon Secours) (witness had only a vague understanding of the term "MSA" but repeatedly referred to the "Richmond market" or "Richmond marketplace," which is essentially synonymous with the Richmond MSA).

121. Because healthcare is delivered locally, provider arrangements are negotiated locally. *See, e.g.*, Wenners 9/30/16 Dep. 27:6–7, 27:10–22; Drozdowski 5/4/16 Dep. 22:19–23:2. Providers set reimbursement rates on a local basis. *E.g.*, [redacted] When insurers negotiate reimbursement rates with providers, the strength of their market power is established on a CBSA basis. Trial Tr. 12/20/16, 3785:18–3786:3 (Dranove); DeVeydt 10/14/16 Dep. 69:14–20.

(ii) The 35 local buy-side markets satisfy the hypothetical monopsonist test.

122. Each of the 35 geographic markets easily satisfies the hypothetical monopsonist test. Because the vast majority of providers would not relocate in response to a SSNRP, a hypothetical monopsonist could profitably impose a SSRNP on providers in each CBSA.

123. As Dr. Dranove testified, relocation is not a reasonable option because moving to a different metropolitan area would be prohibitively expensive for providers. Hospitals and physicians make significant local investments in terms of capital, patient relationships, and community reputation. Trial Tr. 12/20/16, 3783:24–3785:5 (Dranove). Relocating a hospital generates substantial fixed costs, including building or purchasing a new facility, and also would cause significant disruption in operations. Trial Tr. 12/20/16, 3783:13–3784:14 (Dranove). For a physician, relocation would damage professional relationships, including patient relationships developed over time, and further disrupt the physician's personal and family life. Trial Tr. 12/20/16, 3783:24–3785:5 (Dranove). Given these substantial costs associated with relocating to another CBSA, healthcare providers would have no choice but to accept a SSNRP in commercial reimbursement rates. Trial Tr. 12/20/16, 3783:13–3784:5 (Dranove).

C. The merger is presumptively unlawful in most of the relevant markets.

124. Anthem and Cigna's combined market share in 28 of the 35 CBSAs at issue exceed the thresholds presumed to be unlawful. *See* [redacted] For discussion of the presumption and the purpose of measuring market shares, see ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact), Section IV.

125. Consistent with industry realities, Dr. Dranove assessed the competitive significance of commercial insurers to providers in the 35 CBSAs based on the number of patients each can offer to providers in each CBSA. Trial Tr. 12/20/16, 3787:9–18; 3788:9–12, 3708:12–3709:7 (Dranove). Enrollment shares are a relevant proxy for buy-side market power because an insurer with a larger enrollment share will typically account for a greater share of a provider's patient volume and revenue. *See* Trial Tr. 12/20/16, 3793:20–24 (Dranove); Trial Tr. 12/22/16, 4369:16–24 (Israel); [redacted]

[redacted] Enrollment shares are a more accurate measure of competitive significance than reimbursement shares, because larger insurers command lower reimbursement rates. *See* Trial Tr. 12/20/16, 3792:8–22 (Dranove).

126. Commercial enrollment in a given CBSA is a reliable proxy for an insurer's competitive significance as a purchaser of healthcare services for commercially-insured patients in that CBSA. *See* Drozdowski 5/4/16 Dep. 244:13–246:9 (identifying a positive correlation between Anthem's market share in the sale of health insurance products with the percentage of a provider's patients who belong to Anthem). Therefore, the CBSA commercial enrollment shares (the numerator) provide a useful measure of each insurer's likely significance to providers in the CBSA. Trial Tr. 12/20/16, 3709:8–3710:2 (Dranove).

127. Insurer buy-side market power is estimated by calculating "all commercial" shares, combining individual and group enrollment. Trial Tr. 12/20/16, 3788:9–12 (Dranove). Blue Cross Blue Shield insurers are treated as a single entity for this analysis because "[w]hen Anthem is negotiating with a provider in a given market, it's negotiating over all of the lives that it's bringing to that provider, and that includes the BlueCard lives that come with it." Trial Tr. 12/20/16, 3788:14–19 (Dranove); *accord* Drozdowski 5/4/16 Dep. 230:18–231:3; Wenners 9/30/16 Dep. 101:4–14; Pogar 3/30/16 Dep. 299:14–300:13; PX0167 at -768; PX0244 at -433.

128. The approach to calculating the commercial market size is similar to the approach used to calculate large-group market size. Trial Tr. 12/20/16, 3787:9–3789:12 (Dranove); *see also supra* Section I.C.ii. The census approach estimate exceeded the build-up approach estimate for 25 of the 35 CBSAs. Trial Tr. 12/20/16, 3789:13–20 (Dranove).

129. Among the 35 CBSAs, Anthem and Cigna have "very, very high combined shares in a lot of the markets." Trial Tr. 12/20/16, 3789:21–3790:7 (Dranove); *see* [redacted] Under the 2010 Horizontal Merger Guidelines, mergers in highly concentrated markets (resulting in an HHI above 2,500) that raise the HHI by more than 200 points are presumed likely to enhance market power. *See* 2010 Horizontal Merger Guidelines § 5.3. The presumption holds for 28 of the 35 CBSAs. [redacted] Trial Tr. 12/20/16, 3794:6–16 (Dranove). The other seven CBSAs barely miss the 2,500 threshold. [redacted] Trial Tr. 12/20/16, 3794:6–16 (Dranove). The post-merger increases in HHI exceed 200 in every market, and in most cases the increase is far larger than this. [redacted] The increase in HHI exceeds 300 in 33 markets, exceeds 500 in 26 markets, and exceeds 1,000 in 11 markets. [redacted]

130. Graphs presenting market shares and HHIs for the 35 large group CBSAs appear in Appendix A.

131. These market shares are durable, in part, because barriers to entry in the buy-side markets are similar to those that apply on the sell-side. Trial Tr. 12/20/16, 3808:25–3809:11 (Dranove).

D. The merger would substantially lessen competition for the purchase of healthcare services by commercial health insurers in the 35 relevant markets.

(i) Providers would lose the benefits of competition between Anthem and Cigna.

a. Competition enables providers to negotiate more favorable rates and terms of reimbursement with insurers.

132. Competition among insurers allows providers to negotiate for more favorable terms and rates by giving the providers opportunities to access patients through different insurers. Trial Tr. 12/20/16, 3785:4–10 (Dranove); *see also* [redacted] That competition is present during provider contracting with Anthem and Cigna, given

that "[i]n the majority of instances [Anthem and Cigna] have overlap of providers." Trial Tr. 11/30/16, 1652:18–19 (Drozdowski).

133. [redacted]

134. [redacted]

b. Competition leads insurers to be more responsive, for example, in paying claims.

135. From the perspective of providers, insurers compete with one another in areas outside of reimbursement rates and provider collaboration, such as in the payment of claims. For example, Anthem has been non-responsive in dealing with contractual issues with HealthCare Partners, whereas Cigna has been very responsive, making it quicker to resolve these issues.

Aumock (HealthCare Partners) 10/19/16 Dep. 93:2–94:6. Similarly, LRGHealthcare explained that it has "more challenges with getting claims paid through Anthem than Cigna at this point." Trial Tr. 12/16/16, 3278: 2–9 (Lipman/LRGHealthcare). [redacted] As Anthem recognizes, insurers have an incentive to perform well in claims payment because providers may accept lower rates in return. *See* Wenners 9/30/16 Dep. 36:13–18, 39:1–9.

c. Competition to partner with providers on collaborative care leads to better value-based models that enable providers to improve efficiency and quality.

136. For a discussion of how competition between Anthem and Cigna has encouraged innovation and benefited provider collaborations, see Section III, *infra*.

(ii) The merger would increase Anthem's buy-side market power, harming providers and patients.

a. Anthem already has substantial bargaining leverage when negotiating with doctors and hospitals.

137. Anthem acknowledges that [redacted] PX0167 at -768; *see also* PX0378 at -704 [redacted] Anthem generally has the best discount rates among insurers and gets better discounts in states where it has a higher market share. *See* Trial Tr. 11/21/16, 289:21–290:18 (Swedish); *see also* PX0496 at -238; PX0378 at -704; Pogar 3/30/16 Dep. 389:6–389:24; Pogany 4/29/16 Dep. 221:25–223:11; Kehaly 4/28/16 Dep. 76:15–25; Wenners 9/30/16 Dep. 37:13–38:12. Cigna executives agree that market share

helps an insurer get better rates and terms. *See* PX0264 at -063; Muney 4/6/16 Dep. 103:16–105:12, 111:15–112:2.

138. Providers have testified that Anthem's high market share results in lower rates, in large part because it gives Anthem leverage in negotiations. [redacted] Similarly, LRGHealthcare stated that Anthem has been able to exert more control in the contracting process than the smaller insurers, and has therefore obtained lower rates from LRG than any other insurer. Trial Tr. 12/16/16, 3272:13–3273:16 (Lipman/LRGHealthcare). Anthem's size allows it to obtain the lowest rates and lowest escalators of the commercial insurers that contract with Bon Secours' Richmond and Hampton Roads hospitals. Trial Tr. 12/19/16, 3397:14–3398:7 (Wheeler/Bon Secours).

b. The merger would enhance Anthem's bargaining leverage, likely leading to lower reimbursement rates.

139. For both hospitals and physicians, lower provider rates will be the result of providers having fewer options to sell their services post-merger, clearly implicating an increase in market power. Trial Tr. 1/3/17, 4746:16–22 (Dranove).

140. Providers currently have the option to encourage patients to switch to Cigna in response to a low offer from Anthem, but this option would be lost with the merger. Trial Tr. 12/20/16, 3791:3–3792:7, 3796:22–3797:5 (Dranove). Importantly, providers' options would be worse post-merger even in the absence of an ability to steer their patients. The financial consequences of rejecting a low offer are greater the greater the proportion of commercial customers that stand to be lost thereby. Anthem could thus dictate an even lower offer post-merger. Trial Tr. 12/20/16, 3792:8–22 (Dranove).

141. There are two primary mechanisms insurers use when setting upstream prices, which depend on the size of the provider. Solo physicians and small physician groups receive take-it-or-leave-it offers; there is no negotiation. Trial Tr. 12/20/16, 3790:15–3791:19 (Dranove). The price-setting mechanism is somewhat different for hospitals and larger physician groups because reimbursement rates are actively negotiated. Trial Tr. 12/20/16 3792:23–3793:19 (Dranove); Wenners 9/30/16 Dep. 29:9–23, 69:2–8; *see also* Leopold 3/29/16 Dep. 108:3–16, 169:3–170:5, 170:11–17, 171:1–12, 177:3–18, 178:19–179:6, 307:7–308:14. The merger would expand Anthem's market power over small practices, including solo physicians, by substantially increasing the importance of the merged insurer's networks to these providers. Trial Tr. 12/20/16, 3792:8–22 (Dranove). This makes it less likely that a solo physician would refuse to join the insurer's network at a lower reimbursement rate. Trial Tr. 12/20/16, 3792:8–22 (Dranove).

142. The merger would have a similar effect on large physician groups and hospitals: it would change the outcome of those negotiations by substantially increasing the merged firm's bargaining leverage over providers. Trial Tr. 12/20/16, 3793:20–3794:5 (Dranove). Some providers that currently have the option of dropping out of Anthem's network and recapturing profits by convincing employers to switch to Cigna would not be able to do so after the merger. Trial Tr. 12/20/16, 3791:7–3792:7 (Dranove).

143. Dr. Dranove quantified the harm to providers from the lessening of competition upstream through econometric modeling. Trial Tr. 12/20/16, 3802:16–3803:11 (Dranove). This is not as simple as assuming, as Dr. Israel has done, that Cigna will automatically and instantly get Anthem's rates. Trial Tr. 12/20/16, 3803:12–25 (Dranove). Rather, the analysis must take into account how increased leverage would affect negotiated outcomes given both Anthem's and

Cigna's unique characteristics, incentives, and strategies. Trial Tr. 12/20/16, 3803:12–25 (Dranove).

144. Using an econometric model presented by Dr. Israel, and after correcting for several errors, Dr. Dranove concluded that increased leverage would allow Cigna to reduce its annual provider reimbursements by roughly $100–500 million dollars in the 14 Anthem states (which are broader than but fully encompass the 35 local markets). Trial Tr. 12/20/16, 3802:16–3803:11 (Dranove). However, the ultimate price reduction depends on the merged firm's business strategy, "the extent to which they try to convert Cigna lives to Anthem lives," and the aggressiveness with which the merged firm approaches providers and negotiations given Cigna's view that collaborative arrangements are "stronger" when rates are higher. Trial Tr. 12/20/16, 3803:12–25 (Dranove).

c. Anthem's attempt to systematically lower reimbursement rates would likely reduce output, quality, and access to care.

145. While Plaintiffs are not required to provide evidence of downstream effects, providers have testified that lower reimbursement could negatively affect output, quality and access to care. [redacted] Trial Tr. 12/16/16, 3274:4–3275:25 (Lipman/LRGHealthcare).

146. And history shows that when providers' revenues decrease, providers react in a way that may negatively affect the quality and extent of services they offer. *See, e.g.*, [redacted] Wilhelmsen (Southern NH) 10/14/16 Dep. 63:2–64:13; [redacted] Trial Tr. 12/16/16, 3279:5–3280:17 (Lipman/LRGHealthcare); PX0375 at -695. Similarly, in the past, rate reductions have forced providers to cancel planned investments. *See, e.g.*, Wilhelmsen (Southern NH)

[redacted] Lower reimbursement rates may also exacerbate a physician shortage. *See* [redacted] PX0557 at -180-6; [redacted] *see also* PX0375 at -704; [redacted]

147. While other insurers have acknowledged the effect that lower rates can have quality, output, and access, *e.g.*, [redacted] Anthem's CEO testified that this was not something that he even considered: he was not aware of any analysis at Anthem about the effect of the merger on providers, nor did he direct anyone to do such an analysis, *see* Trial Tr. 11/22/16, 314:5–21 (Swedish).

III. THE MERGER WILL REDUCE COMPETITION TO INNOVATE IN BOTH THE LARGE-GROUP AND BUY-SIDE MARKETS.

148. Just as the merger will reduce innovation and value-based care initiatives across the country, ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact) at ¶¶ 215-83, it will have the same effects in the 35 local markets for the sale of commercial health insurance to large-group employers and the purchase of healthcare services by commercial insurers.

149. Competition drives Cigna to innovate on both sides of the market. Its market share, typically below Anthem's, gives it a discount disadvantage with customers and less bargaining leverage with providers. As a result, Cigna needs to offer lower total costs of care and other differentiating innovations to compete on the sell-side. It must also be cooperative and flexible to compete on the buy-side for provider collaboration contracts.

A. The merger will eliminate the competition between Anthem and Cigna to be the preferred collaboration partner for healthcare providers.

150. Because of the difficulties to providers of collaborating with multiple insurers, *see supra* Sections II.A.i., II.D.i.c., insurers such as Anthem and Cigna compete with each other to be providers' preferred partners. The merger will eliminate that competition between Anthem and Cigna.

151. Anthem closely tracks its competitors' provider collaboration initiatives and considers them when deciding whether to establish its own collaborations. If Anthem does not partner with a given provider, "[redacted]." Leopold 3/29/16 Dep. 274:13–275:10, 276:8–277:4, 279:23–280:2; *see, e.g.*, PX0393 at -504 (noting that the other national insurers' programs "[redacted]"); PX0563 at -382-12; Cheslock 10/12/16 Dep. 64:5–65:19; PX0408 at -087. [redacted] *See* PX0457 at -860.

152. Anthem regards Cigna as among its closest competitors for value-based contracts. PX0376. Cigna competes to be a preferred partner with providers by, among other things, delivering actionable data and identifying ways to improve the provider's practice. Muney 4/6/16 Dep. 88:8–89:14; Golias 6/3/16 Dep. 101:10–102:13 (Cigna wants to be among the payors that providers prefer to partner with); *see also* [redacted] These same objectives also help Cigna compete for sales to large-group customers since having strong provider partners and enabling their success in lowering costs improves Cigna's value proposition. *See infra* Section III.C.

153. The merger will lessen Anthem's incentives to innovate and collaborate with providers because it will become more dominant in several local markets. In fact, [redacted] Cheslock 10/12/16 Dep. 179:16–180:16, 183:16–184:3, 185:11–25.

B. The merger will lessen Anthem's incentive to collaborate with providers.

154. *See generally* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact), Section V.D.v; *infra* Section IV.

155. Today, Cigna has substantial incentives to engage in provider collaborations because it does not have the same kind of market share and provider discounts that Anthem enjoys. *See generally* ECF #408 (Plaintiffs' Proposed Findings of Fact) at ¶¶ 220–22. While Anthem's leverage with providers allows it to force their participation in its value-based programs, Cigna has had to *earn* providers' cooperation due to its relatively low share. [redacted] Instead, Cigna had to find ways to create value for providers and for clients. Trial Tr. 12/19/16, 3611:20–3612:4 (Rapisardi). [redacted]

156. Cigna's incentive to overcome its lower share has led it to become a far more flexible and responsive collaboration partner. *See generally* ECF #408 (Plaintiffs' Proposed Findings of Fact), Section V.D.i.b.1. Whereas Anthem has offered its value-based programs on a take-it-or-leave-it basis, Cigna is generally willing to negotiate points of its value-based contracts. *E.g.*, Torcom (Sentara) 10/6/16 Dep. 99:23–100:2, 102:11–20; Trial Tr. 12/19/16, 3400:25–3401:7, 3402:9–20 (Wheeler/Bon Secours); Trial Tr. 12/16/16, 3157:18–25, 3160:7–18 (Gorse/Patient First); [redacted]

C. Anthem's emphasis on discounts conflicts with, and would undermine, Cigna's value-based initiatives.

157. As Anthem has admitted, pursuing collaborative models on the one hand and forcing rates down on the other evidences [redacted] PX0075 at -293–294, -301.

158. [redacted] Trial Tr. 11/21/16, 387:1–289:20 (Swedish). [redacted]

159. A focus on forcing down rates also makes it harder for providers to fund the kind of high-quality care value-based programs are meant to achieve *see supra* Section II.D.i.c, especially since there is no reward—in fact, there is a penalty in lost revenue—for keeping patients healthy under the fee-for-service model. *See* Aumock (HealthCare Partners) 10/19/16

Dep. 40:3–42:7; Muney 4/6/16 Dep. 201:24–202:25; Trial Tr. 12/16/16, 3276:14–20, 3280:20–3281:5 (Lipman/LRGHealthcare) (explaining that "stress on the revenue component" is at odds with "the Triple Aim" of cost, quality, and utilization); *see also* Trial Tr. 12/16/16, 3164:11–17 (Gorse/Patient First). In fact, [redacted] PX0372 at -353–355; *see also supra* Section III.C (discussing Anthem's general refusal to negotiate with providers on value-based care). It has further acknowledged that [redacted] PX0558 at -663-8–9, and admits that without "additional resources" from value-based programs, the service provided by physicians "may not be as comprehensive." Leopold 3/29/16 Dep. 85:1–16, 253:16–254:25.

D. Contrary to Anthem's claims, the merger is not necessary to create the scale needed for provider collaborations.

160. Anthem claims that a merger with Cigna will better enable Anthem to pursue provider collaborations. To the extent there is a minimum viable scale, Anthem and Cigna are both already well above it, as evident in their many viable value-based programs. *See, e.g.*, Trial Tr. 12/2/16, 2231:8 –12 (Willig); Benton (New West) 10/20/16 Dep. 73:11–74:1; Trial Tr. 11/30/16, 1668:2–19, 1669:5–10 (Drozdowski). Notably, Cigna's smaller market share has not prevented it from developing more effective and successful value-based programs—in fact, it is its *lower* share that has driven its innovation in the area. *See supra* Section III.C. Meanwhile, Anthem has much greater scale and share yet has lagged behind. *See* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact), Section V.D.i.

161. Finally, Anthem argued in closing that combining volume would make value-based contracts easier to administer, but [redacted] developing payor-agnostic tools for

providers that facilitate value-based contracting across insurers, making a merger unnecessary for that purpose. [redacted] Wenners 9/30/16 Dep. 76:16–77:7, 90:22–91:8. Dr. Dranove explained that payor-agnostic tools "will allow providers who are engaged in a value-based product with one insurer to also engage in value-based products with other insurers so they could aggregate volume making the volume from any on[e] insurer even less important." Trial Tr. 1/3/17, 4747:20–4748:8 (Dranove).

IV. MARKET-SPECIFIC EVIDENCE

A. Virginia markets

162. The merger is unlawful with respect to three CBSAs in Virginia: Richmond, Virginia-Beach-Norfolk-Newport-News, and Lynchburg.

163. Anthem is the largest health insurer in Virginia in all segments, including large group. Trial Tr. 12/15/16, 3041:2–3, 3041:8–13 (King). In 2015, Anthem determined that each region within Virginia is [redacted] PX0519 at -230. [redacted] *See* PX0564 at -007. As Cigna's mid-Atlantic executive noted, the competitive landscape in Virginia is not uniform throughout the state. Huggins 5/13/16 Dep. 20:4–14. Anthem also looks at different regions within it separately when analyzing the competitive landscape. *See, e.g.*, PX0579 (analyzing Cigna wins from Anthem in 2016 by region within Virginia). In particular, competitive conditions "vary dramatically" in Richmond versus northern or southeastern Virginia. Trial Tr. 12/20/16, 3703:12–24 (Dranove).

164. Cigna has been "very successful" with its commercial business in Virginia.

[redacted] Huggins 5/13/16 Dep. 268:2–18. Cigna has been Anthem's "number one competitor" for accounts with more than 1,000 employees. PX0523 at -008; Trial Tr. 12/15/16, 3054:11–18 (King). Cigna has become more aggressive competing for smaller large-group customers. PX0520 at -873 [redacted]

(i) Richmond, Virginia

165. Four insurers primarily serve large-group accounts in Richmond: Cigna, United, Aetna, and Anthem. *See* PX0665 at -728. [redacted] *see* *supra* Section I.E.i. Anthem has the greatest provider discounts among the major insurers, although Cigna's discounts are "very close" and Aetna and United are further behind. Trial Tr. 12/19/16, 3361:2–8 (Harlin/Wells Fargo).

166. The major hospital systems in Richmond are Hospital Corporation of America ("HCA"), Bon Secours, and Virginia Commonwealth University-Medical College of Virginia ("VCU-MCV"). Trial Tr. 12/15/16, 2979:20–2980:1 (Hawthorne/Scott Insurance); PX0667 at -520; Trial Tr. 12/19/16, 3392:7–15 (Wheeler/Bon Secours). [redacted] PX0394 at -129-12. [redacted] PX0454 at -278.

167. The merger is presumptively unlawful as to both the large-group and buy-side markets in Richmond, based on the following market shares and HHIs calculated by Dr. Dranove using the methodology discussed in Section I.C.:

Richmond, VA		
	Large Group	**Buy-Side**
Anthem	**65%**	**64%**
Cigna	**13%**	**11%**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
Pre-merger HHI	4,594	4,471
Post-merger HHI	6,277	5,841
Delta	1,683	1,371

a. Large-group effects

168. These shares are consistent with those calculated by industry participants. *E.g.* [redacted] *see also* Trial Tr. 12/15/16, 2989:12–20 (Hawthorne/Scott Insurance) (stating that he has more clients with Anthem and Cigna than any other insurer); PX0424.

169. The merger would eliminate substantial head-to-head competition between Anthem and Cigna. *See* Trial Tr. 12/15/16, 2998:16–18 (Hawthorne/Scott Insurance). Anthem and Cigna have often in response to each other given customers concessions to win the business. *See infra* ¶ 60. In the first half of 2016 alone, at least seven large group accounts left Anthem for Cigna in the central Virginia area. Some saved significant amounts—almost $1,000 per employee in one instance and reducing financial exposure by almost $1 million per year in another. Trial Tr. 12/15/16, 3044:4–9, 3045:3–8, 3045:13–21, 3046:1–3, 3046:10–20, 3047:11–23 (King); PX0579.

(1) Cigna is a significant, and growing, competitor in Richmond

170. [redacted]

[redacted] Cigna does particularly well with certain types of accounts found in the Richmond area, including government and education accounts, financial service companies, law firms, and hospitals. [redacted]

171. Between 2010 and 2015, Cigna's membership in the Richmond area grew by [redacted] percent. [redacted]

(2) There is significant competition between Anthem and Cigna.

172. Although Anthem competes against Cigna in various markets in Virginia, Cigna is strongest in the Richmond market. Trial Tr. 12/15/16, 3042:8–3043:2 (King). Anthem often competes against Cigna for large-group accounts in the Richmond area. Trial Tr. 12/15/16, 3048:16–19, 3049:1–4, 3049:13–3051:8 (King); [redacted]

[redacted] The president of Anthem Virginia recognized that Cigna has been more aggressive in the Richmond market in 2016. Trial Tr. 12/15/16, 3043:16–3044:3 (King); *see also* PX0570 at -485 [redacted] In one example, Cigna tried to win the [redacted] account from Anthem in 2014 but failed, Huggins 5/13/16 Dep. 259:22–264:10, only to succeed two years later through a vigorous effort promoting its superior on-site clinic capabilities. Trial Tr. 12/15/16, 3050:23–3051:8 (King); PX0550; *see also* PX0379 at -920–921; PX0604 at -157.

173. As Cigna has taken many of Anthem's large-group clients, Anthem has fought back with "extremely aggressive" quotes on accounts where Cigna is the incumbent. [redacted] For example, Cigna competed head-to-head with Anthem over the [redacted] account. [redacted] Anthem aggressively pursued the opportunity because Cigna was the incumbent, but ultimately Cigna was able to retain the account. [redacted]

174. Some accounts in the Richmond area have gone back and forth between Anthem and Cigna in recent years. Trial Tr. 12/15/16, 3048:13–15 (King). That includes commercial accounts, such as [redacted] and [redacted], both of which Anthem lost to Cigna and then won back a few years later, Trial Tr. 12/15/16, 3049:1–4:3050:7 (King); PX0524 at -158–160 [redacted] as well as [redacted] which Anthem lost to Cigna and won back later after some concessions during the bidding process. Trial Tr. 12/15/16, 3050:8–19 (King); PX0529 at -288–

289.

(3) Anthem and Cigna are the two strongest competitors for some customers.

175. For many Richmond large groups, Anthem and Cigna are the two best options and are selected as finalists to compete in the last round of bidding for an account. For example, Anthem and Cigna competed head-to-head in a 2016 RFP for a self-funded employer in the Richmond area with approximately 1,000 to 1,500 lives. Trial Tr. 12/15/16, 2990:24–2992:13 (Hawthorne/Scott Insurance) (Cigna was the incumbent; Anthem, United, and Aetna were invited to bid, but Anthem's proposal was the strongest); *see also* Parker (PrimeLine) 10/7/16 Dep. 51:18–52:7. The competition between Anthem and Cigna saved the employer approximately $300,000 to $400,000 annually. Trial Tr. 12/15/16, 2995:20–2996:1 (Hawthorne/Scott Insurance); *see also* [redacted] Another 2016 example in which Anthem and Cigna were the two finalists involved a large fully-insured account. Trial Tr. 12/15/16, 2996:16–2998:5 (Hawthorne/Scott Insurance). During the finalist meetings, Anthem and Cigna improved their bids and the account switched from Anthem to Cigna. Trial Tr. 12/15/16, 2996:16–2998:3 (Hawthorne/Scott Insurance); *see also* Trial Tr. 12/15/16, 2988:9–20, 2990:24–2991:6, 2998:10–15 (Hawthorne/Scott Insurance).

176. Anthem and Cigna are often the two finalists for public sector customers and improve their best and final offers in response to each other. For example, in recent bidding for three very large Richmond public sector accounts, Anthem and Cigna were the finalists and each lowered its fixed fees and improved guarantees in the final stage of bidding. Trial Tr. 12/19/16, 3363:9–3364:15 (Harlin/Wells Fargo); [redacted] Trial Tr. 12/19/16, 3361:22–3362:3, 3362:10–3363:8 (Harlin/Wells Fargo) and [redacted] Trial Tr. 12/19/16,

3365:12–19, 3365:24–3366:4 (Harlin/Wells Fargo) and [redacted]

177. For some customers, Cigna is the *only* competitor against Anthem. In looking at 2016, [redacted], found that Cigna was its only alternative to a 22 percent rate increase that Anthem had proposed for renewal and refused to negotiate. Trial Tr. 12/19/16, 3366:5–16 (Harlin/Wells Fargo). While, RFPs were issued to Aetna, United, Cigna, and Optima, only Cigna responded, offering only a [redacted] percent increase that led the customer to leave Anthem. Trial Tr. 12/19/16, 3366:20–3367:15 (Harlin/Wells Fargo).

b. Buy-side effects

178. The buy-side shares shown above in paragraph 163 are consistent with those calculated by industry participants, including Anthem and Cigna, in the ordinary course of business. Defendants estimate that in Richmond, Anthem insures [redacted] percent of all commercial enrollees, Cigna insures [redacted] percent, United insures [redacted] percent, Aetna insures [redacted] percent, Optima, a vertically-integrated health insurer, insures [redacted] percent, and Piedmont insures none. PX0419 at -424.

179. [redacted] PX0454 at -278. [redacted] PX0564 at -007.

180. As Bon Secours' top commercial payer for its Richmond hospitals, Anthem has the lowest rates and escalators of the commercial insurers that contract with Bon Secours. Trial Tr. 12/19/16, 3396:23–3398:24 (Wheeler/Bon Secours); [redacted] Anthem recognizes that it

has a "[redacted]" with Bon Secours after "[redacted]." PX0454 at -278. Cigna is Bon Secours' second largest payer for its Richmond hospitals. Trial Tr. 12/19/16, 3396:23–3397:2 (Wheeler/Bon Secours) [redacted] Anthem views Bon Secours's relationship with Cigna as a "[redacted]" in Richmond. PX0394 at -129-15. [redacted]

181. If Anthem merged with Cigna, the new entity would account for nearly 75 percent of Bon Secours' commercial payments at its Richmond hospital. Trial Tr. 12/19/16, 3397:3–6 (Wheeler/Bon Secours);[redacted]

182. Anthem is also "very crucial to the well-being" of Patient First. Trial Tr. 12/16/16, 3147:2–3147:10 (Gorse/Patient First). Patient First provides primary and urgent care services on a walk-in basis and has nine medical centers in Richmond. Trial Tr. 12/16/16, 3136:1–10, 3142:23–3143:6 (Gorse/Patient First). Anthem already accounts for 58 percent of Patient First's commercial volume in Richmond. Trial Tr. 12/16/16, 3145:21–3146:2; [redacted] The contract is so "material" to Patient First that it is the only negotiation with a health insurer in which Patient First's current vice president for strategy and business development has been involved. Trial Tr. 12/16/16, 3147:2–10 (Gorse/Patient First).

183. Anthem is "the one" commercial insurer from whom Patient First has not been able to secure a reimbursement rate increase to offset the inflation in its costs. Trial Tr. 12/16/16, 3148:14–20 (Gorse/Patient First). If Anthem does not increase its rates, Patient First will have to

lower wages, cut staff, or reduce services—all of which affect the quality of care it provides. Trial Tr. 12/16/16, 3149:12–19 (Gorse/Patient First). Patient First is concerned that a larger Anthem may be able to secure even lower reimbursement rates and risk the sustainability of its operations. Trial Tr. 12/16/16, 3165:21–3167:3 (Gorse/Patient First).

184. Cigna is Patient First's second-largest commercial payer, Trial Tr. 12/16/16, 3134:9–11, 3145:21–3146:10 (Gorse/Patient First), and Anthem and Cigna collectively account for 73 percent of Patient First's commercial volume in Richmond. [redacted].

c. Innovation effects

185. [redacted] Anthem has had to respond to market perceptions that it is [redacted]." PX0379 at -920; *see also* PX0519 at -217 [redacted] PX0522 at -007 [redacted]

186. Competition also incentivizes Anthem and Cigna to form partnerships with providers in Richmond. *See* PX0394 at -129-9 [redacted] *see also* Trial Tr. 12/15/16, 3069:4–24 (King); PX0368. In particular, Anthem executives view the long-term provider collaboration agreement between Bon Secours and Cigna

as "[redacted]." PX0459. [redacted] PX0459.

187. Bon Secours and Patient First testified to very different experiences participating in Anthem's value-based EPHC program versus Cigna's CAC value-based program. Both began participating in Anthem's value-based EPHC program three years ago, but were not able to negotiate any of the terms. Trial Tr. 12/19/16, 3400:25–3401:7 (Wheeler/Bon Secours); Trial Tr. 12/16/16, 3150:12–3151:9 (Gorse/Patient First).

188. Throughout the three years that Bon Secours has participated in the EPHC program, Anthem has failed to provide sufficient analytical reporting to help Bon Secours successfully manage patients and earn incentive payments. Trial Tr. 12/19/16, 3399:24–3401:1 (Wheeler/Bon Secours)*; see also* [redacted] Anthem also has not provided performance goals in a timely manner—and those goals have changed during the time the hospitals are meant to meet them. *See* Trial Tr. 12/19/16, 3401:15–3402:8 (Wheeler/Bon Secours).

189. Patient First also participates in Anthem's EPHC program because Anthem mandated it. Trial Tr. 12/16/16, 3150:12–3151:12 (Gorse/Patient First). Patient First employed Mercer to evaluate the program and presented questions about the targets to Anthem. Trial Tr. 12/16/16, 3155:14–3156:7 (Gorse/Patient First). To date, Anthem has not responded with an explanation of how the targets were developed. Trial Tr. 12/16/16, 3155:14–3156:7 (Gorse/Patient First).

190. Patient First still does not know how it performed under Anthem's EPHC program in 2015 or even what its current targets are three-quarters in its current program year, which makes it impossible for Patient First to perform well under the program. Trial Tr. 12/16/16, 3151:25–3152:17 (Gorse/Patient First). Anthem also attributed fewer of Patient First's patients to

the EPHC than promised, resulting in about $2 million less in payments than Anthem initially represented when they entered into the agreement. Trial Tr. 12/16/16, 3152:18–3153:1, 3153:12–3154:6 (Gorse/Patient First).

191. Anthem and Patient First have agreed to collaborate on an urgent care program in 2017, but Anthem denied Patient First's request to participate in the program's design. Trial Tr. 12/16/16, 3156:8–3157:7 (Gorse/Patient First). Anthem had not informed Patient First of the targets as of about two weeks before the program began. Trial Tr. 12/16/16, 3156:8–3157:7 (Gorse/Patient First). Patient First cannot perform well in value-based programs when it has no input into, ability to prepare for, or understanding of, the program. Trial Tr. 12/16/16, 3157:12–17 (Gorse/Patient First).

192. By contrast, Bon Secours and Patient First were able to negotiate the terms and targets of their CAC programs with Cigna. Trial Tr. 12/19/16, 3402:9–20 (Wheeler/Bon Secours); Trial Tr. 12/16/16, 3160:7–18 (Gorse/Patient First). Moreover, Cigna has been "very good about sharing information." Trial Tr. 12/19/16, 3402:21–3043:3 (Wheeler/Bon Secours); Trial Tr. 12/16/16, 3158:15–20 (Gorse/Patient First). [redacted]

193. Patient First is concerned that the "Anthem culture" will "predominate[]" the combined entity and Cigna's successful collaborations will be lost. Trial Tr. 12/16/16, 3165:21–3166:9 (Gorse/Patient First).

d. Supply response

194. **Optima** is a nonprofit insurer owned by Tidewater health system Sentara. [redacted]

[redacted]

195. [redacted]

see also Trial Tr. 12/19/16, 3398:8–16 (Wheeler/Bon Secours) (Optima has "struggled in the Richmond marketplace relative to their home base"). [redacted] *see generally* ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact), Section VI.E.i., [redacted] *See, e.g.*, Parker (PrimeLine) 10/7/16 Dep. 78:2–9. Optima is not typically successful when bidding for customers with more than 200 or 250 employees and focuses more on smaller large-group employers. PX0519 at -221; Trial Tr. 12/15/16, 2981:17–2982:3 (Hawthorne/Scott Insurance); *see also* Trial Tr. 12/19/16, 3363:9–20, 3366:5–21 (Harlin/Wells Fargo) (noting that Optima declined to quote for two recent large employer accounts).

196. **Innovation Health**, a health insurance joint venture between a hospital system and Aetna, PX0419 at -422, operates in Northern Virginia. *See* [redacted]

[redacted]

197. **Piedmont Community Health Care** ("Piedmont CHC"), a small for-profit health plan owned by Lynchburg-based provider Centra Health Care, Adams (Centra) 10/11/16 Dep. 11:13–12:1, [redacted] PX0419 at -422, -424. [redacted] *see also supra* Section IV.A.iii.

198. **Bon Secours'** Value Health Network is not even a provider-sponsored health plan, because it is not an insurance product. Trial Tr. 12/19/16, 3405:12–21 (Wheeler/Bon Secours). Bon Secours has discussed from time to time the capital requirements necessary to start a provider sponsored plan. Trial Tr. 12/19/16, 3406:5–16 (Wheeler/Bon Secours). Although Bon Secours has net revenue of around $3.3 billion system-wide, it has determined it does not have the capital required to establish a provider-sponsored plan in the five states in which it operates. Trial Tr. 12/19/16, 3406:5–16 (Wheeler/Bon Secours). Even Anthem has noted that [redacted] PX0570 at -488.

199. **Gateway Health** does not sell health insurance in Richmond, as it is limited to south central/southwest Virginia and West Virginia. *See* Jackson (Gateway) 9/28/16 Dep. 50:21–51:8. Gateway does not bid for, serve, or target customers in the Richmond area (or in the Tidewater or Lynchburg areas). Jackson (Gateway) 9/28/16 Dep. 61:12–62:24, 66:15–17, 76:11–23, 77:5–11. It does not have many providers in the Richmond area and does not have any plans

to expand its provider network to the area, as it does not have the membership required to expand its network. Jackson (Gateway) 9/28/16 Dep. 28:2–7, 61:7–15, 62:16–20. It does not expect to expand geographically, Jackson (Gateway) 9/28/16 Dep. 28:2–7, 68:5–12, and will not "ever be in the larger cities . . . or at least not in the foreseeable future." Jackson (Gateway) 9/28/16 Dep. 52:15–22.

200. [redacted] Further, a Richmond-based broker noted that he has not placed any clients with Kaiser in the Richmond area. Trial Tr. 12/15/16, 2982:7–9 (Hawthorne/Scott Insurance).

201. **TPAs:** As with other CBSAs, *see supra* Section I.E.ii., most TPAs in the Richmond area that are not owned by a large insurer rely on rental networks and are not able to offer competitive provider discounts for large group employers. *See, e.g.*, Trial Tr. 12/15/16, 2998:19–2999:10 (Hawthorne/Scott Insurance); Trial Tr. 12/19/16, 3368:1–5 (Harlin/Wells Fargo).

202. **Captives:** The captives programs operated by Scott Insurance rely on the Big Four—Anthem, Cigna, Aetna, and United—for its medical network. Trial Tr. 12/15/16, 3010:22–3011:9, 3018:5–8 (Hawthorne/Scott Insurance). Less than five percent of Scott Insurance's clients are in one of its health insurance captives. Trial Tr. 12/15/16, 3010:19–21, 3018:1–4 (Hawthorne/Scott Insurance).

(ii) Virginia Beach-Norfolk-Newport-News

203. The merger is presumptively unlawful in the Virginia-Beach-Norfolk-Newport-

News, sometimes referred to as Hampton Roads or Tidewater, market based on the following shares and HHIs, calculated by Dr. Dranove using the methodology discussed in Section I.C:

Virginia Beach-Norfolk-Newport-News, VA-NC		
	Large Group	**Buy-Side**
Anthem	**66%**	**64%**
Cigna	**4%**	**4%**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
Pre-merger HHI	4,680	4,569
Post-merger HHI	5,252	5,047
Delta	572	478

a. Large-group effects

204. The evidence shows that head-to-head competition between Anthem and Cigna is increasing in this market, [redacted]

205. [redacted]

206. Other competitors identified by Anthem are unlikely to constrain the company

post-merger. *See supra* ¶ 195. [redacted]

b. Buy-side effects

207. The shares calculated by Dr. Dranove for the buy-side market are consistent with those calculated by Anthem. Anthem estimated that its share of commercial enrollees in the Virginia-Beach-Norfolk-Newport-News market is [redacted] percent while Cigna's share is [redacted] percent. PX0419 at -424. United's share is estimated to be [redacted] percent, Aetna's share is [redacted] percent and Sentara's share is estimated to be [redacted] percent. PX0419 at -424.

208. Patient First, which has nine primary and urgent care centers in the market, Trial Tr. 12/16/16, 3143:3–6 (Gorse), has experienced Anthem's bargaining leverage negotiating reimbursement rates and value-based arrangements. *See supra* Section IV.A.i.c.

209. [redacted] If Sentara were to pull out of its contract with Anthem, Sentara would experience a "very significant" revenue hit. Torcom (Sentara) 10/6/16 Dep. 116:6–117:3.

210. [redacted] Sentara and Cigna entered into an agreement to spur Cigna's share and make it more competitive

relative to Anthem for "multi-sited employers" who have employees located inside and outside of the market. Torcom (Sentara) 10/6/16 Dep. 83:22–84:7, 89:15–90:11. [redacted] Torcom (Sentara) 10/6/16 Dep. 82:6–12, 82:18–83:2, 85:11–22, 86:5–13, 87:3–12. Otherwise, the only option for multi-sited employers is Anthem. Torcom (Sentara) 10/6/16 Dep. 89:15–20.

c. Innovation effects

211. [redacted] Sentara is "concern[ed]" that Anthem's Q-HIP is "arbitrary" and Anthem's EPHC program is "take-it-or-leave-it," not allowing for provider input. Torcom (Sentara) 10/6/16 Dep. 97:21–98:14, 99:12–19. When Sentara sought to negotiate with Anthem regarding Sentara's clinically integrated network, Anthem refused. Torcom (Sentara) 10/6/16 Dep. 102:9–21.

212. [redacted]

(iii) Lynchburg

213. The merger is presumptively unlawful in the Lynchburg large-group market based on the following shares and HHIs, calculated by Dr. Dranove using the methodology discussed in Section I.C.:

Lynchburg, VA		
	Large Group	**Buy-Side**
Anthem	**62%**	**59%**
Cigna	**7%**	**6%**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
Pre-merger HHI	4,062	3,667
Post-merger HHI	4,922	4,314
Delta	861	647

a. Large-group effects

214. The shares calculated by Dr. Dranove are consistent with estimates from industry participants. *See, e.g.,* [redacted]

215. Piedmont CHC, a for-profit health plan owned by Centra Health Care, a not-for-profit provider in the Lynchburg area, is small—with about 42,000–43,000 lives, a quarter of them its own employees. Adams (Centra) 10/11/16 Dep. 11:22–12:1, 69:1–5, 69:10–13. [redacted]

216. Other competitors identified by Anthem are unlikely to constrain the company post-merger. [redacted]

b. Buy-side effects

217. The shares calculated by Dr. Dranove for the buy-side market are consistent with those calculated by Anthem. Anthem estimated that its share of enrollees in the Lynchburg market is [redacted] percent while Cigna's share is [redacted] percent. PX0419 at -424. United's share is estimated to be [redacted] percent, Aetna's share is [redacted] percent, Sentara's share is [redacted] percent and Centra Health (Piedmont CHC)'s share is estimated at [redacted] percent. PX0419 at -424.

218. Centra Health operates hospitals and other healthcare facilities in the Lynchburg area. Adams (Centra) 10/11/16 Dep. 11:13–21. [redacted]

219. [redacted]

B. New Hampshire markets

220. The merger will substantially reduce competition in at least six local markets in New Hampshire: Berlin, Claremont-Lebanon, Concord, Keene, Laconia, and Manchester-Nashua. [redacted] While each CBSA is a separate geographic market, competitive conditions are similar throughout New Hampshire so these markets are discussed below together.

(i) Large-group effects

221. The merger is unlawful in each of the six New Hampshire CBSAs based on the following market shares and HHIs, calculated by Dr. Dranove as discussed in Section I.C.:

Large Group	Berlin	Claremont-Lebanon	Concord	Keene	Laconia	Manchester-Nashua
Anthem	**58%**	**45%**	**55%**	**41%**	**50%**	**44%**
Cigna	**11%**	**23%**	**21%**	**21%**	**19%**	**17%**
[redacted]						
[redacted]						
[redacted]						
Pre-merger HHI	3,864	2,868	3,681	2,376	3,163	2,661
Post-merger HHI	5,091	4,919	6,024	4,067	5,100	4,207
Delta HHI	1,227	2,051	2,343	1,691	1,936	1,546

222. If the state were viewed as a single market, the merger would still be presumptively unlawful, whether the Blues are combined or separate. [redacted]

223. The vast majority of commercial membership in New Hampshire (as much as 90 percent) is held by "the big three"—Anthem, Cigna, and Harvard Pilgrim. [redacted] Trial Tr. 12/19/16, 3482:21–24, 3484:25–3485:9, 3486:7–21 (Guertin); [redacted] PX0500 at -071, -083; [redacted] Anthem frequently notes the high

degree of consolidation in New Hampshire. PX0540 at -694; Trial Tr. 12/19/16, 3485:17–3486:24, 3493:10–3494:12 (Guertin); PX0654 at -137 (New Hampshire tab at cell C6); PX0498 at -157-21; *see also* PX0538 at -914; Trial Tr. 12/19/16, 3524:18–3525:13 (Guertin). And of "the big three," Anthem is by far the largest, with stable market shares in recent years. Trial Tr. 12/19/16, 3482:25–3483:3 (Guertin); [redacted]

224. "The big three" are also the main options for public sector accounts in New Hampshire, which often purchase insurance jointly through municipal risk pools. McKean (Town of Salem) 10/4/16 Dep. 64:6–14. Throughout the state, the big three serve municipalities that use these types of arrangements. [redacted] *see also* McKean (Town of Salem) 10/4/16 Dep. 11:3–17, 41:5–11; Trial Tr. 12/19/16, 3541:21–3542:3, 3578:25–3579:15 (Guertin). And some of the state's large public university and municipal accounts that do not use risk pools do not view Harvard Pilgrim favorably, leaving only Anthem and Cigna as their primary options. [redacted] McKean (Town of Salem) 10/4/16 Dep. 127:3–128:10, 89:5–20, 90:16–20.

225. Cigna has grown its market share in New Hampshire in recent years, largely at the expense of Anthem. [redacted]

[redacted]

226. Anthem and Cigna are particularly close competitors for large groups in the state. Anthem has adopted a strategy of "focus[ing] on Cigna groups" [redacted] Trial Tr. 12/19/16, 3489:5–3490:3, 3495:10–20 (Guertin); PX0500 at -083–084; PX0578 at -666–667. For ASO clients, Anthem's 2015 strategy and marketing assessment for New Hampshire identified Cigna as the *only* insurer at parity with Anthem. PX0500 at -075; Trial Tr. 12/19/16, 3491:8–3492:11 (Guertin). [redacted] *see* PX0504 at -098-70. An Anthem document confirms that Anthem views Cigna as its [redacted] PX0733 at -130.

227. Cigna has also become more active bidding for smaller accounts with 50 to 250 members. PX0475 at -334; Trial Tr. 12/19/16, 3496:2–3497:18, 3501:3–25 (Guertin); [redacted] Butler 4/29/16 Dep. 61:23–62:3, 239:1–240:5, 242:21–243:17, 257:19–258:14; PX0592 at -726. As in other markets, Anthem has identified Cigna's level-funded product as a competitive challenge and has taken steps to respond with its own balance-funded product.Trial Tr. 12/19/16, 3489:5–3490:3, 3492:12–15, 3498:14–3500:21 (Guertin); PX0473 at -304; PX0479 at -672; PX0478 at -056; PX0500 at -075.

228. In 2013 and again in 2015, Anthem and Cigna competed head-to-head for the

[redacted]'s business. PX0477 at -485–486; McKean (Town of Salem) 10/4/16 Dep. 47:7–12; PX0425 at 1–2; [redacted] had "two truly viable insurers, Anthem and Cigna, where we would be relatively free to move our employees around . . . Harvard Pilgrim [is] kind of a distant third." McKean (Town of Salem) 10/4/16 Dep. 113:8–114:3; *see also* PX0477 at -485–486. In 2015, Cigna offered [redacted] in wellness funds compared to $7,000 from Anthem. PX0425 at 1–2; PX0525; [redacted] And for the current plan year, [redacted] convinced Cigna to lower its rates in exchange for not going out to bid—postponing a third showdown with Anthem. McKean (Town of Salem) 10/4/16 Dep. 138:16–140:15.

229. Anthem and Cigna similarly competed head-to-head for the [redacted] account. Trial Tr. 12/19/16, 3502:17–3504:6 (Guertin); [redacted] PX0471 at -505; *see also* PX0472 at -940.

230. In 2012, the [redacted] issued a joint request for proposal. [redacted] Trial Tr. 12/19/16, 3504:7–13 (Guertin). Anthem and Cigna were the finalists. Trial Tr. 12/19/16, 3504:7–3505:1 (Guertin). [redacted] *see also* Trial Tr. 12/19/16, 3504:7–3506:2 (Guertin). [redacted]

[redacted]

231. In competing for the [redacted]—an account with about 10,000 lives—Anthem learned that it had the "highest priced bid" and Cigna's administrative price was [redacted] so it offered a fee, trend, and discount guarantees for three years and then later lowered the administrative fee rates and increased performance guarantees. PX0387 at -886–887, 922–923.

(ii) Buy-side effects

232. The merger is also presumptively unlawful as to the buy-side product market in all six New Hampshire CBSAs, based on the following shares and HHIs calculated by Dr. Dranove:

Buy-Side	Berlin	Claremont-Lebanon	Concord	Keene	Laconia	Manchester-Nashua
Anthem	**59%**	**48%**	**55%**	**43%**	**52%**	**45%**
Cigna	**9%**	**18%**	**18%**	**16%**	**15%**	**14%**
[redacted]						
Pre-merger HHI	3,855	2,876	3,965	2,364	3,262	2,585
Post-merger HHI	4,862	4,607	5,680	3,755	4,839	3,848
Delta HHI	1,007	1,730	1,985	1,391	1,577	1,263

233. If the state were viewed as a single market, the merger would still be presumptively unlawful. [redacted] Market participants confirm that these estimates are accurate and, if anything, conservative. For example, Anthem believes it has at least 50 percent of

the state's commercial enrollment. Trial Tr. 12/19/16, 3483:14–3485:12, 3511:15–3512:4 (Guertin); PX0734 at -375; PX0732 at -711; *see also* [redacted]

234. Anthem's interactions with providers reflect its dominant market share. [redacted] Moreover, Anthem exercises unilateral control and offers little cooperation or flexibility with providers. Trial Tr. 12/16/16, 3272:19–3273:5 (Lipman/LRGHealthcare); Wilhelmsen (Southern NH) 10/14/16 Dep. 57:15–58:10.

235. For example, Anthem was able to dictate the terms of its latest contract with LRGHealthcare, which will result in a reduction in payment of about $1.5 million in the first year, and $2 million in each of the subsequent two years. Trial Tr. 12/16/16, 3272:24–3274:3 (Lipman/LRGHealthcare). Approximately 53 percent of LRGHealthcare's revenue derives from commercial payers. PX0754 at 1. Anthem represents about 37 percent of that revenue; Cigna, [redacted] percent. PX0754 at 2. Anthem's reimbursement rates for LRGHealthcare are lower than those of the other insurers. Trial Tr. 12/16/16, 3272:13–15 (Lipman/LRGHealthcare).

236. Anthem has similarly used its dominant market share position to take unilateral actions against Southern New Hampshire Health System. Wilhelmsen (Southern NH) 10/14/16 Dep. 53:8–20, 54:24–25, 56:1–10. When the Affordable Care Act was enacted, Anthem was the only insurer in New Hampshire on the exchange, and despite the fact that Southern New Hampshire Health "has the largest number of patients in Nashua," Anthem did not "approach[] [the health system] at all, [had] no discussions; and we're not alone." Wilhelmsen (Southern NH) 10/14/16 Dep. 70:17–71:19. The hospital's former CEO testified that with this merger, Anthem would garner an excessively "large market position" in New Hampshire that may result in a

reduction in reimbursement rates. Wilhelmsen (Southern NH) 10/14/16 Dep. 69:8–70:2, 161:10–17; *see also* Trial Tr. 12/16/16, 3279:5–3280:1 (Lipman/LRGHealthcare).

237. The proposed merger would not likely result in additional commercial patient volume because New Hampshire has a fairly stable population. Trial Tr. 12/16/16, 3277:19–3278:1 (Lipman/LRGHealthcare). Nor would claims processing become meaningfully more efficient for providers. Trial Tr. 12/16/16, 3278:2–23 (Lipman/LRGHealthcare) (explaining how Anthem is more difficult to work with on claims processing than Cigna).

(iii) Innovation effects

238. The merger will also harm innovation. Cigna has proven to be an innovative and flexible insurer that will successfully collaborate with providers in New Hampshire. Wilhelmsen (Southern NH) 10/14/16 Dep. 68:22–69:7; Trial Tr. 12/14/16, 2807:5–2808:17 (Rowe/Granite Health); Trial Tr. 12/16/16, 3278:2–23 (Lipman/LRGHealthcare); [redacted] Similar to other local markets, Cigna's focus on collaborating with providers in New Hampshire is driven by competition with Anthem. *See supra* Section III.C; *see also* [redacted]

239. For example, Granite Health approached Anthem in 2012 to engage in a value-based contract without success. Trial Tr. 12/14/16, 2817:11–23, 2818:16–18 (Rowe/Granite Health). While Anthem provided a conceptual framework, it did not set forth a specific proposal for Granite Health to review and refused to share claims data. Trial Tr. 12/14/16, 2817:24–2818:15 (Rowe/Granite Health). Other than this initial framework, Anthem did not offer anything to Granite Health until four years later, in February 2016. Trial Tr. 12/14/16, 2819:8–2820:18 (Rowe/Granite Health); PX0423 at -153. Two months later Anthem told Granite, for the first time,

that it was "operationally unfeasible" to release "non-redacted data" and that Anthem has never shared unredacted data—in fact, member hospitals' *own* data—with a provider in any of its 14 states. Trial Tr. 12/14/16, 2820:19–2822:23 (Rowe/Granite Health); PX0422 at -077–078. Unredacted data is desirable because it allows providers to better coordinate care for patients, and because it enables a successful transition to new payment models. Trial Tr. 12/14/16, 2812:24–2813:25 (Rowe/Granite Health); Wilhelmsen (Southern NH) 10/14/16 Dep. 31:9–32:8, 40:5–41:6, 52:3–16; PX0422 at -079.)

240. Anthem and Granite Health renewed discussions on value-based programs in July 2016, but Anthem has not responded to Granite Health's inquiries related to the potential arrangement, including how Anthem derived its medical cost target and the quality metrics to be used. Trial Tr. 12/14/16, 2823:18–2825:3 (Rowe/Granite Health).

241. In contrast to Anthem, Cigna approached Granite Health in 2011 to explore entering into a shared savings agreement based on population health. Trial Tr. 12/14/16, 2807:5–22 (Rowe/Granite Health); Wilhelmsen (Southern NH) 10/14/16 Dep. 51:10–52:2. Granite Health and Cigna "worked together, very collaboratively" and entered into a value-based overlay contract in July 2012 that shares savings 50/50 between the two organizations. Trial Tr. 12/14/16, 2807:5–25, 2810:15–2811:13 (Rowe/Granite Health).

242. Cigna provides Granite Health with unredacted claims data on a monthly basis and funds the care coordinators on a PMPM basis that reflects the providers' collective achievement of cost and quality benchmarks. Granite Health, in turn, distributes the shared-savings pool to the provider members based on each member's performance. Trial Tr. 12/14/16, 2811:15–2812:23 (Rowe/Granite Health). This arrangement has been successfully maintained for four years, creating "[j]ust over $4 million" in savings, which the member providers use for care coordinators

and to improve overall practice. Trial Tr. 12/14/16, 2814:3–2815:13, 2823:6–17 (Rowe/Granite Health); Trial Tr. 12/16/16, 3277:6–18 (Lipman/LRGHealthcare).

243. If the merger does occur, the Granite Health–Cigna collaboration will be at risk: Anthem has given Granite Health no assurances it will maintain the Cigna contract. Trial Tr. 12/14/16, 2828:22–25 (Rowe/Granite Health). And providers are concerned about the uncertain future of Cigna's collaborations. Wilhelmsen (Southern NH) 10/14/16 Dep. 68:16–69:7.

(iv) Supply response

a. Harvard Pilgrim

244. Post-acquisition, Anthem's only main competitor for large groups would be Harvard Pilgrim. [redacted]

b. Aetna and United

245. Aetna has almost no presence in New Hampshire and does not compete effectively in the state. [redacted] PX0383 at -387; McKean (Town of Salem) 10/4/16 Dep. 23:19–24:5; PX0731; Trial Tr. 12/19/16, 3512:23–3515:7, 3516:8–22 (Guertin); [redacted] United is even smaller, with less than a one percent share of commercial business.

[redacted] *see also* [redacted] Trial Tr. 12/19/16, 3579:19–3581:16 (Guertin); PX0730 at -933; Spinazzola (E&S Insurance) 10/11/16 Dep. 44:16–45:2; [redacted] by Anthem as the incumbent in New Hampshire over the 2013 to 2016 period. [redacted]

246. Market participants confirm that Aetna and United are not viable options. [redacted] *See, e.g.* PX0500 at -075. [redacted] *See also* [redacted] Spinazzola (E&S Insurance) 10/11/16 Dep. 44:7–45:2; [redacted]

c. Tufts Health Freedom Plan

247. Tufts Freedom Health Plan, the most recent entrant in New Hampshire, is a partnership between Tufts Health Plan (Tufts), a regional insurer based in Massachusetts, and Granite Health Network. [redacted] For example, it benefited from Tufts' brand (via its established business in the neighboring states of Massachusetts and Rhode Island);

[redacted]

248. [redacted] Trial Tr. 12/19/16, 3519:5–14 (Guertin). [redacted].

249. [redacted]

250. Anthem does not perceive Tufts Freedom to be a significant threat, giving no weight to its entry in estimating any change in the level of consolidation in the New Hampshire

market. Trial Tr. 12/19/16, 3489:5–3490:17, 3494:13–3495:6 (Guertin); PX0500 at -075, -083.

d. Exiting

251. Over the years, many insurers have exited the New Hampshire markets, including Tufts Health Plan (via a prior product, "Tufts New England"). Spooner (Tufts) 10/13/16 Dep. 197:7–198:5; Trial Tr. 12/19/16, 3521:18–22 (Guertin). [redacted] Most recently, Maine Community Health Options, MVP, Patriot Healthcare, and Assurant have all exited, or announced plans to exit, the state. Spooner (Tufts) 10/13/16 Dep. 202:12–20, 205:6–17; [redacted] Trial Tr. 12/19/16, 3521:23–3523:6 (Guertin).

252. As elsewhere in the country, co-ops have struggled to enter and remain viable in New England. *See* PX0500 at -075 [redacted] As discussed above, co-op Maine Community Health Options has announced plans to exit the state. Trial Tr. 12/19/16, 3522:11–20 (Guertin); [redacted] Spinazzola (E&S Insurance) 10/11/16 Dep. 45:3–13.

253. Minuteman Health, another co-op, is similarly unable to constrain the large-group market. Minuteman offers a narrow provider network that is not "palatable" to many large group customers. McKean (Town of Salem) 10/4/16 Dep. 22:14–23:2; *see also* [redacted]

[redacted]

254. [redacted]

[redacted]

C. California markets

255. The merger is unlawful in six CBSAs in California—three in Northern California and three in Southern California. Because market conditions are distinct in these two regions, *see* [redacted] the competitive effects for the markets in each region are examined separately below.

256. Throughout the state, however, certain themes stand out. First, while seven insurers compete for at least portions of large-group business in California, *e.g.*, Trial Tr. 12/21/16, 4121:24–4122:1 (Rothermel) (listing Aetna, Blue Shield, Cigna, Health Net, Kaiser, and United as Anthem's top large-group competitors for 2015), two of them—Health Net and Kaiser—are at best limited constraints. As a broker testified, "the Anthems, Cignas, Uniteds don't see them as quite the same level. They see them as a lesser level, so they're not willing to match price." Trial Tr. 12/20/16, 3659:7–15 (Mahoney/SML).

257. Second, Anthem and Cigna are particularly close competitors throughout California. [redacted] PX0488 at -528-3. [redacted] PX0491 at -

650. [redacted] PX0491 at -650. [redacted] PX0548 at -169-7; *see also* PX0737 at -822-4.

258. Third, Cigna is the market leader for level-funding products in California, and these products have made it more competitive for large groups. Trial Tr. 12/16/16, 3232:15–22 (Mifsud/Melita); Trial Tr. 12/20/16, 3658:17–23 (Mahoney/SML).This success has not been lost on Anthem, PX0487 at -645, -651, PX0488 at -528-3, which considers Cigna its strongest competitor in these products, Dahms 3/8/16 Dep. 164:24–165:2, 230:13–24, and has been forced to respond. Kehaly 4/28/16 Dep. 54:23–55:19. Indeed, Anthem's alternative funding product was developed "as an alternative" to Cigna's product, partly because it was "losing business to Cigna." Kehaly 4/28/16 Dep. 54:23–55:19. Cigna and brokers view Anthem's product as a "copycat." [redacted] *see also* Trial Tr. 12/16/16, 3232:23–3233:14 (Mifsud/Melita); [redacted]

(i) Northern California markets

259. In Northern California, the merger is likely to substantially lessen competition in three geographic markets: San Francisco-Oakland-Hayward ("San Francisco"), San Jose-Sunnyvale-Santa Clara, and Santa Cruz-Watsonville.

260. The merger is presumptively unlawful in two of the three Northern California CBSAs based on the market shares and HHIs calculated by Dr. Dranove. [redacted] Dr. Dranove found that the harm in these markets will be much greater than market shares suggest

because Kaiser's large share overstates its significance as a competitive constraint. Trial Tr. 12/20/16, 3720:3–25, 3729:18–3731:20 (Dranove); *see also* Trial Tr. 12/16/16, 3235:11–3236:10 (Mifsud/Melita), Trial Tr. 12/20/16, 3659:3–15 (Mahoney/SML), Brown (Arthur J. Gallagher) 10/14/16 Dep. 57:20–59:2 (discussing the limitations of Kaiser as a constraint). He also found that Anthem and Cigna are closer competitors than their shares would suggest. Trial Tr. 12/20/16, 3720:3–25; 3729:18–3731:20 (Dranove). Dr. Dranove's market share calculations are consistent with Cigna's internal market share calculations for Northern California. PX0624 at -153.

a. Large-group effects

261. The merger is presumptively unlawful in two of the three Northern California CBSA large-group markets based on the following shares and HHIs, calculated by Dr. Dranove using the methodology discussed in Section I.C.:

Large Group	San Francisco-Oakland-Hayward	San Jose-Sunnyvale-Santa Clara	Santa Cruz-Watsonville
Anthem	**19%**	**22%**	**43%**
Cigna	**6%**	**8%**	**5%**
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
Pre-merger HHI	2,291	2,032	2,859
Post-merger HHI	2,525	2,372	3,259
Delta HHI	234	340	401

262. These shares are consistent with those calculated by the parties in the ordinary course of business. *See, e.g.*, PX0548 at -169-5; Trial Tr. 12/21/16, 4129:18–4130:7 (Rothermel);

263. PX0548 at -169-7; PX0737 at -822-4. PX0487 at -616. A broker from the Bay Area testified that Cigna's bids are effective in getting Anthem to reduce its price. Trial Tr. 12/20/16, 3658:24 –3659:2 (Mahoney/SML). This competition has benefited San Francisco customers because it "has allowed us to have more innovation for the clients, as well as more companies to go to, more carriers to go to, try to get better price and better products." Trial Tr. 12/20/16, 3659:16–23 (Mahoney/SML).

264.

265. As one example, when competing for the

[redacted] PX0531 at -560. [redacted] PX0531 at -558.

266. Several other large groups in Northern California have benefited from head-to-head competition between Anthem and Cigna. *See* PX0480 at -208–209 [redacted] PX0647 at -787–789 (Legacy Partners account competition from Anthem drove Cigna to add a $44,000 one-time premium credit on top of its "rock bottom" renewal offer); PX0706 (broker presentation analyzing bids for Sarens and showing in the "MedAll" tab that Cigna was offering steep savings over Anthem's current and renewal pricing); Welch 4/29/16 Dep. 224:4–225:11 (Cigna offered Calix a $340,000 premium credit); PX0644 at -910–914 (showing that Cigna won the Calix account by beating Anthem's initially lower bid).

267. As in other regions, a core strategy for Cigna in Northern California has been to make up for Anthem's provider reimbursement advantage by managing total costs more effectively. Welch 4/29/16 Dep. 191:2–193:1. A local Cigna executive testified that this "message around focusing on the total cost of your healthcare spend and the strategies [Cigna has] deployed to help employers do that has resonated." Welch 4/29/16 Dep. 194:18–195:5, 198:19–200:13.

268. Cigna also attempts to make up for Anthem's provider reimbursement advantage through its innovative wellness programs. Welch 4/29/16 Dep. 191:2–193:1. Cigna offers the best wellness programs for self-funded clients in San Francisco. Trial Tr. 12/20/16, 3657:3–6 (Mahoney/SML). Cigna was the first insurer to offer wellness dollars, and other insurers have followed. Trial Tr. 12/20/16, 3658:4–8 (Mahoney/SML). Overall, competition between Anthem and Cigna has benefited Northern California large groups because it "has allowed us to have more

innovation for the clients, as well as more companies to go to, more carriers to go to, try to get better price and better products." Trial Tr. 12/20/16, 3659:16–23 (Mahoney/SML).

b. Buy-side effects

269. The merger is presumptively unlawful in all three Northern California buy-side markets based on the following shares and HHIs, calculated by Dr. Dranove using the methodology discussed in Section I.C.:

Buy-Side	San Francisco-Oakland-Hayward	San Jose-Sunnyvale-Santa Clara	Santa Cruz-Watsonville
Anthem	**19%**	**23%**	**42%**
Cigna	**5%**	**7%**	**4%**
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
Pre-merger HHI	2,419	2,095	2,869
Post-merger HHI	2,620	2,414	3,171
Delta HHI	200	320	303

270. Anthem has not produced evidence suggesting that these shares overstate the competitive effects on providers in Northern California. And considering that the shares include Kaiser, they may in fact understate the competitive harm. As Dr. Dranove testified, "the ability [for providers] to turn to Kaiser upstream may be harder than the ability for employers to turn to Kaiser downstream" because "you're going to have to now become a Kaiser physician. You're going to now have to dump all your current patients…[t]hat's not an attractive option." Trial Tr. 12/20/16, 3795:15-3796:18 (Dranove).

(ii) Southern California markets

271. In Southern California, the merger is likely to substantially lessen competition in three geographic markets: the Los Angeles-Long Beach-Anaheim MSA ("Los Angeles"), the Oxnard-Thousand Oaks-Ventura MSA ("Ventura"), and the Santa Maria-Santa Barbara MSA ("Santa Barbara"). [redacted] It is presumptively unlawful as to the latter two markets, based on the following shares and HHIs:

Large Group	Los Angeles-Long Beach-Anaheim	Oxnard-Thousand Oaks-Ventura	Santa Maria-Santa Barbara	**Buy-Side**	Los Angeles-Long Beach-Anaheim	Oxnard-Thousand Oaks-Ventura	Santa Maria-Santa Barbara
Anthem	**31%**	**41%**	**42%**	**Anthem**	**30%**	**41%**	**49%**
Cigna	**6%**	**4%**	**6%**	**Cigna**	**5%**	**3%**	**5%**
[redacted]							
Pre-merger HHI	2,062	2,438	2,484	Pre-merger HHI	2,040	2,491	3,167
Post-merger HHI	2,417	2,792	3,010	Post-merger HHI	2,354	2,773	3,647
Delta HHI	356	354	526	Delta HHI	314	283	480

272. The competitive landscape in Southern California is distinct from that of Northern California, shaped by different dynamics and competitors. *Compare* [redacted] PX0486 at -731–737 *with* [redacted] PX0486 at -725–729. [redacted]

[redacted] PX0394 at -086-1, -086-20–42. Other market participants do as well. *See* [redacted] Tallman (Centene) 10/14/16 Dep. 81:4–23 (Centene separately tracking its Northern and Southern California medical enrollment results and competitors).

273. Anthem and Blue Shield of California are the dominant insurers in Los Angeles. [redacted]

274. [redacted]

275. [redacted]

a. Large-group effects

276. Dr. Dranove found that the harm from the merger in these markets will be much greater than market shares suggest because Kaiser's large share overstates its significance as a competitive constraint on Anthem and Cigna. Trial Tr. 12/20/16, 3720:3–25 (Dranove). He also found that Anthem and Cigna are closer competitors than their shares would suggest. Trial Tr. 12/20/16, 3720:3–25, 3729:18–24 (Dranove); *see also* Eddy (Tolman & Wiker) 10/14/16 Dep. 148:4–23, 149:10–13 (explaining Kaiser is less effective as leverage against Anthem or Cigna); Eddy (Tolman & Wiker) 10/14/16 Dep. 83:15–84:19 (slicing with Kaiser can cause traditional carriers to raise prices).

277. Hence, the Los Angeles MSA market falls just short of meeting the presumption because of the large presence of Kaiser. Trial Tr. 12/20/16, 3720:3–25 (Dranove).

278. Dr. Dranove's market share calculations are consistent with Cigna's internal market share calculations for Los Angeles. [redacted]

279. [redacted]

280. Cigna's business has grown in Los Angeles through successfully targeting Anthem accounts. [redacted] For example, a broker in Southern California used quotes

from Cigna and United to lower Anthem's renewal rate to a client from 49 percent to 34 percent. Eddy (Tolman & Wiker) 10/14/16 Dep. 136:5–137:18.

281. In particular, Cigna has won large groups from Anthem using its provider collaborations in Southern California. *See, e.g.*, [redacted] *See, e.g.*, PX0489 at -078. The close relationship and trust between Cigna and St. Joseph also have been instrumental in helping Cigna sell the DSA's products. Trial Tr. 12/19/16, 3599:12–22, 3614:13–2615:17 (Rapisardi). [redacted]

b. Buy-side effects

282. Southern California provides a particularly compelling example of head-to-head competition between Anthem and Cigna on the buy-side, where they have each raced to launch provider collaborations. [redacted]

283. Cigna has contemplated DSAs with providers in Southern California since 2012. Trial Tr. 12/19/16, 3595:15–17, 3605:9–18 (Rapisardi); [redacted] Because of competitive pressure and its unit-cost disadvantage to Anthem, Cigna approached the market strategically by targeting opportunities with key providers. Trial Tr. 12/19/16, 3604:3–3606:2 (Rapisardi): [redacted]

284. [redacted] Anthem [redacted] PX0394 at -086-28; *see also* DX0545 at -100–102, -110 [redacted] Anthem [redacted] PX0394 at -086-29.

285. By late 2013, Anthem and Cigna were working in parallel to build their deepest provider collaborations in Southern California. [redacted] DX0544 at -025–026. [redacted]

286. [redacted] A DSA-like approach had never been done before in Southern California. Trial Tr. 12/19/16, 3612:19–3613:3 (Rapisardi); [redacted]

287. Then in September 2014, Anthem publicly launched Vivity. Vivity is an innovative provider-collaboration in which Anthem and the providers split both profits and losses, PX0405 at -315-2, -315-7 [redacted] PX0557 at -180-22; *see also* PX0405 at -315-5 (detail on Vivity financial model).

288. Anthem executives have testified that Vivity helps Anthem win new business and increase its membership in Los Angeles. *E.g.*, Trial Tr. 12/21/16, 4116:21–4117:4 (Rothermel).

Anthem priced Vivity competitively to target large groups in Los Angeles and Orange County. *See* PX0649 at -546, -556. Anthem priced Vivity below its standard HMO product. PX0618 at -529; DX0544 at -037 (Anthem planning to price its product 10 percent below its Select HMO network for large groups).

289. Anthem viewed Vivity [redacted] PX0557 at -180-22 (using Vivity as [redacted]); *see also* PX0649 at -546.

290. [redacted] In an internal e-mail, Eugene Rapisardi wrote, "[I c]annot express to you how unhappy [Chris DeRosa] is about Anthem beating us to market." [redacted] Trial Tr. 12/19/16, 3609:1–3, 3609:13–3610:1 (Rapisardi); [redacted]

291. [redacted]

292. Indeed, though Vivity publicly beat Cigna's DSA to market, DeRosa 10/27/16 Dep. 97:18–22, the Cigna–St. Joseph collaboration has competed with and won clients from Anthem from day one. [redacted] For two of its first three clients using the St.

Joseph HMO product, Cigna competed with and won business from Anthem. Trial Tr. 12/19/16, 3614:13–3615:17 (Rapisardi); [redacted] Cigna's strategic relationship with St. Joseph helped it win those accounts. Trial Tr. 12/19/16, 3614:13–3615:17 (Rapisardi); [redacted]

293. Five months after Vivity's public launch, brokers were "still confused as to what Vivity even is and are "not aggressively marketing it. In contrast local brokers and consultants are very excited with the SJHH Select Plan." PX0618 at -527 [redacted]

294. In May 2015, before the official launch of the DSA, Cigna's general manager and president for Southern California noted that both he and the CEO of St. Joseph [redacted] Trial Tr. 12/19/16, 3618:3–14 (Rapisardi).

295. Finally, in September 2015, Cigna and St. Joseph formally launched their DSA, entering into a [redacted] joint venture. [redacted] Trial Tr. 12/19/16, 3596:12–14 (Rapisardi); *see also* [redacted], the agreement formalized a more integrated, closely aligned partnership. *See* Trial Tr. 12/19/16, 3596:19–23, 3612:5–18 (Rapisardi); [redacted]

296. [redacted] Cigna and St. Joseph plan to share risk and split profits and losses of the DSA. Trial Tr. 12/19/16, 3602:10–3603:12 (Rapisardi); [redacted]

[redacted] *see also* Trial Tr. 12/19/16, 3599:17–3600:1 (Rapisardi) (Cigna and St. Joseph are "equal partners in the alliance"). Finally, the agreement's exclusivity provision prevents [redacted] Trial Tr. 12/19/16, 3601:3–9 (Rapisardi).

297. [redacted]

298. [redacted] Trial Tr. 12/19/16, 3602:7–9 (Rapisardi) (growing business is one of the DSA's objectives). [redacted]

299. [redacted] *accord* Trial Tr. 12/19/16, 3614:3–12 (Rapisardi).

300. Anthem and Cigna tracked and benchmarked themselves against each other's provider collaborations in Southern California. [redacted] PX0488 at -528-3 ([redacted]).

301. [redacted] PX0369 at -160; *see also* Dahms 3/8/16 Dep. 215:6–25.

302. Similarly, Cigna monitored Anthem's provider collaborations in Southern California. [redacted]

303. Cigna views Vivity as a competitive threat. [redacted]

[redacted]

304. [redacted]

305. [redacted] PX0564 at -753. In the last year, Anthem has piloted a narrow-network product with Dignity Health in Ventura. Eddy (Tolman & Wiker) 10/14/16 Dep. 88:4–89:1, 90:17–91:8.

306. Similarly, Cigna recently has expanded its DSA model to San Diego and Los Angeles Counties. Trial Tr. 12/19/16, 3595:18–3596:1 (Rapisardi); [redacted] In 2016, Cigna entered into a DSA arrangement with Scripps Health in San Diego. Trial Tr. 12/19/16, 3595:18–24 (Rapisardi) [redacted] Trial Tr. 12/19/16, 3595:18–3596:1 (Rapisardi); [redacted]

307. [redacted] *see* [redacted].

308. [redacted] *see* [redacted]

309. [redacted]

(iii) Supply response

310. As in the other markets across the country, entry in California is difficult and would not be timely, likely, or sufficient to prevent or counteract the merger's negative effects. [redacted] Even existing competitors arguably best positioned to enter the market face significant barriers, including low profitability, limited geographic footprint, and difficulty acquiring new members. *See, e.g.*, [redacted]

a. Blue Shield of California

311. [redacted]

b. Health Net

312. Health Net is a weak and declining competitor throughout the state, especially for ASO and PPO products. PX0651 at -833-15 (showing 21.7 percent membership decline). Health Net is not a viable option for self-funded customers. Trial Tr. 12/20/16, 3654:10–16 (Mahoney/SML). [redacted]

313. Health Net is not a viable option for large groups that want to offer their employees a PPO option. Trial Tr. 12/16/16, 3230:8–15 (Mifsud/Melita). Its PPO "doesn't compete well on

price with the products offered by the other national players . . . Aetna, United, Cigna and the Blues." Brown (Arthur J. Gallagher) 10/14/16 Dep. 48:3–49:6.

314. Brokers do not consider Health Net as a viable option if more than 10 percent of a client's population resides outside of California. Trial Tr. 12/16/16, 3230:16–3231:2 (Mifsud/Melita). Further, "[m]any . . . clients see them as not as high a quality of a carrier" because of "less flexibility on the plan designs." Trial Tr. 12/20/16, 3654:17–3655:4 (Mahoney/SML). A quote from Health Net is not effective in getting Anthem or Cigna to reduce its price because "the Anthems, Cignas, Uniteds don't see them as quite the same level. They see them as a lesser level, so they're not willing to match price." Trial Tr. 12/20/16, 3659:7–15 (Mahoney/SML).

c. Kaiser

315. Kaiser is an integrated managed care system with a strong focus on fully-insured HMO products. Brown (Arthur J. Gallagher) 10/14/16 Dep. 44:12–44:20; [redacted]

316. Kaiser is rarely competitive for PPO or ASO business. Kehaly 4/28/16 Dep. 67:11–68:13; Brown (Arthur J. Gallagher) 10/14/16 Dep. 44:12–45:21 (Kaiser is not "a good option for those employers that wanted to offer a PPO option for their employees"); Trial Tr. 12/20/16, 3655:19–25 (Mahoney/SML) (Kaiser's self-funded product "has not been as robust as the other carriers'"); *see also* [redacted]

317. [redacted]

the Bay Area can realistically buy [Kaiser's PPO]" because "[t]hey don't price it to sell it." Brown (Arthur J. Gallagher) 10/14/16 Dep. 81:6–81:24; Trial Tr. 12/16/16, 3228:11–19 (Mifsud/Melita) (Kaiser is not a viable option for employees who do not have a Kaiser doctor and want the flexibility and choice of a PPO plan).

318. [redacted]

319. Kaiser appeals to a distinct segment of the population. *See* Trial Tr. 12/16/16, 3228:11–19 (Mifsud/Melita) ("It's kind of a love-hate type thing with Kaiser"). Those that tend not to choose Kaiser include people that "don't have a Kaiser doctor" and "value flexibility and choice," or "receive a lot of care." Trial Tr. 12/16/16, 3228:11–19 (Mifsud/Melita). "[T]hose employee who are a little bit older or who have a medical condition and they want the opportunity to go to a non-Kaiser facility" will generally not select Kaiser. Trial Tr. 12/20/16, 3656:12–18 (Mahoney/SML).

320. Kaiser seldom competes directly with traditional health plans: [redacted] In 2015 and 2016, [redacted] PX0548 at -169-7; PX0737 at -822-4.

321. Kaiser is rarely a full replacement in Northern California. [redacted] *see also* [redacted] PX0487 at -585, -616; *see also* Trial Tr. 12/16/16, 3227:6–12 (Mifsud/Melita) (none of his large group clients have Kaiser as their only health insurance plan option); Trial Tr. 12/20/16, 3656:19–24 (Mahoney/SML) (Kaiser has not won any of her customers from Anthem or Cigna on a full replacement basis in last three years). Kaiser is "an additional option . . . they basically coexist in the same company." Trial Tr. 12/16/16, 3228:4–10 (Mifsud/Melita). But "[e]very carrier has a policy on coexisting with Kaiser," and if Kaiser obtains more than approximately 50 percent of a company's employees, the non-Kaiser insurer will refuse to offer coverage due to "adverse selection." Trial Tr. 12/16/16, 3228:20–2339:14 (Mifsud/Melita); Trial Tr. 12/20/16, 3656:1–7 (Mahoney/SML) ("Most of the carriers have a requirement that they'll only allow 50 percent at the maximum Kaiser penetration").

322. For these reasons, Kaiser does not constrain the prices of Anthem or Cigna. Trial Tr. 12/16/16, 3235:11–3236:10 (Mifsud/Melita) (Kaiser is "not an alternative" to the national insurers, and its quotes are not effective in constraining prices "[b]ecause Kaiser is so different, the other carriers don't look at [it] as a competitor to their membership."); Trial Tr. 12/20/16, 3659:3–15 (Mahoney/SML) ("Kaiser is a completely different model"); Brown (Arthur J. Gallagher) 10/14/16 Dep. 57:20–59:2 (Anthem and Cigna "wouldn't respond to Kaiser's pricing" because they have "[d]ifferent deliver model[s], different economics . . . [they're] different animal[s]"). Brokers are "almost never" able use Kaiser's bid to negotiate down renewal pricing from Anthem or Cigna. Brown (Arthur J. Gallagher) 10/14/16 Dep. 57:20–59:2.

323. In fact, when a company introduces Kaiser as an option for its employees, the non-Kaiser health insurer usually increases its price. Trial Tr. 12/16/16, 3229:15–3230:4 (Mifsud/Melita); Trial Tr. 12/20/16, 3656:8–11 (Mahoney/SML).

d. Sutter

324. Sutter is perhaps the best positioned health system to enter the market with its provider-sponsored plan, [redacted] how unlikely it is that provider-sponsored entry—or any entry—would alleviate the harm from the merger. *See also supra* Section I.E.i.

325. At trial, there was mention of a joint product offered by Sutter, Kaiser, and a company called Western Health (the so-called "Triple Macho Combo"), but this product is not a serious threat. *See* Trial Tr. 12/21/16, 4088:8–20 (Rothermel) (describing combination). Western Health Advantage is a [redacted] health plan in the Sacramento and North Bay region. [redacted] *see also* Brown (Arthur J. Gallagher) 10/14/16 Dep. 49:16–50:12. The one competitive episode involving the Triple Macho Combo that Anthem highlighted at trial was for the County of Sacramento, but Anthem did not even bid for the account. PX0748 at -363; Trial Tr. 12/21/16, 4155:10–20 (Rothermel).

D. Colorado markets

326. The merger would substantially reduce competition in four CBSAs in Colorado: Denver-Aurora-Lakewood (Denver), Fort Collins, Boulder, and Colorado Springs (collectively, the "Colorado CBSAs").

327. In each of the Colorado CBSAs, the merged firm would have approximately 50 percent of the large-group commercial business. *See supra* ¶ 324. The merged insurer's market share in Denver would be slightly lower because Kaiser participates in that market. *See supra* ¶ 324. [redacted] *See, e.g.*, PX0401 at -622-18 [redacted]

(i) Large-group effects

328. The merger is presumptively unlawful in the Colorado CBSA markets based on the following shares and HHIs, discussed in Section I.C.

Large Group	Denver-Aurora-Lakewood	Boulder	Colorado Springs	Fort Collins
Anthem	**25%**	**28%**	**36%**	**38%**
Cigna	**15%**	**20%**	**13%**	**11%**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Pre-merger HHI	1,868	1,954	2,253	2,213
Post-merger HHI	2,624	3,102	3,191	3,025
Delta HHI	756	1,148	938	811

329. [redacted] Anthem [redacted] PX0373 at -316;

Ramseier 4/22/16 Dep. 242:11–18, 68:3–9. As a result, Anthem must [redacted] PX0554 at -573; *see also* Ramseier 4/22/16 Dep. 68:3–9. To remain competitive, Anthem must focus on providing "excellent service," increasing product choice, and improving "provider partnerships and data analytics." Ramseier 4/22/16 Dep. 72:21–73:12, 243:7–24.

330. The merger will eliminate substantial head-to-head competition that has benefited customers in the Colorado CBSAs. *See, e.g.*, PX0501 [redacted] In [redacted], in response to Cigna [redacted], Anthem [redacted] PX0532 at -753. [redacted] PX0492 at -124.

331. Another example of Anthem responding to competition from Cigna is Anthem's introduction of level-funded products in Colorado. [redacted] Anthem identified [redacted] *See* PX0398 at -591-10; *see also* PX0401 at -622-9–622-10, -622-28–622-29 [redacted] *see also* Ramseier 4/22/16 Dep. 209:15–21. [redacted] Anthem [redacted]. PX0535 at -580; Ramseier 4/22/16 Dep. 208:25–209:14. In [redacted], Anthem Colorado's director of large group sales [redacted] PX0533 at -272 [redacted]

332. The merger would also eliminate competition between Anthem and Cigna for wellness offerings in Colorado. Anthem [redacted]

[redacted] PX0398 at -591-10. By contrast, Anthem [redacted] PX0401 at -622-28.

333. Anthem has been forced to respond to Cigna's wellness programs. For example, in [redacted] PX0399 at -388. Anthem [redacted] PX0399 at -388.

(ii) Buy-side effects

334. The merger is presumptively unlawful in the Colorado CBSAs' buy-side markets based on the following shares and HHIs, discussed in Section I.C:

Buy-Side	Denver-Aurora-Lakewood	Boulder	Colorado Springs	Fort Collins
Anthem	**23%**	**28%**	**33%**	**34%**
Cigna	**15%**	**16%**	**12%**	**10%**
[redacted]				
[redacted]				
[redacted]				
Pre-merger HHI	1,735	1,697	1,959	1,692
Post-merger HHI	2,419	2,583	2,760	2,344
Delta HHI	684	886	801	652

335. Anthem is generally one of the largest insurers for Colorado providers. [redacted]

[redacted] McCreary (UC Health) 10/6/16 Dep. 66:25–67:2 (Anthem makes up biggest portion of commercial patient population).

336. Anthem's market share also makes it difficult for providers to go out-of-network with Anthem for an extended period of time, giving Anthem substantial leverage in rate negotiations. [redacted] McCreary (UC Health) 10/6/16 Dep. 71:19–72:7; 80:11–25. But, in the Colorado CBSAs, providers have been able to "keep the health plans competitive by tightly banding the rates they give to the top health plans." Pogar 3/30/16 Dep. 215:10–216:11; *see also* [redacted] Should the merger occur, this competition would likely be substantially diminished. *See* [redacted] Pogar 3/30/16 Dep. 267:2–267:19 ([redacted]), 385:16–386:19 (stating that Anthem hopes to receive better discounts through the merger).

337. The merger would eliminate head-to-head competition between Anthem and Cigna for ACO partnerships. [redacted] Today, New West's CEO believes that the practice has its best ACO relationship with Cigna, in part because Cigna is "more open and transparent with . . . data." Benton (New West) 10/20/16 Dep. 23:2–7, 24:25–25:4. Anthem, by contrast, is "probably the worst of the four [Anthem, Cigna, United, and Aetna] in that they're not transparent." Benton (New West) 10/20/16 Dep. 25:5–8.

Further, as to ACOs generally, "almost every provision" of Anthem's ACO program "could benefit and learn from CIGNA." Benton (New West) 10/20/16 Dep. 60:3–8. Anthem's VP of provider solutions has acknowledged that Anthem must know what its competitors are doing with providers to make sure that its value-based programs are competitive. Pogar 3/30/16 Dep. 271:25–272:16, 292:10–14, 325:18–24. One of Anthem's [redacted] PX0398 at -591-11.

338. Absent the merger, Cigna would continue to innovate and develop new products. Cigna planned to introduce SureFit, a narrow network of value-based providers, in [redacted] on January 1, 2017. Trial Tr. 11/22/16, 445:23–448:3, 453:12–20, 454:1–5 (Cordani); [redacted]

(iii) Supply response

339. No health insurer has entered Colorado in the past few years, Ramseier 4/22/16 Dep. 100:21–101:3, and market shares among the top insurers have been relatively stable. PX0401 at -622-9; PX0401 at -622-28; Pogar 3/30/16 Dep. 293:21–294:1. Smaller competitors in Colorado, including the ones discussed below, are unlikely to expand successfully.

340. [redacted] *see also* Pogar 3/30/16 Dep. 151:14–20 (describing [redacted] membership as "pretty small"). [redacted]

[redacted]

E. Connecticut markets

341. The merger will harm competition in at least five local markets in Connecticut: the Bridgeport-Stamford-Norwalk, Hartford-West Hartford-East Hartford, New Haven-Milford, Norwich-New London, and Torrington CBSAs. Competitive conditions are similar throughout the state (so these MSAs are analyzed together).

(i) Large-group effects

342. The merger is presumptively unlawful in all five large-group CBSAs in Connecticut, based on the following shares and HHIs, discussed in Section I.C:

Large Group	Bridgeport-Stamford-Norwalk	Hartford-West Hartford-East	New Haven-Milford	Norwich-New London	Torrington
Anthem	**34%**	**45%**	**51%**	**55%**	**41%**
Cigna	**22%**	**18%**	**16%**	**7%**	**20%**
[redacted]					
[redacted]					
[redacted]					
Pre-merger HHI	2,450	2,796	3,230	3,874	2,580
Post-merger HHI	3,959	4,446	4,895	4,623	4,263
Delta HHI	1,509	1,650	1,665	748	1,683

343. Anthem is by far the largest health insurer in Connecticut. An Anthem executive confirmed that it has more than [redacted] of the state's commercial enrollment. Augur 5/25/16 Dep. 113:6–8; Hummel 10/18/16 Dep. 246:10–17, 247:8–11. [redacted]

344. Cigna has competed aggressively against Anthem in Connecticut for both fully-insured and self-insured products, Augur 5/25/16 Dep. 175:6–176:10, especially for accounts with over 200 lives. Testa (Lockton) 10/18/16 Dep. 68:12–19. Anthem [redacted] PX0696 at -392–393, -397–398. Dr. Dranove testified that Anthem loses more accounts to Cigna in Connecticut than market shares would predict. Trial Tr. 12/20/16, 3729:18–3730:3 (Dranove); [redacted]

345. Also, Anthem and Cigna have competed aggressively head-to-head. In 2012 and 2013, Anthem considered [redacted] Augur 5/25/16 Dep. 212:21–214:23, 217:17–218:13, 218:22–219:20 [redacted]

346. In the deposition of [redacted] the company's head of purchasing described how his company has benefited from this competition. In

2012, [redacted] conducted an RFP in which United, Aetna, and ConnectiCare were "very, very quickly" eliminated, leaving Anthem and Cigna as the only serious options. [redacted] A "bidding war" over the course of several weeks ensued where "[Anthem's] price came down, CIGNA's price came down, Anthem's price came down, CIGNA's price came down, Anthem's price came down, CIGNA's price came down, and we went back and forth." [redacted] Cigna's initial quote [redacted] down [redacted]

347. Anthem and Cigna have also been particularly close competitors for municipal business in Connecticut. *See* [redacted] Anthem testified that it has probably lost more municipal accounts to Cigna than any other competitor. Augur 5/25/16 Dep. 269:22–25. The only other alternative for municipalities is ConnectiCare. Testa (Lockton) 10/18/16 Dep. 67:15–18, 43:20–44:7, 70:14–24 (noting that Aetna and United rarely even bid), 78:15–79:7 (TPAs are not an option).

348. [redacted] Similarly, Anthem faced [redacted] PX0460. [redacted]

[redacted]

[redacted] Hummel 10/18/16 Dep. 152:8–21, 156:10–15.

(ii) Buy-side effects

349. The merger is also presumptively anticompetitive in all five buy-side markets in Connecticut, based on the following market shares and HHIs, discussed in Section II.C:

Buy-Side	Bridgeport -Stamford- Norwalk	Hartford- West Hartford- East	New Haven- Milford	Norwich- New London	Torrington
Anthem	**32%**	**40%**	**45%**	**55%**	**39%**
Cigna	**18%**	**15%**	**13%**	**6%**	**16%**
[redacted]					
[redacted]					
[redacted]					
Pre-merger HHI	2,138	2,309	2,493	3,714	2,283
Post-merger HHI	3,270	3,522	3,625	4,371	3,515
Delta HHI	1,132	1,212	1,132	657	1,233

350. As discussed above, Stamford Hospital, a health system in the Bridgeport-Stamford-Norwalk MSA, and Yale Medicine, a physician group with offices in the New Haven-Milford MSA, testified how they have benefited from competition between Anthem and Cigna. *See supra* Section II.D.ii.

351. In addition, an example from [redacted] illustrates the potential buy-side harm. [redacted] PX0507 at -098. [redacted] PX0507 at -098. [redacted]

[redacted] PX0507 at -098.

(iii) Supply response

352. Other insurers are unlikely to replace the competition lost by Cigna in Connecticut. Harvard Pilgrim—one of New England's largest regional insurers—entered Connecticut in 2014. Trial Tr. 12/21/16, 3916:20–3917:1 (Dranove). [redacted] Hummel 10/18/16 Dep. 116:1–15, 269:15–21; Trial Tr. 12/20/16, 3745:15–3746:9 (Dranove); [redacted] Moreover, Harvard Pilgrim has no public-sector accounts. Hummel 10/18/16 Dep. 115:14–17, 117:22–25.

353. [redacted] Like other regional insurers, it is at a cost disadvantage because it has to rent a network outside of Connecticut. Augur 5/25/16 Dep. 182:16–22, 183:12–184:5. [redacted] *see also* [redacted] Another broker said that ConnectiCare is typically not competitive for accounts with employees in other states. Testa (Lockton) 10/18/16 Dep. 86:20–24, 128:5–13, 126:17–20.

354. HealthyCT, a local co-op, has failed and is no longer accepting any new enrollment. Hummel 10/18/16 Dep. 76:21–23. [redacted]

[redacted]

F. Georgia markets

355. The merger is presumptively unlawful with respect to two CBSAs in the state of Georgia in both large-group and buy-side markets: Atlanta-Sandy Springs-Roswell ("Atlanta") and Gainesville.

Large Group	Atlanta-Sandy Spring-Roswell	Gainesville	**Buy-Side**	Atlanta-Sandy Spring-Roswell	Gainesville
Anthem	**45%**	**51%**	**Anthem**	**38%**	**43%**
Cigna	**10%**	**8%**	**Cigna**	**8%**	**6%**
[redacted]					
Pre-merger HHI	2,669	2,876	Pre-merger HHI	2,056	2,230
Post-merger HHI	3,558	3,652	Post-merger HHI	2,664	2,753
Delta HHI	889	776	Delta HHI	608	523

356. These shares are consistent with market realities, which show that Anthem and Cigna are strong competitors. *See* Fetherston 5/6/16 Dep. 57:9–16 [redacted] PX0389 at -152 [redacted] PX0461 at -553 (estimating market shares); Novack

4/27/16 Dep. 234:4–235:4; *see also* Caldwell (Alliant) 10/17/16 Dep. 83:16–85:10; PX0498 at -143-3.

357. The competitive conditions in Atlanta and Gainesville are relatively similar, with Atlanta being [redacted] Fetherston 5/6/16 Dep. 57:9–58:3; [redacted] *See* Novack 4/27/16 Dep. 97:7–21; PX0552 at -285-7, -285-9 [redacted] *see also* PX0389 at -153; PX0461 at -553 .

358. Anthem and Cigna are particularly close competitors in Georgia for some large-group customers. An Atlanta-based Anthem[1] senior account executive explained that Cigna [redacted] PX0513 at -871. Anthem's director of large group sales in Georgia [redacted] She also noted that [redacted] PX0509; *see also* PX0389 at -153 (Anthem's [redacted] PX0512 at -467–468 [redacted]

359. Competition between Anthem and Cigna has [redacted] *See, e.g.*, PX0510 at -911–913; PX0387 at -886, -914–917. While Cigna may be at a price disadvantage in certain circumstances, it is able to compete with Anthem by offering higher services levels. *See* [redacted] Novack 4/27/16 Dep. 98:25–99:18. And [redacted] Anthem t[redacted] PX0546 at -405. Competition between Anthem and Cigna has also

[1] In Georgia, Anthem does business as Blue Cross Blue Shield of Georgia. *See* PX0125 at -4.

benefited providers in Georgia. *See supra* ¶ 129.

360. Neither United nor Aetna, the primary alternatives would be able to replace the competition lost between Anthem and Cigna. For many customers, Anthem and Cigna are the two best options. See supra ¶¶ 59–60, 171–173. Anthem has recognized that, in contrast to the aggressiveness of Cigna, "[i]n the large mid market, [United] seems to have gone underground and where it was [Anthem] or UHC for a year to 2 years now [it] seems more us or Cigna on many cases." PX0513 at -871. And Georgia brokers "are critical of Aetna's service and said the company is unresponsive and hard to work with." PX0675 -417-28.

361. [redacted]

362. Entry or significant expansion is unlikely, particularly in Atlanta. Alliant attempted to enter the Atlanta market between 2012 and 2014, but was unable to turn a profit. Caldwell (Alliant) 10/17/16 Dep. 61:18–62:22; *see also* Caldwell (Alliant) 10/17/16 Dep. 65:16–66:9 ("[A]ttempting to go into the Atlanta market was not necessarily a wise decision . . . ."). Alliant failed to develop "market clout" to obtain competitive provider rates. *See* Caldwell (Alliant) 10/17/16 Dep. 61:18–63:20. Alliant's CFO estimated that it would need 75 to 100 thousand lives to successfully compete in Atlanta. Caldwell (Alliant) 10/17/16 Dep. 64:14–25. It would take Alliant "over five years" and "approximately $20 million" to obtain those lives. Caldwell (Alliant) 10/17/16 Dep. 67:7–68:10. The only provider-sponsored plan that "survived" the licensure process of several that tried, Alliant has had minimal success with only 5,500 members,

mostly outside of Atlanta in northwest Georgia, and faces the same limitations as other such plans.[2] Caldwell (Alliant) 10/17/16 Dep. 18:23–19:7, 27:2–28:5, 51:14–52:1, 55:15—56:9, 69:9–14; *see supra* ¶¶ 75–80. [redacted]

G. Indiana markets

363. The merger is unlawful in three CBSAs in Indiana: Indianapolis-Carmel-Anderson ("Indianapolis"), Lafayette-West Lafayette ("Lafayette"), and Terre Haute.

364. [redacted] PX0116 at 13. [redacted] PX0494 at -296 [redacted] PX0564 at -823; *see* Hillman 5/5/16 Dep. 206:23–207:13. [redacted] PX0494 at -296; PX0518 at -652 [redacted] *see* PX0602 at -916.

365. [redacted] PX0391 at -937 [redacted] *see also* PX0391 at -967. [redacted]

[2] While Alliant has seen some modest expansion in Gainesville, the core of its large-group business is in Northwest Georgia, outside of the Atlanta area. See Caldwell (Alliant) 10/17/16 Dep. 30:18–25, 54:21–57:9.

[redacted] Hillman 5/5/16 Dep. 42:8–43:17; [redacted]

366. [redacted] Hillman 5/5/16 Dep. 75:7–13; *see* Hillman 5/5/16 Dep. 71:24–72:7, 74:22–75:6. [redacted] Hillman 5/5/16 Dep. 28:5–29:13. [redacted] Hillman 5/5/16 Dep. 165:24–166:23, 226:16–227:4.

367. [redacted] PX0518 at -652 [redacted] PX0391 at -937 [redacted] PX0395 at -616.

(i) Indianapolis

368. Plaintiffs' Indiana geographic markets are well defined. Industry participants use "Indianapolis market" for Indianapolis and surrounding counties. Trial Tr. 12/14/16, 2858:1–11 (Berfiend/IU Health); PX0638 at -969; *see also* DeVeydt 10/14/16 Dep. 69:21–70:18; PX0638 at -965, -970.

369. The merger is presumptively unlawful in the Indianapolis large-group and buy-side markets based on the following shares and HHIs, calculated by Dr. Dranove using the methodology discussed in Section I.C.:

Indianapolis, IN		
	Large Group	**Buy Side**
Anthem	**61%**	**59%**
Cigna	**4%**	**4%**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
Pre-merger HHI	3,945	3,746
Post-merger HHI	4,469	4,187
Delta	524	441

a. Large-group effects

370. [redacted] PX0391 at -937, -940; Phillips 4/14/16 Dep. 148:23–149:10.

371. In Indianapolis, Cigna wins accounts from Anthem [redacted]

372. Even within its current pricing and profit structure, Anthem has responded to competitive pressure from Cigna. [redacted] PX0395 at -616.

373. Cigna has attempted to use provider collaborations to compete with Anthem and others. [redacted]

[redacted]

b. Buy-side effects

374. [redacted] PX0564 at -823. [redacted] PX0116 at 13.

375. For many years, Anthem has had the "dominant unit cost position—particularly in Indianapolis." PX0602 at -916; PX0518 at -652 [redacted] *see* Hillman 5/5/16 Dep. 68:7–11, 68:19–69:7. [redacted]

376.

377. Hillman 5/5/16 Dep. 260:7–22; In March 2014, Anthem announced an ACO with Franciscan, another hospital system in Indiana.

378. [redacted]

379. [redacted]

380. Despite its lower market share, Cigna has established value-based contracts across Indiana and in Indianapolis in particular. *Contra* PX0391 at -961. Cigna has an ACO with Franciscan Alliance for its Indianapolis facilities. Golias 6/3/16 Dep. 43:23–44:10. [redacted]

381. [redacted]

382. [redacted]

383. In Indianapolis, IU Health's largest commercial payers are Anthem [redacted] Cigna [redacted] United [redacted] and Aetna [redacted] Trial Tr. 12/14/16, 2859:4–17 (Berfiend/IU Health) [redacted] IU Health's volume for each of these insurers is similar statewide. Trial Tr. 12/14/16, 2862:5–12 (Berfiend/IU Health).

384. [redacted]

[redacted] *with* Hillman 5/5/16 Dep. 257:16–259:24, *and* PX0371 at -668 [redacted]

(ii) Lafayette and Terre Haute

385. The merger is presumptively unlawful on both sides of the market in both the Lafayette and Terre Haute markets based on the following shares and HHIs, calculated by Dr. Dranove using the methodology discussed in Section I.C.:

	Large Group		Buy-Side	
	Lafayette-West Lafayette	Terre Haute	Lafayette-West Lafayette	Terre Haute
Anthem	**50%**	**59%**	**46%**	**58%**
Cigna	**6%**	**6%**	**5%**	**6%**
[redacted]				
[redacted]				
[redacted]				
Pre-merger HHI	3,204	3,704	2,738	3,573
Post-merger HHI	3,851	4,466	3,243	4,222
Delta	647	762	505	649

(iii) Supply response

386. IU Health Plan has approximately 200,000 members; however, roughly half of those members are in Medicare or Medicaid plans. Trial Tr. 12/14/16, 2860:6–11 (Berfiend/IU Health). Of the roughly 100,000 members in commercial plans, 80,000 are its employees. Trial Tr. 12/14/16, 2860:6–11 (Berfiend/IU Health). [redacted]

387. While Anthem and Cigna have large networks that cover most Indiana providers, Hillman 5/15/16 Dep. 196:16–197:4; Phillips 4/14/16 Dep. 88:2–10, 97:5–14, 100:15–25, IU Health Plans largely only contracts with its own IU Health facilities. Trial Tr. 12/14/16, 2860:12–20 (Berfiend/IU Health). It has no contracts with providers outside of Indiana. Trial Tr. 12/14/16, 2860:18–22 (Berfiend/IU Health). The patient volume that IU Health Plan steers to IU Health facilities represents [redacted] of its commercial patient volume. Trial Tr. 12/14/16, 2859:4–17 (Berfiend/IU Health) (discussing [redacted]). And this volume represents only use by IU Health's own employees. Trial Tr. 12/14/16, 2859:18–2860:2 (Berfiend/IU Health) (discussing [redacted]).

388. [redacted] Hillman 5/5/16 Dep. 213:8–214:2; PX0514 at -785. However, PHP is not licensed to sell insurance in Indianapolis. Brunnemer and Cahill (PHP) 10/6/16 Dep. 18:11–19:13. And SIHO is a TPA that no longer sells insurance in Indiana. Brunnemer and Cahill (PHP) 10/6/16 Dep. 145:23–148:19. Other insurers have entered and subsequently exited the Indiana market, including Partners Health Plan, Arnett Health Plans, M-Plan, MaxiCare, Wellburn Health Plan, and Advantage Health. Brunnemer and Cahill (PHP) 10/6/16 Dep. 144:19–25, 145:23–148:19.

389. While other insurers have a presence in Indiana, few have more than marginal membership. Brunnemer and Cahill (PHP) 10/6/16 Dep. 52:17–55:1. For example, CNIC has six members in Indiana. Espinoza (CNIC) 10/6/16 Dep. 78:18–20. Questioning by Anthem's lawyers revealed that several deponents "serve clients" in Indiana, but failed to quantify their membership. *See, e.g.*, Archer (HealthSmart) 10/20/16 Dep. 31:12–32:5; [redacted]

[redacted] Tallman (Centene) 10/14/16 Dep. 109:18–24, 110:3–111:24 (Centene has sold commercial Medicare, Medicaid, or Ambetter products in Indiana); Parker (PrimeLine) 10/7/16 Dep. 90:25–91:6 (discussing the states where PrimeLine has membership).

390. Cigna runs a rental network in Indiana, Sagamore Health Network. Benedict 9/21/16 Dep. 39:14–16, 39:19–40:24. Many of the TPAs active in Indiana rely on Cigna's rental network. [redacted]

H. Maine markets

391. The merger is presumptively unlawful with respect to four CBSAs in the state of Maine: Augusta-Waterville ("Augusta"), Bangor, Lewiston-Auburn ("Lewiston"), and Portland-South Portland ("Portland"). While each CBSA is a separate geographic market, competitive conditions are similar throughout Maine, so these markets are discussed together below.

392. The four major players in these highly consolidated markets are Anthem, Aetna, Harvard Pilgrim, and Cigna. [redacted] DX0537 at -107; PX0553 (Large Group tab – ME); PX0562 at -417; [redacted] PX0564 at -841; Corcoran 3/9/16 Dep. 255:21–256:20.

393. The merger is presumptively unlawful as to the large-group market in all four Maine CBSAs and as to the buy-side market in the Portland CBSA, based on the following market shares and HHIs calculated by Dr. Dranove as discussed in Section I.C. *See also* Trial Tr.

12/20/16, 3716:3–3718:16 (Dranove).

Large Group	Augusta-Waterville	Bangor	Lewiston-Auburn	Portland-South Portland
Anthem	**38%**	**40%**	**37%**	**50%**
Cigna	**10%**	**14%**	**12%**	**11%**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Pre-merger HHI	2,235	2,224	2,204	3,136
Post-merger HHI	2,992	3,363	3,070	4,270
Delta HHI	757	1,139	886	1,134

(Maine buy-side table available in Appendix C)

394. [redacted] Corcoran 3/9/16 Dep. 103:5–104:1, 107:16–21, and [redacted] PX0562 at -402, -409. [redacted] PX0498 at -157-4; *see also* Corcoran 3/9/16 Dep. 254:3–15.

395. [redacted] Corcoran 3/9/16 Dep. 168:1–25, 191:9–23; [redacted]

396. [redacted] *see, e.g.*, Corcoran 3/9/16 Dep. 216:4–22, 218:10–219:3, 232:19–235:8, 237:3–23; PX0498 at -157-12; *see also* PX0387 at -924.

397. As in other states, *see supra* Section III.C., Cigna is viewed as a market leader in creating wellness programs provider collaborations in Maine. *See* Butler 4/29/16 Dep. 109:1–18,

110:22–111:4; [redacted] Corcoran 3/9/16 Dep. 65:7–66:7, 199:13–200:13, 227:9–18. [redacted] *See* Corcoran 3/9/16 Dep, 65:7–66:7, 199:13–202:3.

398. Aetna, United, and Harvard Pilgrim have significant weaknesses in Maine. [redacted] *see also* Corcoran 3/9/16 Dep. 162:5–19.

399. Maine Community Health Options, a co-op plagued with financial issues, is even weaker; Anthem does not expect it to compete for large-group accounts with more than 100 lives. Corcoran 3/9/16 Dep. 178:21–179:18, 188:25–189:22.

400. Anthem does not expect entry in Maine for the next three years. Corcoran 3/9/16 Dep. 259:12–260:15. As one of its Anthem's witnesses testified, entrants in Maine face a tough environment. *See* Trial Tr. 12/21/16, 4027:20–24, 4028:6–13 (Burke/Maine Education Association Benefits Trust).

I. Missouri

401. The merger is presumptively unlawful with respect to the St. Louis, Missouri-Illinois CBSA based on the following market shares and HHIs, calculated by Dr. Dranove as discussed in Section I.C. *See also* Trial Tr. 12/20/16, 3716:3–3718:16 (Dranove).

St. Louis, MO-IL		
	Large Group	**Buy-Side**
Anthem	**32%**	**34%**
Cigna	**9%**	**8%**
[redacted]	[redacted]	[redacted]
Pre-merger HHI	2,508	2,567
Post-merger HHI	3,082	3,108
Delta	574	541

402. Anthem and Cigna are good options for large groups in St. Louis. DX0584 at -492 [redacted]

Anthem is the oldest and largest insurer in Missouri, and its market shares have been stable for several years. Martenet 10/19/16 Dep. 17:13–18:4, 19:2–20:5. Cigna is among Anthem's "largest" and "primary" competitors in the state. Martenet 10/19/16 Dep. 23:18–24:6, 53:19–54:19.

403. Cigna has a value-based arrangement with BJC Healthcare in its individual segment and [redacted]

J. New York

404. The merger is presumptively unlawful with respect to the New York-Newark-Jersey City CBSA, otherwise known as "downstate New York," Soumakis 4/13/16 Dep. 23:4–12, based on the following market shares and HHIs calculated by Dr. Dranove as discussed in Section I.C. *See also* Trial Tr. 12/20/16, 3716:3–3718:16 (Dranove).

New York-Newark-Jersey City, NY-NJ-PA		
	Large Group	**Buy-Side**
Anthem	**45%**	**38%**
Cigna	**8%**	**6%**
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
Pre-merger HHI	2,826	2,155
Post-merger HHI	3,531	2,641
Delta	705	486

405. [redacted] Soumakis 4/13/16 Dep. 100:23–101:11; 196:13–197:4. [redacted] Soumakis 4/13/16 Dep. 110:15–111:13, 140:20–141:3, 179:19–180:6.

406. [redacted]

407. [redacted] Soumakis 4/13/16 Dep. 85:22–86:13; [redacted]

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

408. To even be considered as potentially reversing the harm from the merger, efficiencies must be cognizable. As Dr. Dranove testified in Phase 1 of the trial, efficiencies need

to be verifiable, merger-specific, and they cannot result from anticompetitive reductions in output or service. Trial Tr. 11/28/16, 1008:3–21 (Dranove).

409. For the reasons explained in Phase 1, Anthem's purported efficiencies are not cognizable and are not sufficient to offset the harm from the merger. The Plaintiffs incorporate by reference their Phase 1 Proposed Findings of Fact on efficiencies. ECF #408 (Plaintiffs' Phase 1 Proposed Findings of Fact) at ¶¶ 376–427. The current findings focus on the testimony received and issues in Phase 2 of the trial, including Dr. Israel's balancing of efficiencies and harm.

A. Dr. Israel failed to balance purported efficiencies and harm.

410. Dr. Israel failed to analyze the claimed medical-network cost savings on a relevant market-by-market (CBSA) basis. Dr. Israel contends that the total medical-network cost savings for local large groups across the ten states containing at least one CBSA is $1.4 billion. Trial Tr. 12/22/16, 4364:21–4365:4 (Israel). To balance the claimed efficiencies against the potential harm, Dr. Israel ran a merger simulation and presented results for each of the ten states. Trial Tr. 12/23/16, 4486:14–20 (Israel).

411. By using a statewide basis to calculate efficiencies and run his merger simulation, Dr. Israel improperly included out-of-market efficiencies and failed to make the correct calculation to balance efficiencies and harm. *See* Trial Tr. 12/22/16, 4356:9–24, 4357:11–14 (Israel) (calculating efficiencies on a statewide basis for Phase 2); Trial Tr. 12/23/16, 4486:17–4487:8 (Israel), DDX0498 at 5 (presenting merger simulation results on a statewide basis). Dr. Israel also failed to include fully-insured accounts data in his merger simulation. Trial Tr. 12/22/16 4444:16–25 (Israel).

412. Dr. Israel's balancing has an additional flaw. In running his merger simulation, Dr. Israel uses a negotiation model based on an assumption that customers have *perfect* information

about an insurer's best offer. Trial Tr. 1/3/17, 4732:16–4733:16. (Dranove). If Dr. Israel's assumption about perfect information is incorrect, even crediting 100 percent of the $2.4 billion in claimed medical-network cost savings and all $515 million in claimed G&A savings, the merger is still anticompetitive in several CBSAs. Trial Tr. 1/3/17, 4736:6-4738:18 (Dranove); PX0760; *see* Appendix A for estimates of static price harm.

B. Anthem's claimed medical-network cost savings are not cognizable.

413. Furthermore, as Dr. Dranove testified in Phase 1, the claimed medical-network cost savings are not cognizable efficiencies that will outweigh the resulting harm from the merger. Trial Tr. 11/28/16, 845:18–22 (Dranove).

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

414. Anthem is unlikely to achieve 100 percent of its claimed medical-network cost savings by getting the best-of-best rates from all providers. Providers' testimony in Phase 2 confirms Plaintiffs' Phase 1 Proposed Findings. For example, if Anthem asks Bon Secours to move its Cigna business to Anthem's rates after the merger, Bon Secours would look for ways to negotiate this amount. Trial Tr. 12/19/16, 3415:24–3416:2 (Wheeler/Bon Secours).

(ii) The claimed medical-network cost savings result from an exercise of buy-side market power and are not an efficiency.

415. Plaintiffs incorporate by reference proposed findings of fact relating to the monopsony claims. *See supra* Section II.D.

416. Lower rates from increased bargaining leverage are not a volume discount or other purchasing economy. Trial Tr. 12/20/16, 3798:12–24 (Dranove). Providers agree to accept lower rates from insurers with more members "because it's harder to walk away from them. This is not the sort of volume discount or purchasing economy that we would confuse with an efficiency." Trial Tr. 12/20/16, 3798:12–24 (Dranove).

417. Rate reductions would not result from any additional volume. The vast majority of providers are already in both Anthem's and Cigna's networks, and thus there is little new volume that providers will gain by combining them. PX0353 at -122. If Anthem acquires Cigna, Bon Secours does not expect to see additional patients that it is not already seeing today. Trial Tr. 12/19/16, 3417:9–17 (Wheeler/Bon Secours). The merging of these two companies is not "producing extra populations or patients with needs." Trial Tr. 12/19/16, 3417:9–15 (Wheeler/Bon Secours). Patient First does not anticipate receiving more commercial volume as a result of the merger. Trial Tr. 12/16/16, 3164:24–3165:7 (Gorse/Patient First).

418. There will not be savings to providers from dealing with only one insurer instead of two. For example, LRGHealthcare does not expect to save money on claims processing as a result of dealing only with Anthem instead of Anthem and Cigna and has "more challenges with getting claims paid through Anthem than Cigna at this point." Trial Tr. 12/16/16, 3278:2 – 9, 3278:20–23 (Lipman/LRGHealthcare). In terms of claims processing for Patient First, "there's really not any huge efficiency in one payer versus two." Trial Tr. 12/16/16, 3165:8–20 (Gorse/Patient First). In fact, Anthem's payments come in slower than Cigna's currently. Trial Tr. 12/16/16, 3165:8–20 (Gorse/Patient First).

419. Rate reductions may lead to a reduction in the quality of medical care. Trial Tr. 12/16/16, 3166:10–3167:3 (Gorse/Patient First) (lower rates could force Patient First to cut or reduce services that will impact quality of care); Trial Tr. 12/16/16, 3279:4–3280:19 (Lipman/LRGHealthcare) (in response to lower rates, LRGHealthcare could curtail services such as a vascular surgery program to help patients preserve limbs rather than amputating them).

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

420. Dr. Israel failed to directly analyze how much, if any, of the claimed cost savings

would be passed through to fully-insured customers. Dr. Israel did not run a regression to estimate how much of the claimed cost savings would be passed through to fully-insured customers. Trial Tr. 12/22/16, 4436:19–22 (Israel). About $620 million—or more than one-quarter—of the claimed medical-network cost savings come from fully-insured accounts. Trial Tr. 12/22/16, 4435:12–19 (Israel). Medical-network cost savings for fully-insured accounts are not automatically passed through to employers. Trial Tr. 12/22/16, 4359:11–4360:7 (Israel).

421. Anthem will not pass through all of the claimed medical-network cost savings to ASO customers. Anthem seeks to use fee structures that will allow Anthem—not employers—to capture any medical-network cost savings. For example, in the Richmond area, Anthem's network access fee is a percent of the savings achieved through Anthem's provider discounts so that if Anthem increases its provider discounts, it will also increase its network access fees. Trial Tr. 12/19/16, 3368:23–3369:6 (Harlin/Wells Fargo). Consistent with Anthem trying to capture as much margin as it can for itself, Anthem plans to increase ASO fees to capture some of the savings employers receive from Anthem's Enhanced Personal Health Care program. Trial Tr. 12/15/16, 3072:25–3076:15 (King); PX0214 at -069.

C. Anthem's claims of other efficiencies are not supported by the record.

422. Dr. Israel's claims that there are benefits from combining the best attributes of Cigna's and Anthem's products are purely aspirational—they do not flow from economic theory. Trial Tr. 1/3/17, 4723:22–4724:14 (Dranove). Rather, economic theory tells us there is no guarantee that the "best-of-the-best" will be achieved absent a plan and successful execution of that plan. Trial Tr. 1/3/17, 4723:22–4724:14 (Dranove). There is nothing in the record supporting such a plan. Consistently, Dr. Israel does not attempt to quantify any purported benefits. Trial Tr. 12/22/16, 4377:1–4379:9 (Israel).

423. Contrary to Dr. Israel's claims, Anthem acknowledges there are no international efficiencies from the transaction. *See* Trial Tr. 12/22/16, 4373:22–4375:24 (Israel); Trial Tr. 11/30/16, 1496:19–1497:21 (Matheis) ("Anthem does not have an international presence, and so we just assumed, for purposes this work [sic], that there were no efficiencies to be had in the international business.").

424. To the extent Anthem argues the merger will result in increased scale that will facilitate value-based initiatives, it is incorrect. For a discussion of the scale argument with respect to value-based care, *see supra* Section III.D.

Dated: January 9, 2017

Respectfully submitted,

/s/ Jon B. Jacobs

Jon B. Jacobs (D.C. Bar No. 412249)
Scott I. Fitzgerald
Melanie M. Kiser
Aaron Comenetz (D.C Bar No. 479572)
Nathan D. Brenner
U.S. Department of Justice, Antitrust Division
450 Fifth Street, NW, Suite 4100
Washington, DC 20530
Phone: (202) 598-8916
Facsimile: (202) 307-5802
E-mail: jon.jacobs@usdoj.gov

Attorneys for United States of America

Paula Lauren Gibson
Deputy Attorney General
Office of the Attorney General of California
300 S Spring Street
Suite 1702
Los Angeles, CA 90013
Phone: (213) 897-0014
Facsimile: (213) 897-2801
E-mail: Paula.Gibson@doj.ca.gov

Attorney for the State of California

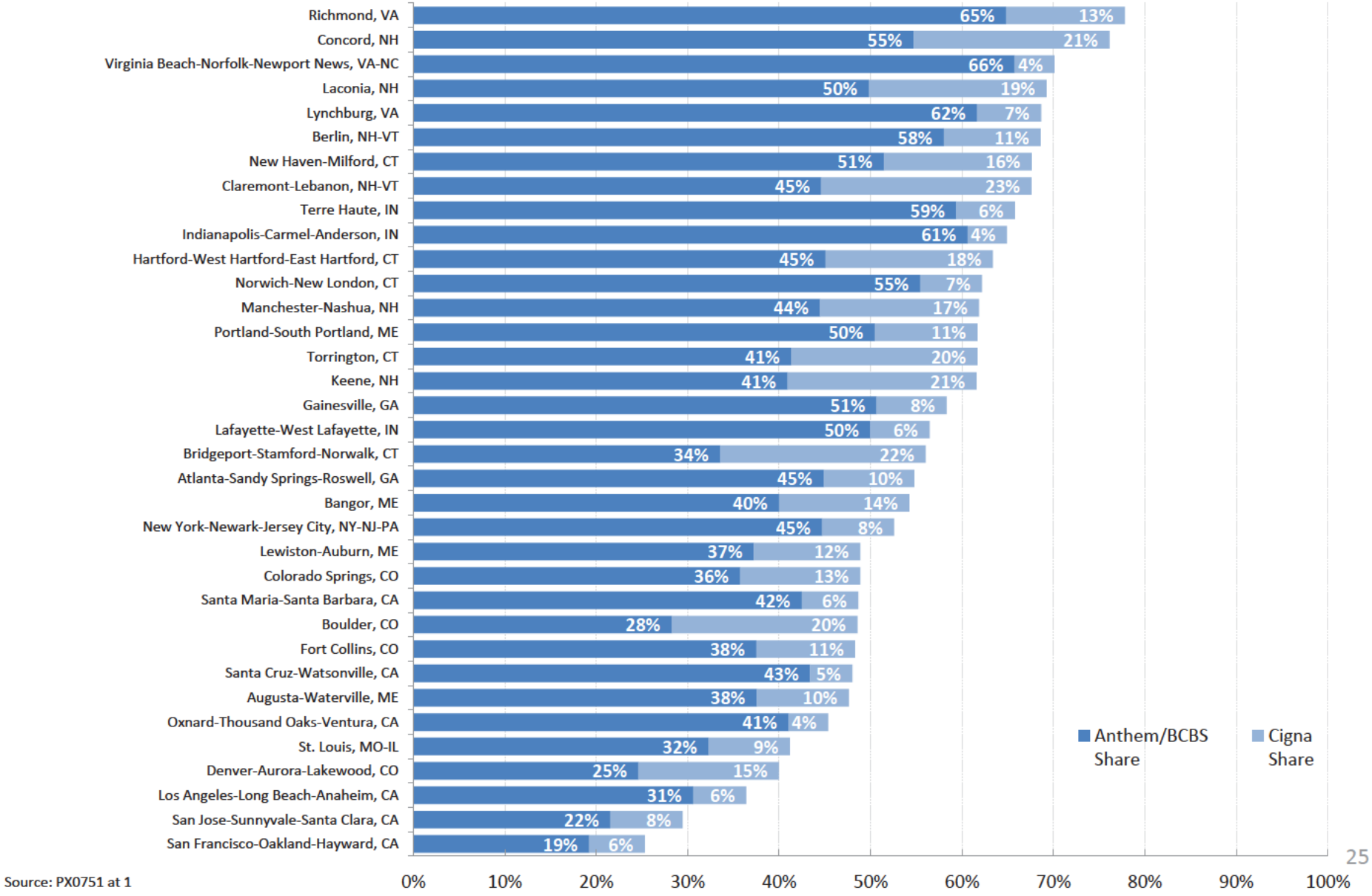
Rachel O. Davis
Assistant Attorney General
Office of the Attorney General of Connecticut
55 Elm Street
PO Box 120
Hartford, CT 06106
Phone: (860) 808-5041
Facsimile: (860) 808-5033
E-mail: rachel.davis@ct.gov

Attorney for the State of Connecticut

Appendix A

Market Shares and HHIs Charts

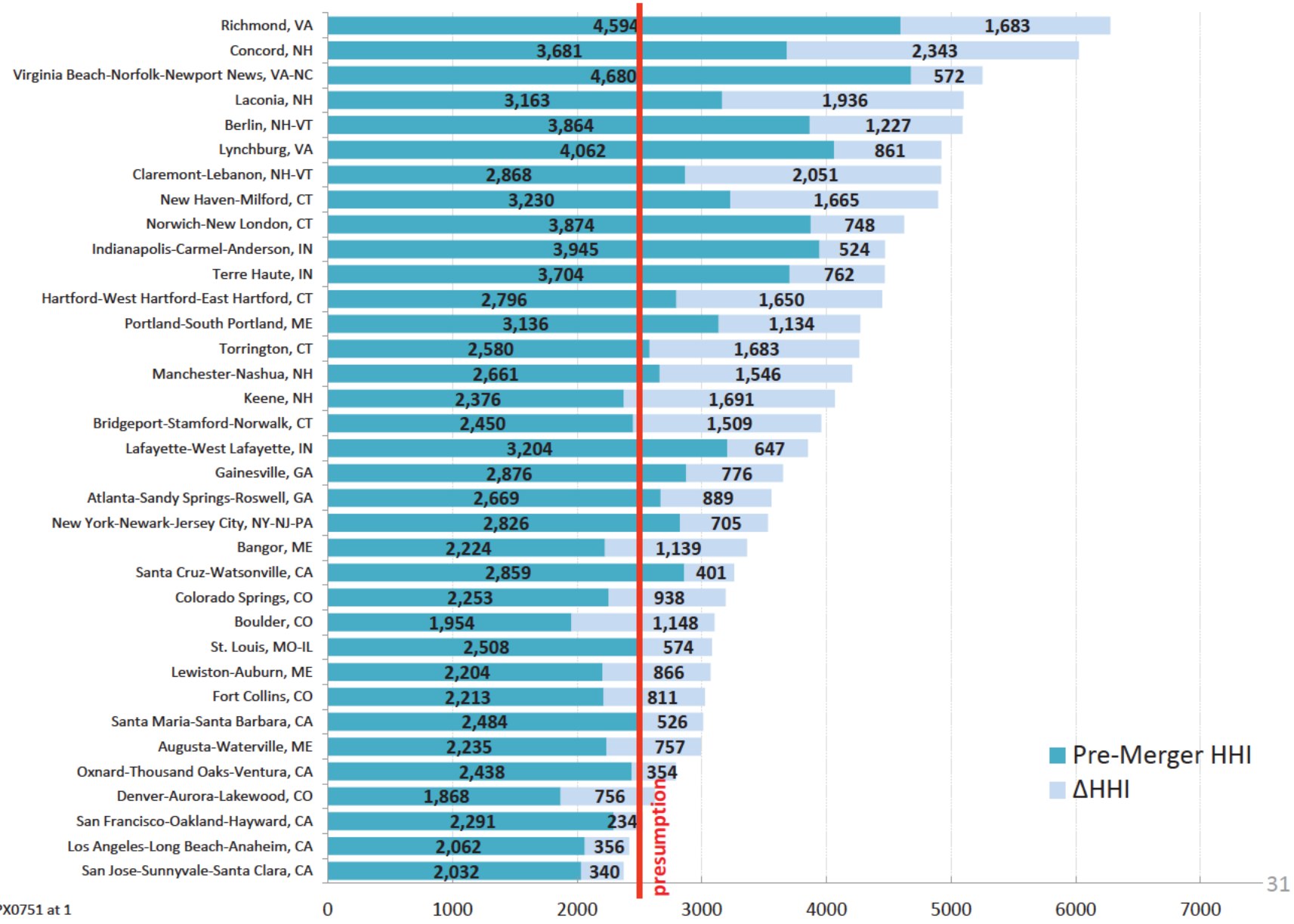
Large Group Shares in 35 CBSAs ASO+FI, Blues Combined



25

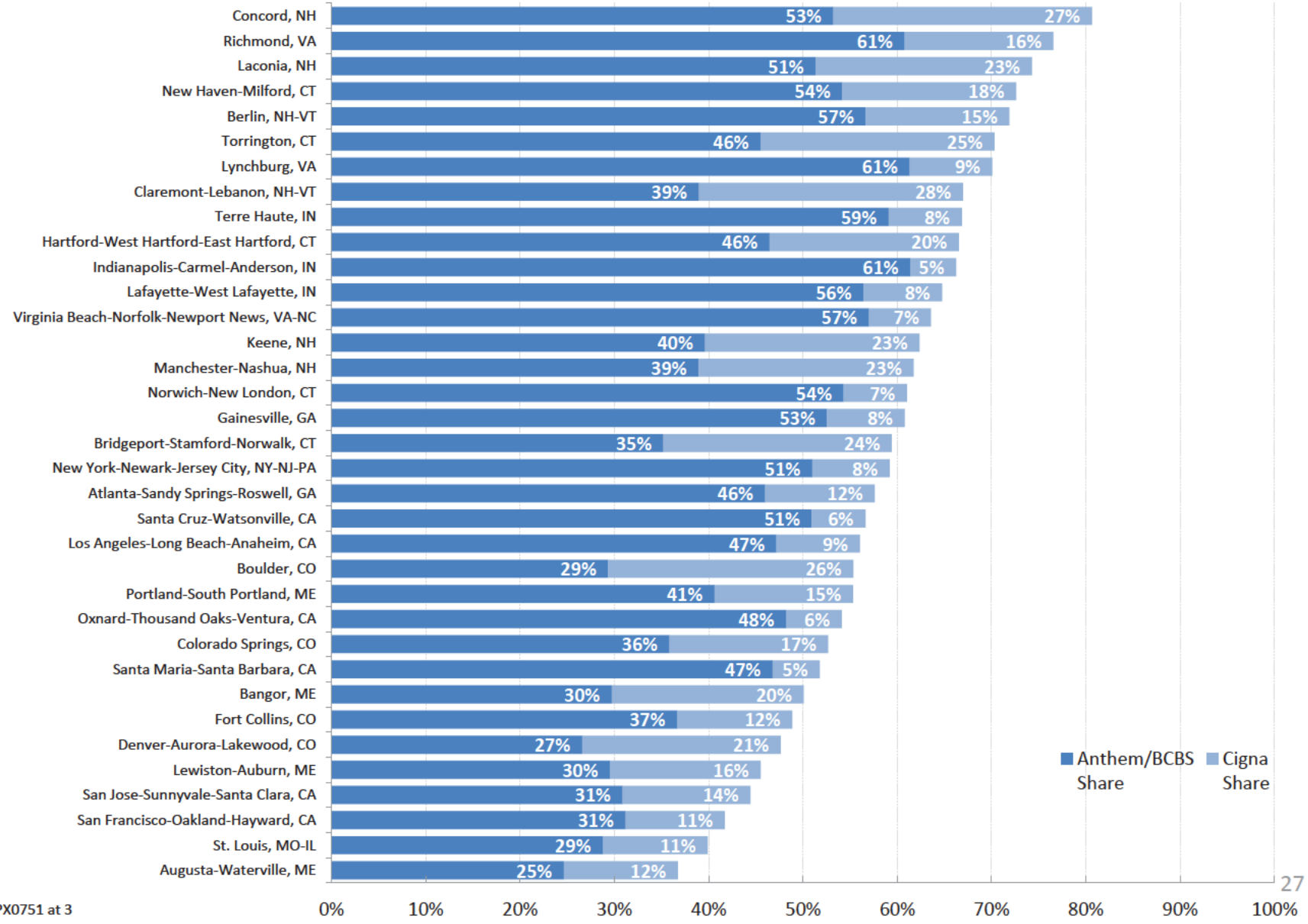
Source: PX0751 at 1

Change in Concentration: Large Groups in 35 CBSAs ASO+FI, Blues Combined



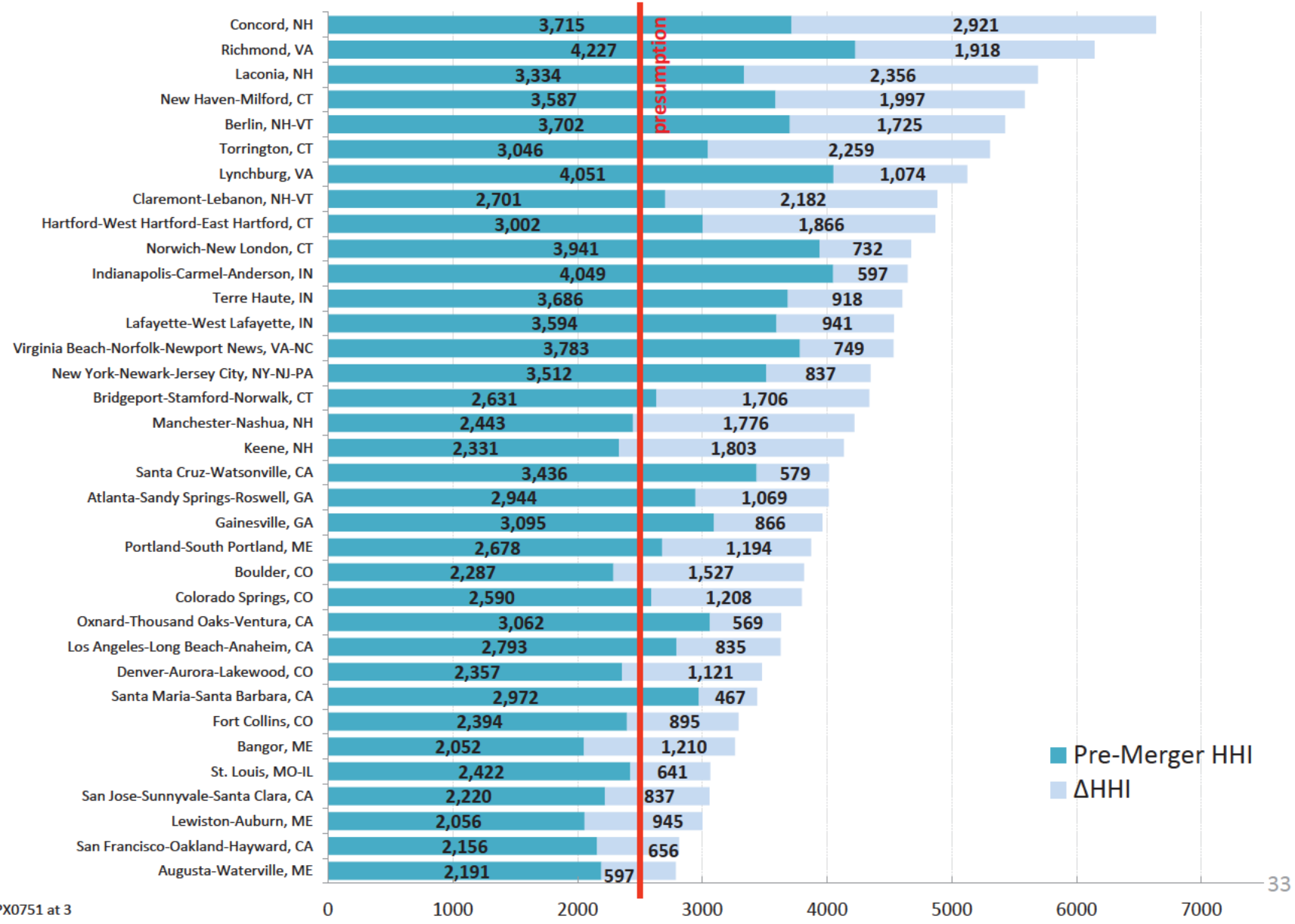
Source: PX0751 at 1

Large Group Shares in 35 CBSAs ASO Only, Blues Combined



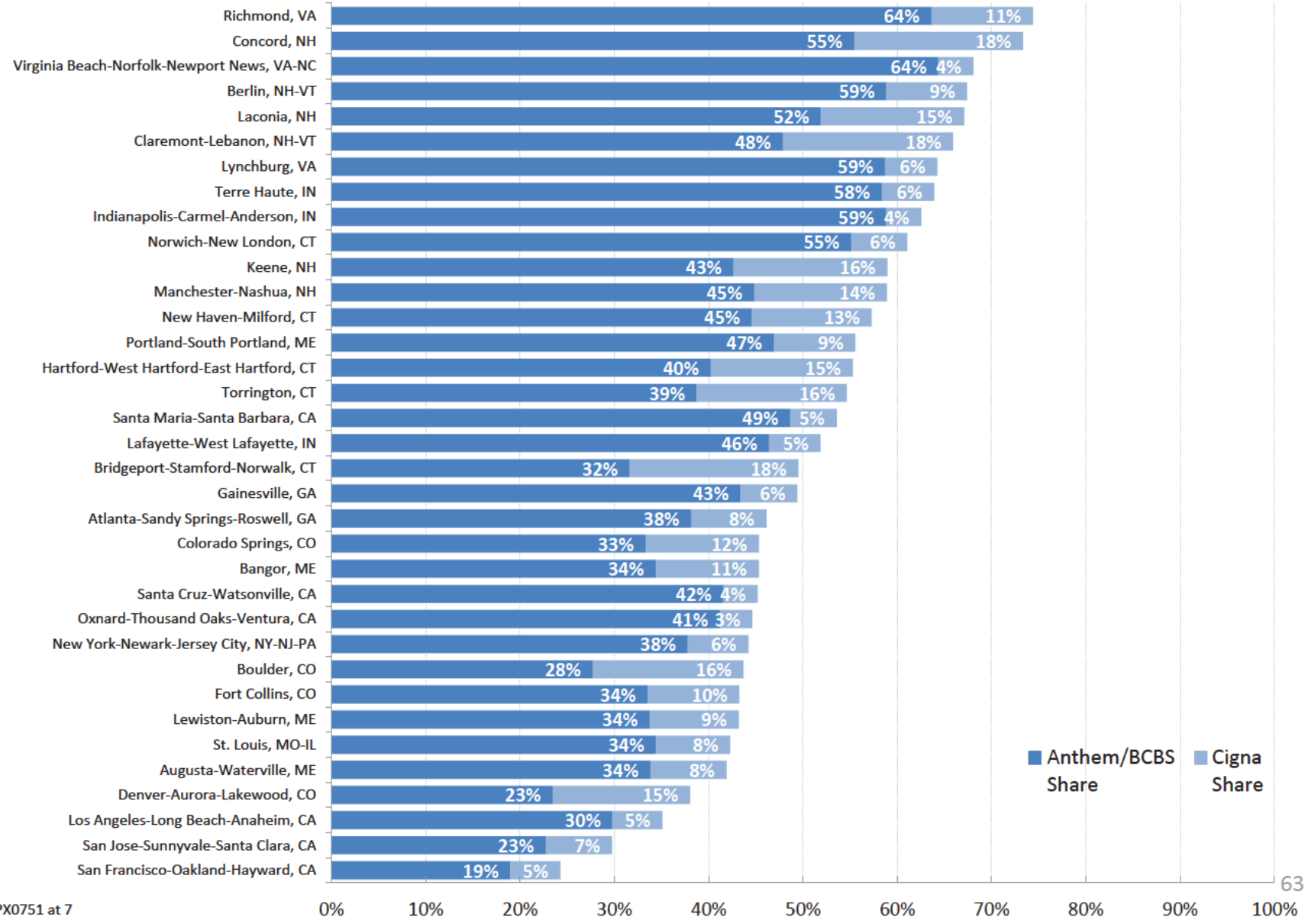
Source: PX0751 at 3

Change in Concentration: Large Groups 35 CBSAs, ASO Only, Blues Combined



Source: PX0751 at 3

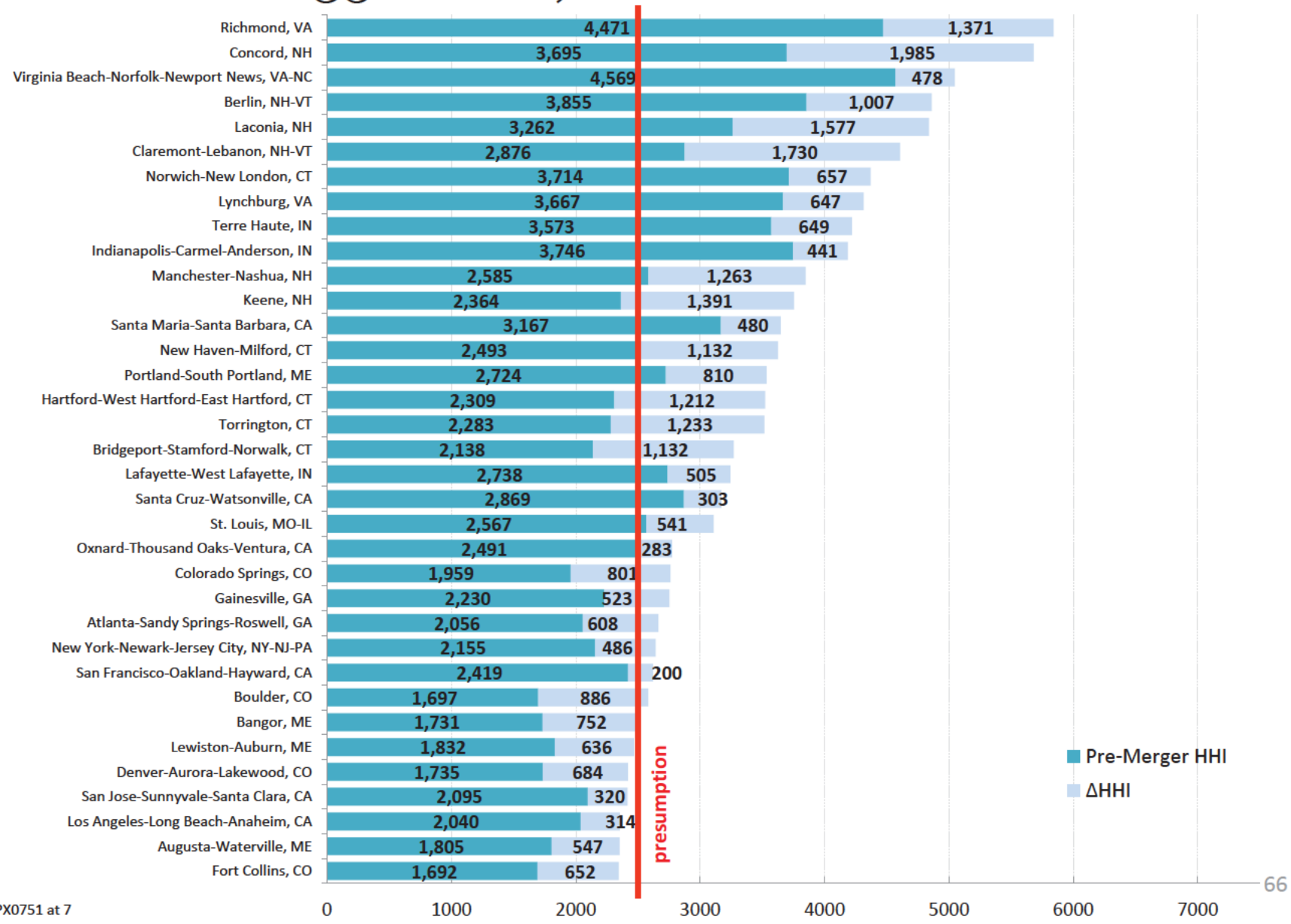
All Commercial Shares in 35 CBSAs Blues Combined



Source: PX0751 at 7

63

Change in Concentration: All Commercial 35 CBSAs, Blues Combined



Source: PX0751 at 7

Appendix B

Summary of Modeling Results

Table 1: Calculations of Claimed Variable Cost Savings

	Integration Team	**Dr. Israel**	**Mr. Quintero**	**Dr. Dranove**
General & Administrative Savings	$515 million. *Tr. at 1502:24–1503:7.*	$515 million. *Tr. at 1949:14–1950:18.*	No more than $192 million. *Tr. at 2524:14–17.*	N.A.
Medical & Network Savings	$2.6–$3.3 billion, including $500–$700 million outside Anthem footprint due to rebranding. *Tr. at 1487:3–1488:3.*	$2.39 billion. *Tr. at 1852:18–1854:1.*	N.A.	No more than $100–$500 million. *Tr. at 2466:9–15, 4730:11–4731:7.*

Table 2: Calculations of Static Price Effects for National Accounts (Anthem Territories)

Assumption	Dr. Dranove's models	Dr. Israel's model
No efficiencies	Predict static price increase of $219.7 million to $930.3 million. *ECF #408 at ¶ 284.*	Predicts static harm absent "substantial efficiencies." *Tr. at 2295:17–20.* Predicts "roughly the same harm" as Dr. Dranove's smallest model "if there are not variable cost efficiencies." *Tr. at 2344:13–17.*
Crediting all of Defendants' claimed G&A savings	Predict static price increase of $153 million to $857.7 million. *ECF #408 at ¶ 285.*	Predicts static harm even if variable G&A savings are included. *Tr. at 2342:6–13.*
Crediting Plaintiffs' maximum calculations of G&A and M&N savings	Predict static price increase, *see Tr. at 1867:5–11 (Dr. Israel acknowledged that under Dr. Dranove's model the merger becomes "procompetitive" with "one-third" of "my number," implying that less than $800 million in M&N savings results in static price increase).*	N.A.
Crediting $515 million in G&A savings and $2.4 billion in M&N savings	N.A.	Running model for *all* ASO members in footprint, not just national accounts, predicts $4.50 PMPM "net benefit" for ASO members, or $1.5 billion per year. *Tr. at 2018:24–2019:2.*

Table 3: Static Price Effects for Large-Group Employers (35 CBSAs)

Assumption	Dr. Dranove's models	Dr. Israel's model
No efficiencies	Predict static price increase of $531 million to $884 million. *PX0752 at Tables E-4 to E-7.*	Predicts static harm absent efficiencies. *Tr. at 4409:17–21 (stating that "[i]f you take out all of the medical cost savings . . . it changes the results," and "the medical cost savings are important to my opinion, as far as driving why the merger is procompetitive").*
Crediting all of Defendants' claimed G&A savings	Predict static price increase of $449 million to $806 million. *PX0752 at Exhibits E-6 to E-8.*	Predicts static harm even if variable G&A savings are included. *Tr. at 4409:22–24 ("I would say that if you use the negotiation model plus the variable cost savings . . . that makes it a much closer call to being even").*
Crediting half of Defendants' claimed savings	Predict static price increase in 14-17 CBSAs (merger sim) and 32 CBSAs (UPP), depending on method used to apportion claimed savings to local markets. *PX0760; Tr. at 4736:6-4738:18.*	N.A.
Crediting $515 million in G&A savings and $2.4 billion in M&N savings	Predict static price increase in 5-11 CBSAs (merger sim) and 22-23 CBSAs (UPP), depending on method used to apportion claimed savings to local markets. *PX0760; Tr. at 4736:6–4738:18.*	Running model on *state level* for *ASO* customers rather than CBSA level for ASO and FI customers, predicts static savings of $.89 PMPM (New Hampshire) to $6.08 PMPM (Colorado), *DDX0498 at 5*, for a total of $1.4 billion across the ten states, *Tr. at 4364:21–4365:1*, but only if one accepts the assumptions that customers have perfect information and that every insurer bargains away half its expected profits after winning RFP. *Tr. at 4732:21–4733:22.*

Appendix C

Maine Market Shares

Maine Large Group and Buy-Side Market Shares

	Augusta-Waterville	Bangor	Lewiston-Auburn	Portland-South Portland
Large Group				
Anthem	**38%**	**40%**	**37%**	**50%**
Cigna	**10%**	**14%**	**12%**	**11%**
[redacted]				
Pre-merger HHI	2,235	2,224	2,204	3,136
Post-merger HHI	2,992	3,363	3,070	4,270
Delta HHI	757	1,139	886	1,134
Buy-Side				
Anthem	**34%**	**34%**	**34%**	**47%**
Cigna	**8%**	**11%**	**9%**	**9%**
[redacted]				
Pre-merger HHI	1,805	1,731	1,832	2,724
Post-merger HHI	2,352	2,483	2,468	3,534
Delta HHI	547	752	636	810

CERTIFICATE OF SERVICE

I certify that on January 17, 2017, I caused a copy of the foregoing to be served upon all counsel of record via the Court's CM/ECF system.

Dated: January 17, 2017

/s/ Jon B. Jacobs
Jon B. Jacobs (D.D.C. Bar #412249)
U.S. Department of Justice
Antitrust Division, Litigation I Section
450 Fifth Street, NW #4100
Washington, D.C. 20530
Telephone: (202) 598-8916
Facsimile: (202) 307-5802
jon.jacobs@usdoj.gov

Attorney for United States of America