ORAL ARGUMENT SCHEDULED FOR MARCH 24, 2017

Nos. 17-5024 (L), 17-5028 (Con.)

United States Court of Appeals for the District of Columbia Circuit

UNITED STATES OF AMERICA, *et al.*,
Plaintiffs-Appellees,

v.

ANTHEM, INC. and CIGNA CORP.,
Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA
No. 1:16-cv-01493-ABJ (The Honorable Amy Berman Jackson)

REPLY BRIEF FOR DEFENDANT-APPELLANT ANTHEM, INC.

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

OTHER AUTHORITIES

GLOSSARY

ASO: Administrative Services Only

HMG: 2010 Horizontal Merger Guidelines

UPP: Upward Pricing Pressure

The Antitrust Division seeks to assure this Court that the District Court "applied established law" and "did not . . . reject modern antitrust law" (Appellees' Br. 20), but the Division never addresses the District Court's statements that "there is no support for Anthem's contention that the Court should consider claimed benefits to consumers" (SA102), and that "no court has held that a potential general benefit to consumers at the end of the day can negate competitive harm" (SA127). These statements simply cannot be squared with modern antitrust law, which, as the Division acknowledges, makes consumer welfare "the object" of the antitrust laws. Appellees' Br. 26. The District Court's failure to account for consumer welfare appears to have colored its overall consideration of Anthem's claimed medical cost savings, as the District Court applied unduly high legal standards in refusing to give these savings any weight whatsoever.

SUMMARY OF ARGUMENT

The Division does not attempt to defend the District Court's erroneous conclusion that the product being sold by health insurers does not include medical cost savings. Br. 19-24. Instead, the Division skirts the issue and tries to re-write the District Court's conclusion in a footnote near the end of its brief, which asserts that the District Court's "point" was not that the savings were excluded from the product. Appellees' Br. 59 n.3. In fact, the District Court unambiguously concluded, in its analysis of efficiencies, that medical cost savings are not part of

the product being sold by health insurers. SA6-7, SA123-24. This fundamental error caused the District Court to overlook the fact that the merged company will provide its core product more cheaply to employers.

The District Court's finding that a "Cigna product at the Anthem price" is "dubious" (Appellees' Br. 31-40 (quoting GSA119)), is clearly erroneous. First, the Cigna attributes that Anthem seeks to incorporate are customer-facing ones, such as Cigna's sophisticated wellness and technology programs, rather than provider-facing ones. Furthermore, while the District Court assumed that paying higher reimbursement rates is conducive to provider collaboration, the evidence established that, in fact, patient volume is conducive to both provider collaboration and lower reimbursement rates. Therefore, not surprisingly, Anthem has far more provider collaborations than Cigna and does a better job of controlling healthcare utilization, even though it has lower rates. Thus, Anthem's favorable reimbursement rates are no obstacle to providing a Cigna product at Anthem rates.

The District Court's finding that lower rates would not be achieved is inconsistent with the Division's Complaint, in which it affirmatively alleged that the merger would "likely lead to lower reimbursement rates" (JA124 at ¶64), as well as with overwhelming evidence establishing that: greater patient density leads to lower rates; Cigna is currently saddled with generally higher rates; Anthem has provider contracts permitting its affiliates to enjoy Anthem's preferential rates;

Anthem can, in any event, negotiate to apply its preferential rates to benefit customers coming from Cigna; Dr. Israel's conservative analysis quantified $2.4 billion in medical cost savings; and Dr. Israel's analysis was corroborated by a separate analysis conducted by McKinsey, working with Anthem and Cigna employees, and is consistent with industry-consultant calculations. Moreover, the achievability of medical cost savings was further supported by the Division's provider witnesses at trial, who bemoaned the lower rates they would have to charge after Cigna was absorbed by Anthem.

In disputing merger specificity, the Division perpetuates the District Court's confusion over the term "rebranding." Anthem is not asserting that convincing Cigna customers to buy an existing Anthem product generates cognizable efficiencies. But enabling Cigna customers to enjoy Cigna's customer-facing attributes at Anthem's lower rates is a merger-specific efficiency; absent the merger, neither Anthem's nor Cigna's customers are likely to enjoy a new product combining Cigna's attractive customer-facing attributes with Anthem's lower rates.

Lastly, as to the "large group" market in Richmond, the Division persists in relying upon a "net harm" analysis that its own expert could not explain. The District Court's acceptance of this *ipse dixit* evidence from the Division contrasts starkly with the skeptical scrutiny applied to Anthem's evidence.

ARGUMENT

I. THE ANTITRUST DIVISION DOES NOT DENY THAT MEDICAL COST SAVINGS MUST BE INCLUDED IN THE PRODUCT MARKET

In response to Anthem's argument that the District Court erred in finding that medical cost savings are outside the relevant product market (Br. 19-24), the Division responds only in a footnote, stating that "Anthem misunderstands" the District Court's "observation" and "[t]he court's point was *not* that the medical cost savings are outside the relevant market." Appellees' Br. 59 n.3 (emphasis added). In fact, Anthem has no misunderstanding: the District Court clearly concluded that medical cost savings are outside of the relevant market. SA6-7, SA123-24. Furthermore, this erroneous conclusion is not merely an "observation," but rather a fundamental premise of the District Court's efficiencies analysis.

The District Court exposed its misperception of the relevant market most unequivocally on pages 123-24 of its opinion, in a section with a heading that stated there is no evidence of efficiencies "in the relevant market." SA123. There, the District Court stated that "the medical cost savings that are being touted here do not . . . result in a reduction of the price of the new firm's products." SA123. The District Court added:

> [W]hile the total healthcare cost that a national account customer will incur at the end of the day may be reduced if the network savings can actually be realized, there is no evidence that the merger will enable the combined

> firm to offer the only 'product' it sells in the relevant market — that is, claims administration, claims adjudication, etc. — at a lower price because its own 'costs' are going to be reduced. The 'product' being sold is not the employer's entire healthcare spend — ASO is only one portion of that expenditure — and Anthem is not arguing that either its costs of production or the price of what *it* is selling will go down.

SA123-24 (emphasis in original). In light of these statements, the Division has no basis to deny that, in analyzing efficiencies, the District Court considered medical cost savings to be outside the relevant market and not part of the insurers' product.

Health insurers sell — as their core product — access to a medical network at discounted rates; they function as purchasing agents for their customers. *See Ball Mem'l*, 784 F.2d at 1334 (describing health insurers as "purchasing agents for the consumers of medical services"); JA454:20-456:11 (Israel). Health insurers distinguish themselves from their competitors in large part by the magnitude of the discounts they can negotiate, and customers — who spend about 95% of their health insurance dollars on medical expenses — select an insurer largely in part based on those discounts. Br. 17, 22 (citing SA765); *see also* JA2380 (20:18-21:15) (Monti) and JA2399 (customer describing how its consultant uses a database "to benchmark discounts of different insurance companies" to secure "the most competitive prices/terms and benefits" for employers); JA2023-2028/SA1541-1546. And in the case of most "large group" employers, such as "national accounts," insurers invoice their customers for medical costs under ASO

contracts. Br. 23; *see also* JA2386 (53:22-54:12) (Little) (customer testifying that "[e]ach week we receive an invoice from Anthem saying here's the amount owed for the claims that they adjudicated during that week for us"); JA2188:7-17 (Kendrick).

The Division recognizes that medical cost savings are part of the relevant product. Appellees' Br. 33-34 (describing "the two companies' products" as including discounted medical costs); Appellees' Br. 13 (equating cutting "prices" with guaranteeing a "0% trend [in a customer's total medical costs]") (citations omitted). On its own, the District Court concluded otherwise, despite its recognition that a relevant product may include a cluster of services. SA40.

In its prima facie and competitive effects analyses, the District Court defined the relevant product to include medical cost savings. SA3, 18, 19, 55. The District Court's about-face in its efficiencies analysis was clearly erroneous as a factual matter and legal error as well; a court must properly define the product market and assess efficiencies in that market. Br. 23-24. That error fundamentally undermines the District Court's decision to disregard Anthem's claimed medical cost savings in their entirety. Indeed, immediately before addressing verifiability and merger specificity, the District Court stated that it would not consider "claimed benefits to consumers or society in general" when assessing competition "within the relevant

market." SA102. In short, the District Court's inconsistent and erroneous definition of the relevant product undermines its efficiencies analysis *in toto*.

II. THE DISTRICT COURT ERRED LEGALLY AND FACTUALLY IN FINDING THAT THE MEDICAL COST SAVINGS ARE NOT VERIFIABLE

The Division fails to address seriously the District Court's legal error in imposing a nearly insurmountable burden on Anthem to establish that its efficiencies are verifiable. *See* Br. 45-46. The proper legal standard requires "a rigorous analysis of the kinds of efficiencies" offered to ensure that they "represent more than mere speculation and promises." *Heinz*, 246 F.3d at 721. Even the Division agrees that efficiencies are verifiable if they "are likely to be achieved." Appellees' Br. 30. But the District Court — ignoring that "Section 7 deals with *probabilities*, not certainties or possibilities," *Baker Hughes*, 908 F.2d at 984 (emphasis in original) — essentially demanded that Anthem prove its efficiencies with certainty, rejecting them because: "doctors could rebel and negotiate for more favorable terms" (SA113); Anthem "may be unable" to use the affiliate clause "to the extent originally predicted" (SA114); and there were "reasons to doubt" that all providers would continue to participate in value-based care if their rates were lowered (SA119).

The District Court disregarded the claimed efficiencies in their entirety because Anthem did not prove that certain theoretical possibilities would not come

to pass. SA112-14; *but see Baker Hughes*, 908 F.2d at 991-92 (refusing to impose even a "clear showing" burden on defendants because to do so "shifts the government's ultimate burden of persuasion to the defendants," and reiterating that the focus under Section 7 is on probabilities); *see also Arch Coal*, 329 F. Supp. 2d at 153 (considering $35-$50 million in efficiencies that were "likely" to be realized, even though such efficiencies were not precisely quantifiable and not "as great as defendants have claimed").

The District Court also clearly erred, as a factual matter, in finding that these theoretical obstacles made the entire amount of medical cost savings unverifiable. To rebut a prima facie case presenting "high market concentration levels," a defendant may present "proof of extraordinary efficiencies," *Heinz*, 246 F.3d at 720, that is, proof of an amount of savings likely to exceed expected anticompetitive harm. Here, the record establishes that $2.4 billion in medical cost savings is likely to be achieved — more than three times the savings needed to render the merger procompetitive even using Prof. Dranove's merger simulation model. JA451:18-452:17 (Israel). Prof. Dranove admitted that, based on a regression analysis he ran, "there would be somewhere between $100 million and $500 million worth of lower rates that Cigna would enjoy" and "I think it's something to factor." JA2309:9-19 (Dranove). Rather than determining what portion of savings was likely to be achieved notwithstanding any theoretical

problems, the District Court rejected all of the savings wholesale. *See*, *e.g.*, *Arch Coal*, 329 F. Supp. 2d at 153.

A. The Affiliate Clause, Renegotiating, and Rebranding Are Verifiable Means of Achieving Medical Cost Savings

The Division contends that the calculated savings are "speculative" and that "Anthem failed to detail practical steps that could achieve the savings." Appellees' Br. 22, 43-45. This contention is wrong on both counts.

The savings are not speculative: the integration team, an independent consultant (McKinsey), economics experts for both sides, and healthcare providers all testified that the merger will result in lower reimbursement rates. *See* Br. 36-38; JA2369-370/SA2025-026 [redacted]; JA2365/SA2021 [redacted]; JA2377/SA2033 (24:15-25:7, 25:10-26:2) (Taheri). Indeed, *provider witnesses confirmed that the savings are likely to be achieved*. Br. 32, 40 (citing testimony from four provider witnesses that, at their facilities alone, the merger will generate more than [redacted] in savings). Like the Division, the District Court inexplicably ignored this unrebutted testimony.

Additionally, Anthem introduced exhaustive evidence of a detailed plan to achieve at least $2.4 billion in medical cost savings by invoking the affiliate clause, renegotiating provider contracts, and "rebranding" Cigna customers. *See*, *e.g.*, JA396:23-398:5, 404:2-19, 405:3-24 (Drozdowski); *see also infra* Sections II.A.1-

3. As noted above, so long as at least one-third of the $2.4 billion of savings are likely to be achieved, the merger is procompetitive.

1. The Affiliate Clause in Most Anthem Provider Contracts Allows Cigna to Access Anthem's Rates Post-Merger

[redacted]. JA567:19-568:9/SA150:19-151:9 ([redacted]); SA662 ([redacted]); SA696; SA717. The Division does not contest that [redacted] of the medical cost savings can be achieved rapidly via the affiliate clause. Br. 40 ([redacted]). Nor does the Division dispute that these savings alone are enough to make the merger pro-competitive. JA451:18-452:17 (Israel). Instead, the Division relies on the District Court's speculation that "doctors could rebel and negotiate more favorable terms." Appellees' Br. 41 (quoting SA113). But speculation that some providers theoretically "could rebel," does not justify the Division or the District Court ignoring *all* of the savings by effectively assuming that *all providers* would terminate their contracts and negotiate higher rates than what they have already agreed to with Anthem.

Moreover, the Division and the District Court ignore the fact that *virtually none* of Anthem's 100,000 provider contracts have been renegotiated to remove

the clause at a provider's request. Br. 39. They also ignore testimony that providers have no intention of terminating their contracts, even though Anthem could invoke the clause. *E.g.*, JA566:4-8/SA149:4-8, JA567:15-17/SA150:15-17, SA2005:9-10 ([redacted]) ([redacted]). And while the Division and the District Court incorrectly assert that, according to Mr. Swedish, Anthem would not invoke the clause because it would be like "drop[ping] the hammer" on providers (Appellees' Br. 41-42 (citing SA113)), Mr. Swedish never even discussed the affiliate clause in his testimony. Instead, as Anthem's head of provider contracting explained, Anthem will use the clause (in conjunction with renegotiating and rebranding) to achieve the savings. JA396:23-398:5, 404:2-19, 405:3-24 (Drozdowski). In sum, the affiliate clause is a concrete, immediate step to achieve massive medical cost savings that Anthem will use, not "mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 721.

And to the extent using the clause may cause some providers to terminate and renegotiate their contracts (Appellees' Br. 41), the savings likely will be achieved during contract renegotiation for the reasons discussed immediately below.

2. Routine and Frequent Provider Negotiations Will Lead to Lower Medical Costs

The Division next asserts that contract renegotiation would be ineffective. Appellees' Br. 41-43 (citing predictions that there may be some provider resistance or abrasion due to the merger). But Dr. Israel's efficiency modeling *specifically accounts* for provider pushback, both *before* and *after* the merger. JA2307:5-16 (Israel) ("The entire basis for the economic analysis of bargaining and negotiations is that each side attempts to get the best deal it can and they arrive at an agreement.").

Larger insurers negotiate greater medical discounts (Br. 17), a fact the Division does not contest. Dr. Israel's analysis predicts that the combined firm, with its increased volume, will do no worse in those negotiations than the individual firms would on their own. JA2308:14-25, 2204:19-2205:24 (Israel); *see also* JA356:15-358:9 (Matheis) (confirming Anthem was conservative by not assuming renegotiation would yield lower rates than either company has achieved today); JA383:5-384:11 (Drozdowski) (explaining Anthem achieves "the best possible discounts … by bringing an entire block of business to a particular negotiation with a provider," and agreeing with the District Court that "volume plays a role in the amount of the discount").

Moreover, Dr. Israel's results are not the product of an "abstract accounting exercise" (Appellees' Br. 37, 40, 45), but rather a methodology that parallels the

technique used by industry specialists to compare the relative competitiveness of insurers. JA2231:19-22, 2242:22-2245:8 (Israel); JA224:21-225:3 (Abbott); JA766 (37:4-6, 8-10, 12-20)/SA195 [redacted]; JA385:13-386:6 (Drozdowski) (explaining that this approach is similar — but superior — to consultant calculations). [redacted]

[redacted]. *See* JA450:7-24 (discussing SA1163).

Finally, the Division suggests that renegotiation would not work where Cigna has the lower rates, because in some instances providers may have given Cigna lower rates to help it compete. Appellees' Br. 45 (citing GSA115 (citing SA147-148)). But the evidence cited by the District Court for this finding confirms that, even where providers help Cigna by lowering its rates, [redacted]. *See* JA564:6-565:7/SA147:7-148:7 ([redacted]). The only other "evidence" cited by the Division to support its theory is unsupported hearsay from its expert, Prof. Dranove, who claimed that he "heard about" unidentified providers that "[s]ometimes" give Cigna better than Anthem rates simply to "prop it up." JA521:8-15 (Dranove). But the Division fails to cite testimony it later elicited confirming that Prof. Dranove had no evidence to back up this claim. JA2310:4-10 (Dranove).

3. The Merged Firm Will Achieve Savings Through Rebranding

Anthem also intends to rebrand customers to achieve medical cost savings beginning about six months after closing. JA587:25-589:12 (King). "Rebranding" in this context means offering Anthem's low provider rates with Cigna's state-of-the-art consumer-facing features in one new, unified Anthem-branded product. JA377:13-378:21 (Matheis). Cigna customers, thus, get lower Anthem rates with the features that first led them to purchase a Cigna plan. Anthem customers likewise benefit from the added Cigna features. JA343:9-16 (Schlegel); JA418:14-419:1 (DeVeydt).

The Division and the District Court both misinterpret rebranding as "nothing more than marketing the Anthem product to existing Cigna customers and persuading them to buy it, and Cigna customers can do that now." Appellees' Br. 15-16 (quoting GSA106). Yet the District Court also admitted that this approach will apply only "in the short term" (SA106) — i.e., in the few months before the *new* Anthem product combining the best Cigna and Anthem features rolls out. As Mr. Matheis explained, in "the short term" Cigna customers would be offered the same Anthem product that exists today. JA374:20-25 (Matheis). After the first few months, however, there is no dispute that the merged firm will offer a new product combining the best aspects of both companies' products with lower rates. JA587:25-589:12 (King).

Additionally, the Division is mistaken that Anthem must rebrand "many Cigna customers" to comply with the "best efforts" rule. Appellees' Br. 52. Rebranding is simply one strategy that Anthem will employ over the 2.5 years it has to come into compliance, and Anthem would need to rebrand just 23% of Cigna's customers to come into compliance. JA377:18-378:21 (Matheis); JA345:19-24, 2189:1-2190:6, 2191:1-14 (Schlegel).

Nevertheless, the Division assumes that Cigna customers would not choose the new Anthem product because Anthem's and Cigna's customer-facing products "reflect fundamentally different strategies for providing value to customers," and thus the new product without "the Cigna provider network and Cigna provider relationships" cannot possibly have "the features Cigna customers value." Appellees' Br. 33. But, as Anthem explained, the Division conflates customer-facing products with provider-facing contracts. Br. 33-35; *see also* JA260:17-261:4 (Cordani) (discussing two different buckets of programs: demand side (customer-facing) and supply side (provider-facing)).

The Division and the District Court assert that rebranding will not happen, because lower payments to providers are inconsistent with value-based care (Appellees' Br. 33-37 (citing GSA111)), but they fail to recognize that Anthem has significantly more value-based contracts than Cigna, despite Anthem's substantially lower provider rates on average. JA400:12-401:1 (Drozdowski)

(discussing SA383, [redacted]); JA456:13-458:15 (Israel) (noting that Cigna's value-based care arrangements are almost entirely "fee-for-service, plus some performance piece," whereas Anthem has "substantially more" arrangements that involve actual risk-sharing with providers).

The Division and the District Court also ignore that, despite the nascent trend towards value-based care, the overwhelming majority of both Anthem's and Cigna's claims are still based on fee-for-service payments. *See*, *e.g.*, JA457:7-458:15 (Israel) (explaining that 99.7% of Cigna's claims data analyzed were fee-for-service claims); JA387:13-388:12 (Drozdowski) (testifying that 95% of Anthem's claims are fee-for-service based).

Moreover, even in value-based arrangements, insurers negotiate discounts (JA296:15-20 (Cordani)), and both sides benefit from increased membership. *See* JA2220:9-2222:7 (Israel); JA2383 (55:17-56:16, 56:19) (Benton); JA293:17-294:15 (Cordani) (describing how "density" fuels value-based arrangements); JA2356/SA2011 [redacted]; *see also* Br. 44-45; JA407:24-408:11 (Drozdowski).

Like the District Court, the Division also argues that providers must receive a "higher level of compensation" to participate in value-based arrangements that lower healthcare costs overall. Appellees' Br. 35 (quoting GSA111). But it is

illogical to suggest that insurers and their customers must pay providers *more overall* to reduce healthcare costs, which of course requires paying providers *less overall*.

In fact, increased discounts incentivize providers to collaborate with insurers because they cause providers facing lower fee-for-service revenue to focus on improving quality and eliminating waste to share in the savings generated by these more efficient practices. JA2373-374/SA2029-030 [redacted]; JA2357-358/SA2013-014 (185:15-186:10) (Drozdowski). [redacted]. *See* SA2099 ([redacted]); JA2403/SA2122 ([redacted]); SA883.

Indeed, the District Court found that providers have offered Cigna lower rates *to bolster their value-based provider arrangements*. SA115. And it is undisputed that, even though Cigna engages in provider collaboration, it has lower rates than Anthem with certain providers where Cigna enjoys greater patient density (Appellees' Br. 43 (citing GSA96)), further proving that collaboration and lower rates are compatible. SA108-09 (finding that "Cigna has been successful in

some markets in negotiating lower provider prices on its own" and "using its leverage to negotiate provider discounts"); *see also* Br. 42.

While the Division and the District Court note that Cigna's provider collaborations aim to reduce the utilization of medical services (*see, e.g.*, Appellees' Br. 34-35 (citing GSA111)), neither acknowledges that Anthem, with its lower rates, is already more successful at lowering utilization than Cigna. JA479:10-480:16 (Israel). Anthem's success in lowering utilization is one reason why rebranding will be driven by a new product combining Cigna's customer-facing options with Anthem's better provider programs (in terms of lower rates, value-based care, and lower utilization). SA2042-044 ([redacted]).

The Division erroneously argues that, according to Mr. Cordani, paying providers less will "'dramatically unwind' Cigna's collaborative arrangements." Appellees' Br. 37 (quoting GSA121-22 (quoting JA284-285 (Cordani)). But Mr. Cordani was not talking about paying providers less; he was referring to reducing the number of lives that Cigna would bring to a provider when negotiating a collaborative relationship. JA284:14-285:15 (Cordani). That only proves the point that patient volume is important to value-based care, and the combined firm will be

able to bring more lives to a provider — meaning that the merger fosters value-based care. Br. 44-45.

B. Dr. Israel's Calculations Are the Product of a Well-Established Economic Theory of Bargaining That Is Fully Verified

The Division attempts to fault Dr. Israel for (1) identifying "inexplicably large" discount differentials, (2) failing to account for the total cost of healthcare and service mix, and (3) failing to analyze individual contracts. Appellees' Br. 48-49. But these critiques are either inapposite or contrary to the evidence.

First, relying on Mr. Quintero, the Division attempts to discredit $815 million in savings because such savings were based on "inexplicably large" rate differentials. Appellees' Br. 49 (citing JA544 (Quintero)). But Mr. Quintero was "not offering any opinion here today with respect to Dr. Israel's work." *See* JA2311:24-2312:9 (Quintero). Nevertheless, the differentials between Anthem and Cigna calculated by Dr. Israel are not inexplicably large, but are consistent with the actual differentials discussed by the Division's own provider witnesses. *See, e.g.*, JA560:7-17 ([redacted]) (discussing SA1913-14) ([redacted]); JA606:18-607:4 ([redacted]) (discussing SA1912) ([redacted]).

Second, Dr. Israel's analysis fully accounts for the total cost of care and for differences in service mix. JA448:9-449:14, 2233:4-16 (Israel). The Division cites Mr. Cordani for the criticism that Dr. Israel ignored total cost of care, arguing

that "the court was entitled to credit Cordani's testimony rather than Israel's." Appellees' Br. 48. However, Mr. Cordani admitted he did "not know [Dr. Israel's] analysis nor the gentleman." JA290:7-11 (Cordani). Beyond Mr. Cordani's testimony, the District Court cited nothing to support its finding that Dr. Israel failed to account for "reductions in utilization" except *questions from Cigna's counsel* (SA114 n.46), and ignored Dr. Israel's testimony that, in fact, he accounted for utilization (JA448:9-449:14 (Israel)).

Lastly, although Dr. Israel did not calculate savings based on a review of individual contracts, Prof. Dranove also did not analyze individual contracts to determine how alleged price increases would be transmitted. *See* GSA345:17-22 (Dranove). Rather, Prof. Dranove's analysis was based solely on economic theory. It is legal error to hold Anthem to a standard far higher than what the law requires or what the District Court applied to the Division's prima facie case. *See* Br. 38, 45-46.

III. THE DISTRICT COURT ERRED LEGALLY AND FACTUALLY IN FINDING THAT THE MEDICAL COST SAVINGS ARE NOT MERGER SPECIFIC

The Division does not dispute the standard set forth in its own guidelines: efficiencies are merger specific if they are "unlikely" to be accomplished without the merger, and "likely" to be accomplished with the merger, considering what is "practical in the business situation faced by the merging firms." HMG § 10;

Appellees' Br. 51. But, like the District Court (SA103-04), the Division proceeds to assess not what is likely or practical, but what is theoretically possible. Appellees' Br. 51-56.

Contrary to the Division's suggestion (Appellees' Br. 52-53), Anthem does not contend that what the Division calls "rebranding" (i.e., a customer simply switching from a Cigna product to an existing Anthem product) results in merger-specific efficiencies. Anthem *does* contend that merger-specific efficiencies result if the merger delivers Anthem discounts to Cigna customers or Cigna features to Anthem customers. Br. 26-32.

The Division does not appear to contest that the delivery of Anthem discounts to Cigna customers would be a merger-specific efficiency. The Division notes that the District Court questioned whether projected medical cost savings are merger specific given that they are based upon the application of existing discounts. Appellees' Br. 51. But the Division does not appear to embrace the District Court's reasoning, which contradicts *Heinz*. 246 F.3d at 722, 725 (holding that Heinz's application of Beech-Nut's superior recipes could be a merger-specific efficiency if evidence established that Heinz could not practically develop comparable recipes on its own). In any event, the medical cost savings created by this merger are quintessentially merger specific. Br. 27.

As to whether Anthem could develop Cigna's customer-facing products, Cigna has, for almost a decade, been developing personalized "customer-centric" products, including a broad array of clinical and service programs, such as incentive- and engagement-based programs that promote customer awareness and drive different health outcomes and lifestyle changes. JA252:20-255:11, 262:24-263:21 (Cordani); *see also* JA2388 (Swedish) (testifying that Cigna brings "distinctive strengths, including consumer-centric technology platforms"). Cigna has created these customer programs over time by investing in "digital, mobile, gamification, social media and big data," and by "leverag[ing] technology, information and analytics globally." JA1804 (Cigna 2015 10-K).

[redacted]. JA2353/SA2008 [redacted]; JA2361/SA2017 [redacted]; *see also* Br. 28. Indeed, in developing a new, post-merger product (*see supra* Section II.A.3), [redacted]. JA2362/SA2018 [redacted].

In the evaluation of merger-specificity, "only alternatives that are *practical* in the business situation faced by the merging firms are considered." HMG § 10 (emphasis added); *see also* Appellee Br. 30, 51. But both the District Court and the Division ignore this practicality requirement and the legal standard for merger-specificity: that the efficiency is *likely* with the merger and *unlikely* absent the merger. Br. 24. Instead, the Division makes sweeping, unsupported assertions about what Anthem "could" do, without any consideration of business practicalities or likelihood. Appellees' Br. 55 ("Anthem could develop better wellness programs or value-based products if it chose to do so."). Notably, the District Court's opinion lacks any factual finding that Anthem's development of Cigna's programs is likely or even practical. This is fatal to the District Court's conclusion about merger-specificity.

Lastly, the Division — which affirmatively alleged in its Complaint that the merger will "likely lead to lower reimbursement rates" (JA124 at ¶64) — acknowledges again that there would be "*some* reduction in provider reimbursement rates" as a result of the merger. Appellees' Br. 58 (emphasis in original). While the Division contends that those reductions would result from the exercise of market power (Appellees' Br. 56-57), Dr. Israel rebutted that contention. Br. 6. Nonetheless, despite the Division's acknowledgement of *some*

reductions, the District Court legally erred by not balancing *any* medical cost savings against the alleged anticompetitive effects of the merger.

IV. MEDICAL COST SAVINGS ARE EFFICIENCIES

The Division defends the District Court's questioning (SA101-02) of whether medical cost savings can be efficiencies (Appellees' Br. 58-63), but the District Court's opinion rested on the faulty premise that insurers are not selling medical cost savings. SA123-24. Once it is understood that medical cost savings are the core component of the insurers' product (*see supra* Section I), it is clear that the merged entities' ability to provide greater medical cost savings — i.e., the same healthcare coverage at a lower cost to employers — is a cognizable efficiency.

The Division's defense of the opinion is premised on a new distinction, not found in the decision below, between "real" and "pecuniary" savings. Appellees' Br. 59-61. The Division's authorities describe "pecuniary" savings, i.e., those based in accounting, such as "tax savings," as savings that merely "increase the profitability of the firm." *See 60 Minutes with Douglas H. Ginsburg, Assistant Attorney General, Antitrust Division*, 55 Antitrust L.J. 255, 269 (1986) ("tax savings, and so on, are irrelevant"); Appellees' Br. 60 (quoting Areeda & Hovenkamp: pecuniary savings increase firm profitability). The Division relies upon *Hershey*, which elaborates on what "real" savings are: so long as savings

"would benefit the public by, for example, lower prices" they are cognizable. *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 350 (3d Cir. 2016); HMG § 10 ("a primary benefit of mergers to the economy is their potential to generate significant efficiencies . . . which may result in lower prices"). In his concurrence in *Procter & Gamble*, Justice Harlan labeled as "real," those savings in the "resources applied to the accomplishment of the objective." Appellees' Br. 61 (quoting *FTC v. Procter & Gamble Co.*, 386 U.S. 568, 604 (1967) (Harlan, J., concurring)); *id.* at 59-60 ("same output is produced using fewer resources"). Here, post-merger, employers will be paying less (i.e., "using fewer resources") for the product at issue: health insurance coverage. Appellees' Br. 60.

The Division makes no serious attempt to refute that medical cost savings will pass through to customers at a very high rate. Br. 18. Nor does the Division question that, by definition, ASO contracts allow for no markup on the medical costs. Appellees' Br. 6; Br. 17-18; JA108 at ¶16. A typical Anthem ASO contract provides that the employer is responsible for "[redacted]" SA2055. Thus, the merger's medical cost savings are consumer savings. *See* JA2193:5-21 (Drozdowski) ("[E]very time a healthcare dollar is spent, it's their money. And so if we can reduce that unit price, it saves them money."); JA2192:19-24 (Matheis) ("Any improvement in our network

efficiencies, if you're an ASO client, they would immediately get that benefit."); JA380:22-25 (Matheis).

The most the Division can muster to respond to this remarkably high rate of pass-through is that Anthem "considered" ways to "capture" a portion of the medical cost savings for itself. Appellees' Br. 58 (citing JA2159); SA7-8. But, as the District Court recognized, according to Dr. Israel's undisputed economic analysis, Anthem will pass through 98% of medical cost savings to ASO customers and retain just 2%. Br. 18; SA127 (noting this is "$48 million" out of the $2.4 billion). Even the Division seems to concede that consumers will reap the "lion's share" of the cost savings. Appellees' Br. 61. And due to its business model, Anthem has a profit motive to pass on those savings. JA467:10-468:5 (Israel) ("The pass-through decision is a profit-maximizing decision."); Appellees' Br. 34 ("Anthem offers customers access to industry-leading discounts from providers' fees.").

The merger's lower medical costs will increase competition from insurers such as United and Aetna. JA2192:22-2193:1 (Israel) ("So if we have a situation where United is the winner and NewCo is number two, and NewCo gets a more attractive cost position, . . . United is going to have to react to that in order to be able to keep the business."). Prof. Dranove admits that United is Anthem's closest competitor and, post-merger, would remain larger than the merged company.

JA2182:14-2183:3, 2184:18-2185:5, 2186:19-2187:4 (Dranove) ("Q. [T]he No. 1 company that Anthem loses customers to, according to your analysis, is United, correct? A. Yes.").

The Division misguidedly imagines healthcare as a fixed pie limited to providers and insurers (Appellees' Br. 28, 61), but again this ignores the nature of the product, healthcare *coverage* for employees, where Anthem is a purchasing agent and the medical cost savings flow to employer-customers. *See, e.g.*, *Nw. Wholesale Stationers, Inc. v. Pac. Stationery & Printing Co.*, 472 U.S. 284, 295-97 (1985) (holding that purchasing cooperatives "would seem to be 'designed to increase economic efficiency and render markets more, rather than less, competitive'") (citation omitted); DOJ and FTC Statements of Antitrust Enforcement Policy on Health Care, at Statement 7 (1996) (joint purchasing arrangements allow efficiencies through volume discounts).

Especially where "medical costs are high and increasing and . . . the situation is unsustainable," (SA128), consumer welfare is undoubtedly promoted if employers use fewer resources to provide healthcare coverage for their employees. *See Procter & Gamble*, 386 U.S. at 604 (savings in "resources applied to the accomplishment of the objective") (Harlan, J., concurring); *Hershey*, 838 F.3d at 350 ("benefit the public by . . . lowering prices"); HMG § 10 ("lower prices"); Br. 10-16.

V. A FLAWED, UNSUPPORTED DOCUMENT CANNOT ESTABLISH A NET ANTICOMPETITIVE EFFECT IN RICHMOND

In attempting to distract from the inquiry into *net* competitive effects, the Division suggests that there will be anticompetitive effects in Richmond based on market shares, loss of competition, and barriers to entry. Appellees' Br. 64-65. But evidence of some possible anticompetitive effects is not a weighing of *net* competitive effects. *See* SA140. These arguments fail to address that the District Court only relied on a single, unreliable document as proof of net competitive effects.

But the fact that Prof. Dranove's model finds that *no amount* of savings could make the merger procompetitive in some markets shows that his model is seriously flawed. JA1266/PX760 ("no amount of cost savings could offset employer harm"). Prof. Dranove could not explain this absurd result, and the Division cannot save this analysis by suggesting portions of a document created by their expert should just be ignored. Appellees' Br. 67.

On its face, Prof. Dranove's chart remains incredible. Because medical costs are approximately 95% of the employer's health care costs for self-insurance (SA93; SA96; Br. 54), it is implausible that Prof. Dranove could find that "no amount of costs savings could offset employer harm."

Prof. Dranove presented this inexplicable conclusion despite the record evidence of very large savings in Richmond. [redacted]

[redacted] (Br. 53), [redacted]. JA599:24-601:8 ([redacted]) (discussing JA838/SA785). None of these medical cost savings were plugged into Prof. Dranove's UPP or merger simulation models, and thus, medical cost savings are misrepresented in JA1266/PX760.

While the Division's brief discusses some evidence of a loss of competitors and high barriers to entry, Anthem presented counter evidence and discredited the Division's evidence. *See* Br. 55 (citing testimony of ample competitors in Richmond, including multiple recent and potential entrants). With such evidence defeating the Division's prima facie case (SA137), a weighing of net competitive harm is "necessary." *Univ. Health*, 938 F.2d at 1222-23. Dr. Israel's weighing is unrebutted because of the facial implausibility of PX760/JA1266.

The Division falsely claims (Appellees' Br. 66) that Anthem did not "fault" Prof. Dranove's "underlying analysis" beneath PX760/JA1266: his UPP and merger simulation. But the Division does not deny that Prof. Dranove refused to simulate the merger at issue in this case: Prof. Dranove combined all 30 of the Blues in calculating Anthem's market share in his models (Br. 48), and never incorporated even a dollar of medical cost savings in his models (Br. 47). Anthem timely criticized these failings at trial. *E.g.*, JA2176 ¶371; JA2178-179/SA2001-002 ¶¶66-69; JA2180/SA2003 ¶358.

VI. REMAND IS UNNECESSARY

The Division's reliance on *Pullman-Standard* and *TDC Management* to justify remand is misguided. *See* Appellees' Br. 70. Unlike those cases, here the factual record is exhaustive. The Division had 20 trial days, called 19 witnesses, entered over 700 exhibits, and designated volumes of deposition testimony after 16 months of discovery and pre-complaint investigation. Any purported gap in the fact finding (*id.* at 71) "is a flaw in plaintiff's case not defendants'." *SunGard*, 172 F. Supp. 2d at 185; *Arch Coal*, 329 F. Supp. 2d at 116.

Had the District Court properly credited Dr. Israel's analysis, a finding that the merger is procompetitive for so-called "national accounts" (in either the 14-state or nationwide market) and in all local markets is unavoidable. *See* Br. 47-49 (explaining that only Dr. Israel balanced the efficiencies against the purported harm, and that even a third of the efficiencies would make the merger procompetitive under Prof. Dranove's models). Indeed, the District Court accepted Anthem's critique that the Division's calculation of harm "rises and falls with Anthem's efficiencies defense." SA59.

Dr. Israel's testimony regarding the Division's monopsony claim also stands unrebutted, confirming that lower medical costs due to the merger are not monopsonistic because prices would trend towards the competitive level and

would not result in reduced output. *See* Br. 50-52. No further fact finding is necessary.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Rule 32(a)(7)(B) of the Federal Rules of Appellate Procedure. This brief contains 6,500 words (as calculated by the automatic word count function of Microsoft Word), excluding the parts of the brief exempted by Rule 32(f) of the Federal Rules of Appellate Procedure.

This brief complies with the typeface requirements of Rule 32(a)(5)(A) of the Federal Rules of Appellate Procedure and the type-style requirements of Rule 32(a)(6) of the Federal Rules of Appellate Procedure because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point, Times New Roman font.

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CERTIFICATE OF SERVICE

I hereby certify that on March 20, 2017, a true and correct copy of the foregoing Reply Brief of Defendant-Appellant Anthem, Inc. ("Reply Brief") was electronically filed with the Clerk's Office of the U.S. Court of Appeals for the District of Columbia Circuit, and further certify that the parties' counsel will be notified of, and receive, this filing through the "Notice of Docket Activity" generated by this electronic filing.

Pursuant to Local Rule 47.1, the original and six copies of the sealed Reply Brief, and the original and eight copies of the public Reply Brief were also delivered to the Clerk's Office of the U.S. Court of Appeals for the District of Columbia by courier.

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