AMA
AMERICAN MEDICAL ASSOCIATION

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February 28, 2017

Brent Snyder
Acting Assistant Attorney General
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Re: The Anthem-CIGNA Merger: A Deal That Should Never Close

Dear Acting Assistant Attorney General Snyder:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing to express our alarm regarding recent statements by Anthem, made in the Delaware Court of Chancery, asserting that the company expects to close its merger transaction with CIGNA through "resolution *with a new DOJ*" (emphasis added). *See attached transcript of February 15, 2017 proceedings in the State of Delaware Chancery Court in Anthem v. CIGNA, at page 5 lines 16-24.* Moreover, an Anthem attorney stated in open court that the company believes that its prospects for a timely closing are enhanced by a "supportive" Vice President Mike Pence. *Id.* There have also been press reports of settlement negotiations.

On February 8, 2017, Judge Amy Berman Jackson of the U.S. District Court for the District of Columbia issued a ruling that blocked the proposed merger between Anthem and Cigna, finding that the merger would violate federal antitrust laws by stifling competition and harming consumers by increasing health insurance prices and hindering innovation that could lower health care costs. We find it implausible that the U.S. Department of Justice (DOJ), eleven states, and the District of Columbia—that have diligently and successfully prosecuted this antitrust merger case—could now be swayed to allow this merger to close pursuant to politically-driven settlement negotiations as Anthem has suggested. To do so would cause irreparable harm to the integrity of the federal courts to adjudicate anticompetitive behavior in a fair and impartial manner, leaving consumers at risk. We strongly believe that political influence should play no role in the enforcement of the antitrust laws and urge you to vigorously defend Judge Jackson's ruling. We believe the evidence presented to the District Court is compelling and that blocking the proposed merger in its entirety is the only way to adequately protect patients and physicians from the anticompetitive effects of an Anthem-Cigna merger.

The AMA has explained, in great detail, why an Anthem-CIGNA merger would adversely affect health care access, quality, and affordability for consumers. *See attached November 11, 2015 letter to the Hon. William Baer.* Without the steadfast opposition of the DOJ and state government plaintiffs, the merger of Anthem and CIGNA—presently the nation's second and third largest health insurer carriers—would have created the single largest seller of health insurance to large commercial accounts in a market in which there are only four national carriers remaining. We are pleased that after weeks of trial and the

testimony of many experts, Judge Jackson's decision and her thorough, well documented opinion, confirm that the proposed merger would likely have a substantial adverse effect on competition in what is already a highly concentrated market.

In conclusion, the AMA strongly supports Judge Jackson's ruling and respectfully urges the DOJ and state plaintiffs to reject any offers to settle the Anthem-CIGNA litigation.

Sincerely,

James L. Madara, MD

cc: Jeff Sessions
State Attorney General Plaintiffs

Attachments

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November 11, 2015

The Honorable William Baer
Assistant Attorney General
United States Department of Justice
Antitrust Division
950 Pennsylvania Avenue, NW
Washington, DC 20530

Dear Assistant Attorney General Baer:

The American Medical Association (AMA) greatly appreciates the opportunity to provide our comments to the Antitrust Division as it engages in the vital work of investigating Aetna's proposed acquisition of Humana and Anthem's proposed acquisition of Cigna. We believe that high insurance market concentration is an important issue of public policy because the anticompetitive effects of insurers' exercise of market power pose a substantial risk of harm to consumers. Our analyses of the proposed health insurance mergers reveal significant concerns with respect to the impact on consumers in terms of health care access, quality, and affordability.

SUMMARY

- The proposed mergers are occurring in markets where there has already been a near total collapse of competition. Under the U.S. Department of Justice/Federal Trade Commission Merger Guidelines, the proposed mergers are presumed to enhance market power in a vast number of commercial and Medicare Advantage markets. Because of persisting high barriers to entry in health insurance markets, the lost competition through these proposed mergers would likely be permanent and the acquired health insurer market power would be durable.

- A growing body of peer-reviewed literature suggests that greater health insurer consolidation leads to price increases, as opposed to greater efficiency or lower health care costs. The proposed mergers can be expected to lead to a reduction in health plan quality. Insurers are already creating very narrow and restricted networks that force patients to go out of network to access care. The mergers would reduce pressures on plans to offer broader networks to compete for members and would create fewer networks that are simultaneously under no competitive pressure to respond to patients' access needs.

- Health insurer monopsony, or buyer power, acquired through the proposed mergers would, as the Department of Justice has found in earlier cases, likely degrade the quality and reduce the quantity of physician services. Consumers do best when there is a competitive market for purchasing physician services. When mergers result in monopsony power and physicians are reimbursed at below competitive levels, consumers may be harmed in a variety of ways. Physicians may be forced to spend less time with patients to meet practice expenses. They also may be hindered in their ability to invest in new equipment, technology, training, staff, and other practice infrastructure that could improve the access to and quality of patient care and could enable physicians to successfully transition into new value-based payment and delivery models. Furthermore, in the long run health insurer exercise of monopsony power may motivate physicians to retire early or seek opportunities outside of medicine that are more rewarding. This would exacerbate an already significant shortage of primary care physicians in the United States.

- There is no evidence supporting the insurer's claim that the proposed mergers would lead to greater efficiencies and innovative payment and care management programs. There is also no economic evidence that consumers benefit when health insurers merge to respond to hospital consolidation by acquiring countervailing power.

- Fostering competition, not consolidation, benefits American consumers through lower prices, better quality, and greater choice.

- Accordingly, the AMA urges the Department of Justice to block the proposed mergers.

THE FOUNDATION FOR AMA'S CONCLUSIONS

The AMA has participated in Congressional hearings on Anthem's proposed acquisition of Cigna and Aetna's proposed acquisition of Humana. In the course of these hearings, the AMA has analyzed the likely competitive effects of these mergers both in the sell-side market for insurance and the buy-side market for physician services. The AMA has considered data compiled annually by the AMA on competition in health insurance, recent studies on the effects of health insurance mergers, the testimony of experts called by House and Senate committees, and the written submissions and testimony of the merging parties.

The AMA has reviewed this matter from the long-standing AMA perspective that competition in health insurance, not consolidation, is the right prescription for health insurer markets. Competition will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

The AMA has concluded that these mergers are likely to impair access, affordability, and innovation in the sell-side market for health insurance, and on the buy side, will deprive physicians of the ability to negotiate competitive health insurer contract terms in markets around the country. The result will be detrimental to consumers. "If past is prologue," notes Leemore Dafny, Ph.D., "insurance consolidation will tend to lead to lower payments to healthcare providers, but those lower payments will not be passed

on to consumers. On the contrary, consumers can expect higher insurance premiums."[1] Moreover, monopsony power acquired through the mergers would enable the health insurers to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers.[2] Therefore, the AMA opposes the proposed mergers.

MARKET SHARES AND MARKET CONCENTRATION

Competition is likely to be greatest when there are many sellers, none of which has any significant market share. Unfortunately, health insurance markets are mostly highly concentrated, meaning that typically there are few sellers and they possess significant market shares. The AMA has determined that the proposed mergers are likely to create, enhance, or entrench market power in numerous markets.

Commercial Health Insurance

For the past 14 years, the AMA has conducted the most in-depth annual study of commercial health insurance markets in the country. From 2001 to 2010, the study was based on the 1997 U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) Horizontal Merger Guidelines. Beginning with the 2011 Update, the AMA's study utilizes the 2010 iteration of the Merger Guidelines to classify markets based on whether mergers announced in those markets would raise anticompetitive concerns.[3] The AMA's most recently published study, *Competition in Health Insurance: A Comprehensive Study of US Markets* (2015 update) is intended to help researchers, policymakers, and federal and state regulators identify areas of the country where consolidation among health insurers may have harmful effects on consumers, on providers of care, and on the economy. It presents health insurance market shares and concentration levels in states and metropolitan statistical areas (MSA). The AMA's study shows that there has been a near total collapse of competition in commercial, combined HMO + PPO + POS markets. In seven out of 10 metropolitan areas, these markets are highly concentrated. Moreover, 38 percent of metropolitan areas had a single health insurer with a commercial market share of 50 percent or more. Fourteen states have a single health insurer with at least a 50 percent share of the commercial health insurance market.

Medicare Advantage

The 2015 Update to its Competition in Health Insurance study does not cover the Medicare Advantage markets, which is where the merger of Humana and Aetna will be most acutely felt. However, competitive conditions in Medicare Advantage markets appear to be even more troubling than in the commercial health insurance market studied by the AMA. According to a Commonwealth Fund study published last month, 97 percent of Medicare Advantage markets (evaluated geographically at the county level) are highly concentrated and therefore characterized by a lack of competition.[4]

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[1] See Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?" Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.

[2] Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, available at:http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans

[3] U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines (Aug. 19, 2010), *available at*: https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf.

[4] B. Biles, G. Casillas, and S. Guterman, *Competition Among Medicare's Private Health Plans: Does It Really Exist?* The Commonwealth Fund, August 2015.

Aetna has argued that insurer share of Medicare Advantage is of no antitrust relevance given that consumers have the option of enrolling in traditional Medicare and therefore, in Aetna's view, traditional Medicare and Medicare Advantage plans are not separate product markets.[5] This argument glosses over the many critically important differences between Medicare Advantage and traditional Medicare that explain why Medicare is not an adequate substitute for Medicare Advantage, such that the proposed mergers should be evaluated for their effects in the Medicare Advantage market separately. Medicare Advantage plans offer substantially richer benefits at lower costs than traditional Medicare.[6] Moreover, in Medicare Advantage plans seniors can receive a single plan covering a variety of benefits that seniors in traditional Medicare must assemble themselves. The combination of richer benefits and one stop shopping accounts for the strong preference by many seniors for Medicare Advantage plans. Accordingly, seniors are not likely to switch away from Medicare Advantage plans to traditional Medicare in sufficient numbers to make an anticompetitive price increase or reduction in quality unprofitable to a Medicare Advantage insurer.[7] The closest competition to one Medicare Advantage insurer's plan is another insurer's Medicare Advantage plan and the presence of many competing Medicare Advantage insurers is what keeps quality competitive. Consequently, the Medicare Advantage and traditional Medicare programs constitute separate and distinct product markets and the proposed mergers should be evaluated for their effects in a Medicare Advantage market.[8]

THE HEALTH INSURER MERGERS CREATE, ENHANCE, OR ENTRENCH MARKET POWER IN THE SALE OF HEALTH INSURANCE

The Anthem-Cigna Merger

Utilizing data obtained from HealthLeaders-Interstudy Managed Market Surveyor from January 1, 2013, the AMA has determined the commercial health insurance market concentrations and change in market concentrations that would result from the Anthem-Cigna merger. The AMA analysis shows the proposed Anthem-Cigna merger would be presumed likely, under the Merger Guidelines, to enhance market power in 85 commercial (combined HMO + PPO + POS) MSA markets. The AMA also considered the effect of the merger using states as a geographic market. The AMA found that within 10 of the 14 states (NH, IN, CT, ME, VA, GA, CO, MO, NV, and KY) in which Anthem is licensed to provide commercial coverage, the merger is likely to enhance market power. In the remaining four states (OH, CA, NY, and WI), the merger would potentially raise significant competitive concerns and warrant scrutiny under the Merger Guidelines.

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[5] Bertolini, "Examining Consolidation in the Health Insurance Industry and its Impact on Consumers," Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 5.

[6] *See U.S. v. United Health Group and Sierra Health Services Inc*., Civil No1:08 –cu-00322 (DDC2008); United States v. Humana, No. 12-cv-00464 (D.D.C. Mar. 27, 2012), *available at*: www.justice.gov/atr/cases/f281600/281618.pdf).

[7] See competitive impact statement, *United States v. United health*, supra, at 4-5.

[8] *See U.S. v. United Health Group and Sierra Health Services Inc*., Civil No1:08 –cu-00322 (DDC2008) (the DOJ alleged that MA is a distinct market separate from the Medicare market and obtained a consent decree requiring the divestiture of United's MA business in the Las Vegas area as a precondition to obtaining merger approval); *see also* Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, "At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11," 34 *Health Affairs* (Millwood) 48, 51 (Jan. 2015), *available at*: http://content.healthaffairs.org/content/34/1/48.full.pdf; R. Town and S. Liu (2003), "The Welfare Impact of Medicare HMOs," *RAND Journal of Economics* 34(4): 719-36; L.Dafny and D. Dranove (2008), "Do Report Cards Tell Consumers Anything They Don't Already Know?" *RAND Journal of Economics* 39.

Confirming the grave structural harm found by the AMA in numerous commercial health insurance markets is a slightly different market study commissioned by the American Hospital Association (AHA). That study examined MSAs *and rural counties* as the relevant geographic markets. The AHA reports that the transaction threatens to reduce competition in the sale of commercial health insurance in at least 817 relevant geographic markets. In 600 of these markets the transaction would be presumed to be likely to enhance market power under the Merger Guidelines. In another 217 markets the AHA found that under the Merger Guidelines the merger would potentially raise significant competitive concerns.

The health insurers have asked regulators to assume, without evidence, that health insurance markets are competitive "due to numerous competitors" and "other market realities." For example, in Anthem's Competitive Impact Analysis that was part of its September 22, 2015, Connecticut Insurance Department application, the insurer contends:

> Due to the numerous competitors, changing health care dynamics, new entrants, public and private exchanges, new distribution channels and business models, increasing transparency, sophisticated purchasers, and other marketplace realities, Anthem believes that Anthem's acquisition of control of CIGNA will not substantially lessen competition in insurance or tend to create a monopoly in the State of Connecticut with respect to any line of business.

Notably, the Anthem "competitive analysis" provides no evidence in support of its contention that the health insurance industry in Connecticut is highly competitive and becoming more competitive. Anthem provides no data to support this opinion—no reporting of market shares, Herfindahl-Hirschman Indices (HHI), or changes in either as a result of the proposed merger. Anthem's only mention of market shares is the motivation for why it prepared the analysis in the first place: In the commercial health insurance lines of business (as well as vision and dental standalone lines of business), the Anthem-Cigna merger does not meet the pre-acquisition notification exemption standard set forth in the Connecticut General Statutes. Instead, Anthem simply lists competitors to Anthem and Cigna in the individual, small group, large group, standalone vision and standalone dental lines of business as its primary evidence of competition, and argues that the growing use of public and private exchanges, benefit administration platforms, and other technology improvements will further ensure that "competition within the health insurance market will remain vigorous and vibrant."

In contrast, a review of data from the AMA's 2015 Update to its Competition in Health Insurance study, the Connecticut Insurance Department, and the Government Accountability Office's December 2014 report on private health insurance concentration, show that Connecticut's health insurance market is already highly concentrated. Using data from its 2015 Update, a special analysis conducted by the AMA in September 2015 shows that the proposed merger between Anthem and Cigna would exceed federal antitrust guidelines in Connecticut (i.e., increase in HHI of 1,311 points for a post-merger total HHI of 3,855) and in six of its metropolitan areas (MSAs).

The Aetna-Humana Merger

Turning to the proposed merger of Humana and Aetna, that merger would combine one of the two largest insurers of Medicare Advantage (Humana) with the fourth largest (Aetna) to form the largest Medicare

Advantage insurer in the country.[9] This would further concentrate a market that is already "highly concentrated among a small number of firms."[10] As in the case of the Anthem/Cigna merger, the Aetna/Humana merger would have a substantial impact on a staggering number of markets. According to a market study commissioned by the AHA, more than 1000 markets (defined geographically as counties) would become highly concentrated. Under the Merger Guidelines, the merger is presumed to be likely to enhance market power in 924 counties and potentially raises significant competitive concerns in another 159 counties.

In addition to presumptively enhancing market power in Medicare Advantage markets, the Aetna/Humana merger will exacerbate the near total collapse of competition in commercial markets. AMA analysis shows that the merger would be presumed to enhance market power in the commercial markets of health insurance in 15 MSAs within seven states (FL, GA, IL, KY, OH, TX, and UT).

Competition for Contracts in National Market

There may also be a national market in which the health insurers compete or potentially compete for the contracts of large national employers. In that market there are only five national health insurance companies remaining today: Anthem, Cigna, Aetna, Humana and United Healthcare. The proposed Anthem/Cigna and Aetna/Humana mergers would pare the number of national players to three.

THE HEALTH INSURER MERGERS CREATE, ENHANCE, OR ENTRENCH MONOPSONY POWER IN MARKETS FOR THE PURCHASE OF PHYSICIAN SERVICES

Just as the health insurer mergers would enhance market power on the selling side of the market, the mergers also would enhance monopsony or buyer's power in the purchase of inputs such as physician services, eviscerating physicians' ability to contract with alternative insurers in the face of unfavorable contract terms and ultimately inefficiently reducing the quality or quantity of services that physicians are able to offer patients. As Professor Dafny explained in her Senate testimony on these mergers, "Monopsony is the mirror image of monopoly; lower input prices are achieved by reducing the quantity or quality of services below the level that is socially optimal."[11] When as here firms can also exercise seller power, the reduced prices for inputs (physician services) cause higher, not lower, output prices (health insurance premiums). See *Telecor Communications, Inc. v. S.W. Bell Tel. Co.*, 305 F.3d 1124, 1136 (10th Cir. 2002) (explaining that monopsony affects consumers because "there is a dead-weight loss associated with imposition of monopsony pricing restraints," and "[s]ome producers will either produce less or cease production altogether, resulting in less-than-optimal output of the product or service, and over the long run higher consumer prices, reduced product quality, or substitution of less efficient alternative products"). In addition to producing higher insurance premiums and a reduction in the quantity and quality of physician services, the lower than competitive physician reimbursements will deny physicians the rates necessary to support delivery reforms associated with value-based care, the cost of which the physicians—not the health insurers—must bear.

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[9] Gretchen Jacobson, Anthony Damico, and Marsha Gold, Kaiser Family Foundation Issue Brief, *Medicare Advantage 2015 Spotlight: Enrollment Market Update*, (June 30, 2015), Figure 1, available at: http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/.

[10] Id. at 13.

[11] Dafny at 10

In concluding that the mergers would enhance monopsony power, the AMA has followed the analytical techniques supplied by the Merger Guidelines, which require a definition of both a product market and geographic market.

The relevant product market is physician services. Insurers purchase many inputs, including physician services. There are no adequate substitutes for physician services, due to training and expertise.[12] Moreover, physicians are confined to supplying services within their training and licensure and cannot do something else in response to a decrease in compensation.[13]

The geographic markets in which health insurers secure services from physicians roughly coincide with the localized geographic markets in which the insurer sells its services to consumers.[14] Health insurers must obtain physician coverage in each locale where they sell insurance. Physicians are not mobile—they invest and develop their practices locally. Accordingly, the DOJ has embraced the notion of a localized market in which health insurers purchase physician services.[15] As the DOJ explained in the Aetna/Prudential complaint:

> The patient preferences that define a localized geographic market for the sale of HMO and HMO-POS products also define a localized geographic market for physician services. Moreover, for an established physician who has invested time and expense in building a practice, the costs associated with moving his or her practice to a new geographic market are considerable, including paying for new office space and equipment and building new relationships with hospitals, other physicians, employees, and patients in the area.[16]

A loss of competition on the buy side can occur within the localized geographic markets when the merging health insurers hold contracts with a significant number of providers who are financially dependent on contracting with the merging health plans and could not readily replace that business by dealing with other payers.[17]

According to Professor Dafny, the "textbook monopsony scenario…pertains when there is a large buyer and fragmented suppliers."[18] This characterizes the market in which dominant health insurers purchase the services of physicians who typically work in small practices with 10 or fewer physicians.[19] Moreover, if physicians were to refuse the terms of any health insurer, they would likely suffer an irretrievable loss of revenue. That is because medical services can neither be stored nor exported. Consequently, a physician's ability to consider realistically terminating a relationship with the merged insurers because of

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[12] *See U.S. v. United Health Group and Sierra Health Services Inc*., Civil No1: 08 –cu-00322 (DDC2008), affidavit of Professor David Dranove, PhD (February 25, 2008).
[13] Id.
[14] See e.g., Capps, C. Buyer Power in Health Plan Mergers, J Comp Law and Econ. 2009; 6:375-391
[15] See e.g. *U.S. v. Aetna Inc.*, Complaint, No. 3-99CV 1398-H, ¶ 20 (June 21, 1999), available at http://www.justice.gov/file/483516/download, (alleging that the relevant geographic markets were the MSAs in and around Houston and Dallas, Texas).
[16] Id. at ¶¶ 19-20.
[17] Christine White, Sarahlisa Brau, and David Marx, Antitrust and Healthcare: A Comprehensive Guide, at 163 (2013); see also U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines, supra 1, at page 33; Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July, 2004), at 15.
[18] See Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?," Testimony before the Senate Committee on the Judiciary, September 22, 2015, at 10.
[19] Carol K. Kane, PhD, American Medical Association Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership, July 2015.

low payment rates depends on that physician's ability to make up lost business by immediately switching to an alternative health insurer. However, it is difficult to convince consumers (which in many cases are employers) to switch to different health insurers.[20] Also, switching health insurers is a very difficult decision for physicians because it impacts their patients and disrupts their practice. The physician-patient relationship is a very important aspect to the delivery of high-quality healthcare. And it is a very serious decision both personally and professionally for physicians to disrupt this relationship by dropping a health insurer.

Given the nature of physician practices, even in markets where the merged health insurers lack monopoly or market power to raise premiums for patients, the insurers still may have the power to force down physician compensation levels, raising antitrust concerns. Thus, in the *UnitedHealth Group Inc./PacifiCare* merger, the DOJ required a divestiture based on monopsony concerns in Boulder, Colorado, even though the merged entity would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase.[21]

Moreover, the reductions in the number of health insurers can create health insurer oligopolies that, through coordinated interaction, can exercise buyer power. Indeed the setting of payment rates paid to physicians is highly susceptible to the exercise of monopsony power through coordinated interaction by health insurance companies. The payment rates offered to large numbers of physicians by single health insurers are fairly uniform, and health insurance companies have a strong incentive to follow a price leader when it comes to payment rates.

Some have argued that physicians who are unhappy with the fees they receive from a powerful insurer could turn away from that insurer and instead treat more Medicare and Medicaid patients. However, physicians cannot increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer payment. Enrollment in these programs is limited to special populations, and these populations only have a fixed number of patients. Physicians switching to Medicare and Medicaid plans would have to incur substantial marketing costs to pull existing Medicare and Medicaid patients from their existing physicians. Moreover, public programs underpay providers. Thus, even if a physician dropping a commercial health insurer could attract Medicare and Medicaid, this strategy would be a losing proposition, especially at a time when value-based payment models require practice investments. Consequently, health insurers can exercise monopsony power in the commercial health insurance market.[22]

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[20] See e.g. *U.S. v. UnitedHealth Group and Pacificare Health Systems*, Complaint, No. 1:05CV02436, ¶ 37 (December 20, 2005), available at http://www.justice.gov/file/514011/download. (As alleged in the United/PacifiCare complaint, physicians encouraging patients to change plans "is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan's network" or the patient would have to use the physician on an out-of-network basis at a higher cost)..

[21] *See* Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light*, 74 ANTITRUST L.J. 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers); Marius Schwartz, *Buyer Power Concerns and the Aetna-Prudential Merger*, Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), available at: http://www.usdoj.gov/atr/public/spceches/3924.wpd.

[22] Peter J. Hammer and William M. Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004)

Given the high market concentration levels and large commercial and MA market shares that would result from the proposed mergers in the numerous MSAs and counties identified by the AMA and AHA, the proposed Mergers would create, enhance, or entrench monopsony power.

BARRIERS TO ENTRY AND THE NEED TO PRESERVE POTENTIAL COMPETITION

The market share and concentration data do not overstate the mergers' future competitive significance in health insurance and physician markets. This is not a case where new market entry could defeat an exercise of monopoly or monopsony power. Instead, lost competition through a merger of health insurers is likely to be permanent and acquired health insurer market power would be durable because barriers to entry prevent the higher profits often associated with concentrated markets from allowing new entrants to restore competitive pricing. These barriers include state regulatory requirements; the need for sufficient business to permit the spreading of risk; and contending with established insurance companies that have built long-term relationships with employers and other consumers.[23] In addition, a DOJ study of entry and expansion in the health insurance industry found that "brokers typically are reluctant to sell new health insurance plans, even if those plans have substantially reduced premiums, unless the plan has strong brand recognition or a good reputation in the geographic area where the broker operates."[24]

Perhaps the greatest obstacle is the so-called chicken and egg problem of health insurer market entry: health insurer entrants need to attract customers with competitive premiums that can only be achieved by obtaining discounts from providers. However providers usually offer the best discounts to incumbent insurers with a significant business—volume discounting that reflects a reduction in transaction costs and greater budget certainty. Hence, incumbent insurers have a durable cost advantage.[25]

The presence of significant entry barriers in health insurance markets was demonstrated in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark Inc. and Independence Blue Cross. Substantial evidence was introduced in those hearings, showing that replicating the Blues' extensive provider networks constituted a major barrier to entry. The evidence further demonstrated that there has been very little in the way of new entry that might compete with the dominant Blues Plans in the Pennsylvania health insurance markets. In a report commissioned by the Pennsylvania Insurance Department, LECG concluded that it was unlikely that any competitor would be able to step into the market after a Highmark/IBC merger:

> [B]ased on our interviews of market participants and other evidence, there are a number of barriers to entry—including the provider cost advantage enjoyed by the dominant firms in those areas and the strength of the Blue brand in those areas...On balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is

[23] *See* Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237 (1988); Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July,2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988).

[24] Sharis A. Pozen, Acting Assistant Att'y Gen., Dep't of Justice Antitrust Div., *Competition and Health Care: A Prescription for High-Quality, Affordable Care* 7 (Mar. 19, 2012) [hereinafter Pozen, *Competition and Health Care*], *available at* http://www.justice.gov/atr/speech/competition-and-health-care-prescription-high-quality-affordable-care.

[25] Id. at 7.

> unlikely that other health insurance firms will be able to step in and replace the loss in competition.[26]

The merging health insurers have argued that times have changed and the health insurance marketplaces have made entry easy. The facts however do not bear out that claim. Recent state developments only highlight the barrier to entry problem. The *New York Times* recently reported "tough going for health co-ops" created under the Affordable Care Act (ACA) to inject competition into health insurance markets.[27] According to the *Times*, many co-ops "appear to be scrambling to have enough money to cover claims as well as enroll new customers as they enter their third year." According to the *Washington Post* of October 10, nearly half of the 23 ACA insurance co-ops, subsidized by millions of dollars in government loans, have been told by federal regulators that their finances, enrollment, or business model need to "shape up." One co-op has folded and four others are preparing to close in late December, including top-tier co-ops that federal officials had regarded as best poised to succeed.[28] More closure announcements are expected.[29] The quick death of these co-ops illustrate that even with heavy federal subsidies, health insurance is a tough business to enter.

Moreover, only two for-profit companies that were not already health insurers, reports the *Times*, have entered the state marketplaces. One of them is Oscar, which was touted by the CEOs of Aetna and Anthem as an example of successful entry in their testimony before the Senate Judiciary Committee. (Anthem's CEO referred to Oscar as "emblematic of the changing face of the competitive landscape in the insurance industry.") However, according to the *Times*, Oscar estimated in a regulatory filing that it lost about $27.5 million last year, roughly half of its 2014 revenue. The CEO of Oscar, one of the very few new companies to even attempt entry, described the task as "quite daunting."[30] In any event, the insurers' bold claim of new entry is not evidence and their descriptions of new entry opportunities are as consistent with the insurance markets experiencing net exit as with their assertions of net entry.

The Loss of Potential Competition

One of the most important implications of the barriers to entry that persist with the advent of the exchanges is the need to preserve the potential competition that would be lost if an incumbent insurer is acquired. Thus, when one of the two largest insurers of Medicare Advantage (Humana) is acquired by the fourth-largest (Aetna) to form the largest Medicare Advantage insurer in the country, the highly concentrated geographic markets where Humana faces little competition are deprived of their most likely entrant, Aetna. The foreclosure of this future market role serves to lessen competition. Professor Dafny expressed concern about this loss of potential competition in her Senate testimony: "[C]onsolidation even in non-overlapping markets reduces the number of potential entrants who might attempt to overcome price-increasing (or quality-reducing) consolidation in markets where they do not currently operate."[31]

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[26] LECG Inc., "Economic Analyses of the Competitive Impacts From The Proposed Consolidation of Highmark and IBC." September 10 2008, Page 9.
[27] "Tough going for Co-ops," the New York Times, September 15, 2015, available at http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html?ref=health
[28] "Financial health shaky at many Obamacare insurance co-ops," The Washington Post, October 10, 2015, available at https://www.washingtonpost.com/national/health-science/financial-health-shaky-at-many-obamacare-insurance-co-ops/2015/10/08/2ab8f3ec-6c66-11e5-9bfe-e59f5e244f92_story.html?postshare=3211444658813888
[29] Id.
[30] This $1.5 billion Startup is Making Health Insurance Suck Less, Wired, March, 20, 2015, available at http://www.wired.com/2015/04/oscar-funding/.
[31] Dafny, supra note 15, at 13.

Commenting on the loss of potential competition that would accompany the proposed mergers, Professor Thomas L. Greaney, who is one of the country's leading experts on antitrust in healthcare, observes:

> An important issue…is whether the proposed mergers will lessen *potential competition* that was expected under the ACA (the potential entry by large insurers into each other's markets, incidentally, was the argument advanced as to why a "public option" plan was unnecessary). At present all four of the merging companies compete on the exchanges and they overlap in a number of states. [citation omitted]. Notably, prior to the announced mergers, these insurers appear to have been considering further expanding their footprint on the exchanges by entering a number of new states. [citation omitted]. Thus reducing the array of formidable potential entrants into exchange markets from the "Big 5" to be "Remaining 3" will undermine the cost containment effects of competition in exchange markets. The lessons of oligopoly are pertinent here: consolidation that would pare the insurance sector down to less than a handful of players is likely to chill the enthusiasm for venturing into a neighbor's market or engaging in risky innovation. One need look no further than the airline industry for a cautionary tale.[32]

THE PROPOSED MEGAMERGERS ARE LIKELY TO HARM CONSUMERS

The AMA has evaluated the potential effects of the proposed megamergers on both: (1) the sale of health insurance products to employers and individuals (the sell side); and (2) the purchase of health care provider (including physician) services (the buy side).[33] The AMA has concluded that on the sell side the mergers are likely to result in higher premium levels to health care consumers and/or a reduction in the quality of health insurance that can take the form of a reduction in the availability of providers, a reduction in consumer service, etc. On the buy side, the mergers could enable the merged entities to lower payment rates for physicians such that there would be a reduction in the quality or quantity of the services that physicians are able to offer patients.

Likely Detrimental Effects for Consumers in the Health Insurance Marketplace

Price Increases

A growing body of peer-reviewed literature suggests that greater consolidation leads to price increases, as opposed to greater efficiency or lower health care costs.

Two studies have examined the effects of past health insurance mergers on premiums. A study of the 1999 merger between Aetna and Prudential found that the increased market concentration was associated with higher premiums.[34] Most recently, a second study examined the premium impact of the 2008 merger between UnitedHealth Group Inc. and Sierra Health Services. That merger led to a large increase in concentration in Nevada health insurance markets. The study concluded that in the wake of the merger,

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[32] Greaney, "The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition," Testimony before the House Committee on the Judiciary, September 22, 2015, at 10.

[33] *U.S. v. Aetna Inc.*, supra note 12, at ¶¶ 17-18; *United States v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at www.usdoj.gov/atr/cases/f213800/213815.htm.

[34] Leemore Dafny et al, "Paying a Premium on your Premium? Consolidation in the US health insurance industry," *American Economic Review* 2012; 102: 1161-1185.

premiums in Nevada markets increased by almost 14 percent relative to a control group. These findings suggest that the merging parties exploited their resulting market power, to the detriment of consumers.[35]

Also, recent studies suggest premiums for employer sponsored fully insured plans are rising more quickly in areas where insurance market concentration is increasing.[36]

Consistent with the observation that the loss of competition accompanying health insurer mergers results in higher premiums is research finding that competition among insurers is associated with lower premiums.[37] Research suggests that on the federal health insurance exchanges, the participation of one new carrier (i.e., UnitedHealth Group Inc.) would have reduced premiums by 5.4 percent, while the inclusion of all companies in the individual insurance markets could have lowered rates by 11.1 percent.[38] Professor Dafny observes that there are a number of studies documenting lower insurance premiums in areas with more insurers, including on the state health insurance marketplaces, the large group market, and in Medicare Advantage.[39]

Medical Loss Ratio Does Not Protect Consumers

The health insurers claim that medical loss ratio (MLR) regulations will protect consumers from the anticompetitive merger consequences predicted by research. The MLR measures how much of the premium dollar goes to pay for medical claims and quality activities instead of administrative costs and marketing. Large group insurers must devote at least 85 percent of premium revenues-net of taxes and licensing fees to medical claims and quality improvement. (An 80 percent requirement applies to small group/individual plans). However, the MLR requirements do not apply to more than half of Americans under age 65 with health insurance coverage because the rules do not apply to privately-insured enrollees in self-insured plans. Also, as Professor Dafny has observed, for the regulations to constrain an exercise of market power "they must 'bind:' the statutory floors must be higher than we would otherwise see."[40] Thus, there may be substantial room for profitable merger-related price increases in the individual market in particular, notwithstanding the minimum MLR requirement. She further observes that because the MLR is calculated at the state and market level, it is conceivable that mergers can enable insurers to offset low MLRs in one geographic area or sub-segment with high MLR in another.[41] In addition, the MLR does not address the level of the premium increase, only the percentage used for claims and quality activities. Finally, MLR regulation does not address non-price dimensions of health insurer competition such as product design, provider networks, and customer service. Therefore the MLR does not protect consumers from post-merger harm along "value" dimensions.

[35] Jose R. Guardado, David W. Emmons, and Carol K. Kane, "The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra" *Health Management, Policy and Innovation*, 2013; 1(3) 16-35.
[36] Dafny, supra note 15, at 11.
[37] Dafny et al., supra note 34.
[38] "More Insurers, Lower Premiums? Evidence from Initial Pricing in the Health Insurance Marketplaces," *Kellogg Insight* (July 7, 2014), http://insight.kellogg.northwestern.edu/article/more_insurers_lower_premiums.
[39] Dafny, supra note 15, at 11.
[40] Dafny, Id., at 14.
[41] Id.

Plan Quality

The mergers can be expected to adversely affect health insurance plan quality. Insurers are already creating very narrow and restricted networks that force patients to go out-of-network to access care. A merger would reduce pressures on plans to offer broader networks to compete for members and would create fewer networks that are simultaneously under no competitive pressure to respond to patients' access needs. As a result, it is even more likely that patients will find themselves in inadequate networks and be forced to access out-of-network care at some point. Similarly, it is very likely that patients will find themselves at in-network hospitals where, given their restricted network plans, many of the hospitals' physicians will not have been offered a contract by the insurer.

While the relationship between insurer consolidation and plan quality requires additional research, one study in the Medicare Advantage market found that more robust competition was associated with greater availability of prescription drug benefits.[42] As Professor Dafny observes, "the competitive mechanisms linking diminished competition to higher prices operate similarly with respect to lower quality."[43]

Merger Efficiency Claims are Unsupported and Speculative

Professor Dafny noted in her Senate testimony that claims of offsetting efficiencies cannot ameliorate the competitive harm from these mergers. "Efficiencies must be merger-specific and verifiable…and there is still the question of whether benefits will be passed through to consumers in light of that diminished competition."[44] Insurers have a dismal track record of passing any savings from an acquisition on to consumers, and there is no reason to believe that this transaction would be any different. Under these circumstances, we suggest that the DOJ review the merging insurers' efficiency claims with skepticism similar to that expressed by the Ninth Circuit Court of Appeals in the merger case of *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775 (9th Cir, 2015). ("The Supreme Court has never expressly approved an efficiencies defense to a section 7 claim…We remain skeptical about the efficiencies defense in general and about its scope in particular.")[45]

Turning to the health insurers' specific efficiency claims, "[t]here is no evidence that larger insurers are more likely to implement innovative payment and care management programs…[and] there is a countervailing force offsetting this heightened incentive to invest in…reform: more dominant insurers in a given insurance market are less concerned with ceding market share."[46] In fact, "concerted delivery system reform efforts have tended to emerge from other sources, such as provider systems…and non-national payers," according to Professor Dafny, not commercial health insurers.[47]

In any event, the vague "innovative payment" and "care management" claims made by the health insurers in their Congressional testimony are undermined by the studies of consummated health insurance mergers discussed above, which show that the mergers actually resulted in harm to consumers in the form of higher, not lower, insurance premiums.

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[42] *See* R. Town and S. Liu, supra note 6.
[43] Dafny, supra note 15, at 11.
[44] Id. at 16.
[45] *St. Alphonsus Medical Center and Federal Trade Commission v. St. Luke's*, 778 F.3d 775, 789-790 (9th Cir, 2015)
[46] Dafny, supra note 15, at 16.
[47] Id.

Countervailing Power Is Not a Consumer Welfare Enhancing Efficiency

Several scholars have observed that one of the motivations for the health insurer mergers is to respond to hospital consolidation by acquiring countervailing power to force hospital prices down to the benefit of consumers.[48] There is, however, no economic evidence that the formation of bilateral hospital/health insurer monopolies—a battle between proverbial Sumo wrestlers—benefits consumers. Professor Greaney observes that such matches often end in a handshake and consumers get crushed.[49] The better answer to hospital consolidation is to recognize that integrated care does not necessarily require hospital-led consolidation and that by encouraging entry into hospital markets, hospital markets can be made competitive.

Fortunately, regulators can take steps to encourage new entry.[50] Low-hanging fruit in this area would be removing barriers to health care market entry that the government itself has erected. These include strengthening and expanding program integrity exemptions for physicians participating in alternative payment and delivery models, more flexible antitrust enforcement policies to foster physician networks engaged in alternative payment models (APMs) and the elimination of state certificate of need (CON) laws and the ban placed by the ACA on physician-owned specialty hospitals (POH). This latter restriction is radically inconsistent with the general thrust of the ACA, which is to encourage competition, such as the creation of health insurance exchanges and the formation of new delivery systems.

The Health Insurer Monopsony Power Acquired Through the Mergers Would Likely Degrade the Quality and Reduce the Quantity of Physician Services

Just as the proposed mergers would enable the merged firms to raise premiums or reduce levels of service, they would also be likely to be able to lower payment rates for physicians to a degree that would reduce the quality or quantity of services that they offer to patients such that the mergers would violate section 7 of the Clayton Act.

The DOJ has successfully challenged two health insurer mergers (half of all cases brought against health insurer mergers) based in part on DOJ claims that the mergers would have anticompetitive effects in the purchase of physician services. These challenges occurred in the merger of Aetna and Prudential in Texas in 1999,[51] and the merger of UnitedHealth Group Inc. and Pacific Care in Tucson, Arizona and in Boulder, Colorado in 2005.[52]

In a third merger matter occurring in 2010—Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan—the health insurers abandoned their merger plans when the DOJ complained that

[48] See Prof. Mark Pauly of the Wharton School at *Health Care Management Professor Mark Pauly PhD Discusses Proposed Health Care Insurance Company Mergers*, available at: http://knowledge.wharton.upenn.edu/article/whats-driving-health-insurers-merger-mania/, and Prof. Thomas Greaney, "*Examining Implications of Health Insurance Mergers*," available at: http://healthaffairs.org/blog/2015/07/16/examining-implications-of-health-insurance-mergers/.

[49] Greaney, "Examining Implications of Health Insurance Mergers."

[50] Id.

[51] *U.S. v. Aetna Inc.*, supra note 12, at ¶¶ 17-18; *see also U.S. v. Aetna, Inc.*, No. 3-99 CV 1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at *http://www.usdoj.gov/atr/case/s/f2600/2648.pdf*.

[52] *United States v. United Health Group Inc.* No. 1:05CV02436 (D.D.C., Dec. 20, 2005) (complaint), available at: www.usdoj.gov/atr/cases/f213800/213815.htm.

the merger "…would have given Blue Cross Michigan the ability to control physician payment rates in a manner that could harm the quality of healthcare delivered to consumers."[53]

DOJ's monopsony challenges properly reflect the Agency's conclusions that it is a mistake to assume that a health insurer's negotiating leverage acquired through merger is a good thing for consumers. On the contrary, consumers can expect higher insurance premiums."[54] Health insurer monopsonists typically are also monopolists.[55] Facing little if any competition, they lack the incentive to pass along cost savings to consumers. Also, the demand for health insurance is inelastic—when the price is raised, the insurer's total revenue increases, and when price falls so do total revenues.[56]

Consumers do best when there is a competitive market for purchasing physician services. This was the well-documented conclusion reached in the 2008 hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark, Inc. and Independence Blue Cross. Based on an extensive record of nearly 50,000 pages of expert and other commentary,[57] the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would have granted the merged health insurer undue leverage over physicians and other health care providers. This leverage would be "to the detriment of the insurance buying public" and would result in "weaker provider networks for consumers who depend on these networks for access to quality healthcare."[58] The Pennsylvania Insurance Department further concluded:

> Our nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an "economic fallacy" and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services. LECG also found this theory to be borne out by the experience in central Pennsylvania, where competition between Highmark and Capital Blue Cross has been good for providers and good for consumers.[59]

For example, compensation below competitive levels hinders physicians' ability to invest in new equipment, technology, training, staff and other practice infrastructure that could improve the access to, and quality of, patient care. It may also force physicians to spend less time with patients to meet practice expenses. Mergers may also cause even tighter provider networks, reducing patient access to physicians and effectively curtailing the quantity of their services. When one or more health insurers dominate a market, physicians can be pressured not to engage in aggressive patient advocacy, a crucial safeguard of patient care.

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[53] Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans | OPA | Department of Justice, available at: http://www.justice.gov/opa/pr/blue-cross-blue-shield-michigan-and-physicians-health-plan-mid-michigan-abandon-merger-plans.

[54] Dafny, supra note 15, at 9.[55] Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST. L.J. 949 (2004).

[55] Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 ANTITRUST. L.J. 949 (2004).

[56] Su Liu & Deborah Chollet, supra note 39.

[57] See *http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf* for background information, including excerpts from the experts.

[58] *See* Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (January 22, 2009).

[59] Id.

Verifying the threat to consumers, a consumer representative testified in the Senate Judiciary Committee hearing on the mergers that they could "force doctors and hospitals to go beyond trimming costs, to cut costs so far that it begins to degrade the care and service they provide below what consumers value and need."[60]

Such reduction in service levels and quality of care causes immediate harm to consumers. In the long run, it is imperative to consider whether monopsony power will harm consumers by driving physicians from the market. Health insurer payments that are below competitive levels may reduce patient care and access by motivating physicians to retire early or seek opportunities outside of medicine that are more rewarding, financially or otherwise. According to a 2015 study released by the Association of American Medical Colleges, the U.S. will face a shortage of between 46,000-90,000 physicians by 2025. The study, which is the first comprehensive national analysis that takes into account both demographics and recent changes to care delivery and payment methods, projects shortages in both primary and specialty care.[61] Recent projections by the Health Resources and Services Administration similarly suggest a significant shortage of primary care physicians in the United States.[62]

Moreover, according to a recent survey by Deloitte, six in 10 physicians said it was likely that many physicians would retire earlier than planned in the next one to three years, a perception that Deloitte stated is fairly uniform among all physicians, irrespective of age, gender, or medical specialty.[63] According to the Deloitte survey, 57 percent of physicians also said that the practice of medicine was in jeopardy and nearly 75 percent of physicians thought that the "best and the brightest" may not consider a career in medicine. Finally, most physicians surveyed believed that physicians would retire or scale back practice hours, based on how the future of medicine is changing.[64]

Monopsony Anticompetitive Effects May be Especially Felt by Consumers and Physicians in The Market for Medicare Advantage

Mergers resulting in monopsony power within the MA market would likely be felt most acutely by physicians who specialize in providing services to the elderly. With limited capacity to expand their business to traditional Medicare, these physicians may be especially harmed by the exceptionally high degree of concentration in the MA market where the lack of competition enables insurers to depress fees paid to physicians for services under MA.

DOJ Should Block the Mergers to Protect the Quality and Quantity of Physician Services

Given that the proposed mergers would result in countless highly concentrated commercial and MA markets where the merged entities either possessed substantial market shares or could exercise buyer power through coordinated interaction, it is critical for antitrust enforcers to oppose the proposed mergers

[60] Statement of George Slover, Senior Policy Counsel, Consumers Union, Hearing of the Senate Committee on the Judiciary (September 22, 2015), *available at*: http://www.judiciary.senate.gov/meetings/examining-consolidation-in-the-health-insurance-industry-and-its-impact-on-consumers.
[61] *See* IHS Inc., The Complexities of Physician Supply and Demand: Projections from 2013 to 2025. Prepared for the Association of American Medical Colleges. Washington, DC: Association of American Medical Colleges; 2015.
[62] *See* health resources and services administration, projecting the supply and demand for primary care physicians through 2020 in brief (November 2013).
[63] Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform in the future of the medical profession.
[64] Id.

so that physicians have adequate competitive alternatives. Unless successfully opposed, the merged entities would likely be able to lower payment rates for physicians to a degree that would reduce the quality or quantity of services that physicians offer to patients.

REMEDIES: DIVESTITURES WOULD BE UNWORKABLE AND INADEQUATE TO PROTECT CONSUMERS

Any remedy short of blocking the mergers would not adequately protect consumers. A divestiture would not protect against the loss of potential competition that occurs when two of the five largest health insurers are eliminated. Moreover, divesture could be highly disruptive to the marketplace and cause harm to consumers, especially in Medicare Advantage markets where the elderly would be faced with a new insurer.

As a practical matter, the overwhelming number of markets adversely affected by the proposed mergers, along with the barriers to entry to health insurance most recently demonstrated by the failure of the federally subsidized co-op program, makes unlikely that the DOJ could find proposed buyers of assets that could supply health insurance at a cost and quality comparable to that of the merger parties in the huge number of affected markets. Moreover, any qualified purchaser able to contract with a cost competitive network of hospitals and physicians, if found, would likely already be a market participant, and a divestiture to such an existing market participant would not likely return the market to even pre-merger levels of competition.

Also troublesome is the apparent absence of a viable divestiture remedy in a national market where five national insurers compete for employer contracts. There are no would-be purchasers with the size and scope of the existing five national insurers that could replace the lost national competition.

Accordingly, the AMA respectfully urges DOJ to block the mergers in order to protect consumers from premium increases, lower plan quality, and a reduction in the quantity and quality of physician services. We thank the Antitrust Division for its vigilant merger enforcement and look forward to helping augment your analysis with data and insights gleaned from our studies of health insurance markets.

Sincerely,

James L. Madara, MD

EXHIBIT A

United States of America, et al. v. Anthem Inc.
Appeal No. 17-5024 (D.C. Cir.)

IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

ANTHEM, INC.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	C.A. No. 2017–0114-JTL
	)	
CIGNA CORPORATION,	)	
	)	
Defendant.	)	
	)	

ORDER GRANTING MOTION
FOR TEMPORARY RESTRAINING ORDER

Effective immediately, pending further order of this court, defendant Cigna Corporation is subject to a temporary restraining order and is enjoined from terminating the Agreement and Plan of Merger dated as of July 23, 2015, among Anthem, Inc., Anthem Merger Sub Corp., and Cigna Corporation.

Vice Chancellor
Dated: February 15, 2017

IN THE COURT OF CHANCERY OF THE STATE OF DELAWARE

ANTHEM, INC.,	:	
	:	
Plaintiff,	:	
	:	
v.	:	C.A. No.
	:	2017-0114-JTL
CIGNA CORPORATION,	:	
	:	
Defendant.	:	

- - -

Chambers
Leonard L. Williams Justice Center
500 North King Street
Wilmington, Delaware
Wednesday, February 15, 2017
4:00 p.m.

- - -

BEFORE: HON. J. TRAVIS LASTER, Vice Chancellor

- - -

TELECONFERENCE
PLAINTIFF'S MOTION FOR A TEMPORARY RESTRAINING ORDER
AND THE COURT'S RULING

APPEARANCES: (via telephone)

KEVIN M. COEN, ESQ.
D. MCKINLEY MEASLEY, ESQ.
RICHARD LI, ESQ.
Morris, Nichols, Arsht & Tunnell LLP
-and-
GLENN M. KURTZ, ESQ.
CLAUDINE COLUMBRES, ESQ.
of the New York Bar
White & Case LLP
for Plaintiff

DAVID E. ROSS, ESQ.
ADAM D. GOLD, ESQ.
Ross Aronstam & Moritz LLP
-and-
WILLIAM SAVITT, ESQ.
of the New York Bar
Wachtell, Lipton, Rosen & Katz LLP
for Defendant

- - -

THE COURT: Good afternoon, everyone. This is Travis Laster speaking.

I'd like to start by asking Delaware counsel for Anthem to speak up and tell me who is on the line and who will be making the presentation this afternoon.

MR. COEN: Good afternoon, Your Honor. This is Kevin Coen at Morris Nichols here on behalf of Anthem. With me in my office is Mac Measley, and on the line is Glenn Kurtz and Claudine Columbres from White & Case. Mr. Kurtz will be speaking today on behalf of Anthem.

THE COURT: Okay. I have the same request for Delaware counsel for CIGNA.

MR. ROSS: Good afternoon, Your Honor. David Ross of Ross, Aronstam & Moritz on behalf of CIGNA. Adam Gold of our office is here with me. Also on the line is Bill Savitt of Wachtell Lipton Rosen & Katz, for whom we filed a pro hac motion a few minutes ago. And with the Court's permission, Mr. Savitt will be speaking on behalf of CIGNA.

THE COURT: All right. That's fine.

So to let you know what I have done, I have read the entire complaints in both the

Anthem-initiated case, which we're technically here on, as well as the CIGNA-initiated case that is its companion.

I have looked at but I can't pretend to have read fully by any means the termination provisions in the merger agreement; and I have read memorandum of law in support of the TRO; and I have looked at the proposed form of orders; and most recently, I have read Mr. Ross' letter.

So I say that because you all have radically different views of the underlying facts, and I don't think it will behoove any of us to use this time to review your respective positions on the underlying facts or how you reached this phase.

What I think would be helpful is if you all focused your minds and your comments on whether a TRO should be granted and then what type of schedule we should have, depending on what happens, with or without a TRO.

So with that framing, Mr. Kurtz, I'd ask you to go first.

MR. KURTZ: Thank you, Your Honor. Good afternoon.

THE COURT: Good afternoon.

MR. KURTZ: I will try to avoid talking about too many of the merits which are in dispute. I think we could say that there is one matter that has been agreed to, and that is that the merger is a unique and transformative merger; that it would offer better and lower cost health care to tens of millions of consumers; and it would pay over $13 billion of deal premium value to CIGNA shareholders. So without intending a pun here, there is a great deal at stake.

This case and this motion are brought to preserve that value by maintain the status quo in the deal and, specifically, by enjoining termination and interference with ongoing efforts to clear the merger.

I think it's important for the Court to understand that there are at least two pathways to a closing here. One is through appeal and the other is through resolution with a new DOJ. And the motion is intended to preserve those options, primarily.

There's reasons that we believe the merger is still able to clear. Notably, now Vice President Pence was supportive of the transaction as the governor of Indiana. The merger would allow

Anthem to expand into nine new states under the Affordable Care Act.

That seems particularly important now, as Aetna has pulled out of certain states and it's mulling over whether to reduce its presence further. And today, timely enough, Humana announced a decision to pull out of the exchanges altogether. Looking at new rules, this is a way to sort of help with that as well.

And then on the appeal front, Anthem promptly filed a motion to expedite. The D.C. Circuit Court set a schedule that had the Government's papers going in today and a reply by Anthem tomorrow at 12:00. And we think that's what generated the termination notice, because now the Government has taken enormous advantage of this to oppose the expedition as saying the deal is now dead. And we're looking to get a TRO in place in order to be able to let the D.C. Circuit Court know by tomorrow at noon that the deal has not been terminated.

Obviously, the lynchpin of a TRO is ordinarily irreparable harm. We have two forms of irreparable harm here. The termination of a unique and transformative merger is irreparable harm. The

courts in Delaware have repeatedly recognized that: True North, Oracle, Hollinger, Revlon. There's no replacement. There is no replacement here.

The second irreparable harm here is the damage if not the entire thwarting of an appeal. If there's no merger in place, then we can expect DOJ to move to strike an appeal as no longer available. Then it wouldn't be justiciable if you were litigating a decision that couldn't result in the consummation of a merger. That has been recognized by several courts, that the loss of an appellate right is irreparable harm, harm that can't be compensated for with money damages.

And then a third way to get to irreparable harm is that CIGNA agreed that a breach of the merger agreement constitutes irreparable harm. Delaware courts have enforced those provisions. It seems particularly appropriate here, where you have extremely large and sophisticated parties represented by lots of counsel to support that and enforce it. And I'll get to momentarily why we think that we have a clear right to keep the merger alive. So we think this presents a textbook case of irreparable harm.

When you have irreparable harm, the

colorable claim element of a TRO is a really low threshold, we think. We've seen it described as claims are colorable if the facts that are alleged are true would make them colorable or that they're nonfrivolous. And we think that the verified complaint more than demonstrates colorable claims. We think they're clear.

There's fundamentally two claims here at issue. The first one is that Anthem, on January 18th, extended the termination date of the agreement. The original termination date was January 31st. That's Section 7.1(b) of the merger agreement. That's not a drop-dead date. The merger stays in place unless and until it's validly terminated. But the original termination date was January 31st.

Section 7.1(b) permitted Anthem to unilaterally extend the termination date through April 30. That's what we did. That's been recognized throughout this case. In fact, at the time that the District court -- and that's the underlying antitrust case -- was considering a schedule, all parties indicated that the merger would stay around through April 30. And in reliance on that, the District Court

set the schedule. And then, notably, in the recent opinion in which the Court enjoined the transaction, she said that the merger agreement is in place through April 30.

So we think that one is more than colorable. We think that's clear. That maybe even irrefutable. I'll come back in a second to CIGNA's response to that.

The second reason that a termination would be invalid is that CIGNA just doesn't have a right to terminate because the termination right, as set forth in 7.1(b), does not permit termination where a party has failed to fully perform its obligations in a manner that proximately causes the merger to not close by the termination date.

We set out a whole host of conduct that I won't go over, given the Court's statement on it, about why we think that's a pretty clear breach. I will say only as an overall matter that you have two different stories. You have identified, that's true, I think, that when the time comes to get into the details, you know, we'll be able to demonstrate why our story is the right one.

But I think, objectively, looking at

what happened and didn't happen, we demonstrated very clearly a breach of best efforts. Best efforts is a daunting standard. It's got a hell or high water obligation with respect to the regulatory clearance matter. That's been described as bracketed only by financial disaster by a leading case, Bloor v. Falstaff, which was also cited in Hexion, in this court, as the standard.

And we think that if Your Honor looks at all the conduct that's been pled, you'll see that, objectively, that's a lack of best efforts and that the kinds of things that CIGNA raises are in the nature of excuses. And the best efforts is an objective criteria that doesn't really accommodate excuses or reasons. It demands behavior.

The balancing of equities -- actually I'll direct my comments to the balancing of the equities but I'll also note that the merger agreement contains a provision where the parties agree that injunctive relief should be issued to enjoin breaches of the agreement. It also includes specific performance. We obviously haven't sought that today.

And, again, we're with sophisticated parties, and we think that we've pretty clearly

demonstrated that these are breaches; that a termination is a breach in and of itself, in addition to the best efforts issues.

Balancing of the equities we think decisively weighs in favor of a TRO. As I've already addressed, there's enormous irreparable harm to Anthem in losing a unique and transformative merger. The same is true with respect to tens of millions of consumers who will lose out on better and less expensive health care at a time when health care is in a bit of a state of flux if not distress.

And then, of course, CIGNA stockholders stand to lose $13 billion of deal premium that's not easily replicated either.

When balancing that against CIGNA, we think it's pretty overwhelming. I don't see any harm to CIGNA. CIGNA is merely basically sitting around, probably, while we try to get this deal through. And it's abiding by the terms of the agreement. And the only thing it loses is its ability to continue its efforts to avoid a merger.

And we're going to work diligently. And if we can get the merger cleared through a settlement or through an appeal, then everybody is

going to benefit. And if we are unsuccessful in that, then the termination is going to come soon enough.

But certainly there's no urgency to anything that's going on in terms of CIGNA being restrained. And I think some of that is even reflected in the submission that CIGNA made a few minutes ago, which we sort of have been able to get through but largely seems to suggest that they would continue to cooperate, going forward, both on an appeal -- and I don't think that actually works because I think they've just undermined, and hopefully not irreparably, our motion to expedite -- but also in terms of taking steps to get to a close.

And CIGNA points out that they're not at the point -- it's not imminent that they need to sign certificates of merger or anything like that. And I agree with that. We haven't asked for that.

But the reality is if this is a terminated deal, then the cost of entry for us in settlement has been revoked, and, as I mentioned, I think also potentially our appeal. We can't go and negotiate a settlement, with or without divestitures, with new DOJ if DOJ says, Well, you don't have a merger to negotiate around.

And as I mentioned, we're a little afraid that there will be a problem perfecting an appeal in the D.C. Circuit if there is an argument that's already been made heavily by DOJ that there's no merger to protect.

So there's a lot of damage here. We lose a deal, and we lose an appeal, potentially, on one end; and there's really nothing that we see on the other end. CIGNA has been living around the merger agreement for many, many months. It contracted to live through April 30, just for the asking. And we don't see any harm at all. And, frankly, by the time we get to April 30, we probably have a better record and understanding about where we can go with this.

And then the last thing that I'd like to address, Your Honor, is the CIGNA notion that Anthem is in breach of the agreement and, therefore, Anthem is not able to extend the -- and I know there hasn't been a lot of time to focus on the niceties of the language, but 7.1(b), that provides for both pieces of the puzzle. One is the termination right, which is surrounded by the breach language. That's the right that requires a party, before they could exercise termination, to have performed fully the

obligations, not have breached them, and not to have proximately caused the problem.

The extension, which was designed just to allow the parties to extend in order to get more time if more time was needed with regulators, doesn't replicate that language at all. It just talks about conditions other than regulatory approval that are satisfied or are capable of being satisfied. And, of course, all of this is still capable of being satisfied. We can still get regulatory approval.

And even as to the best efforts allegations, if regulatory approval is forthcoming, then there can't really be an argument that we got there but we didn't get there in the best possible way and that, therefore, somehow, there's no need to close the transaction.

And the last point on the contract is the condition is set up, it cross-references over to the Article Sixth conditions. And those conditions are satisfied expressly, either by satisfaction of the condition or waiver of it. And, again, it's capable -- the magic language in the contract -- the condition is capable of being satisfied, not only, therefore, through the regulatory approval but also

it's capable of being satisfied through waiver.

So I'm happy to answer questions, but without getting into any of the factual matters that Your Honor has read and didn't need repeated, that would be my opening remarks.

THE COURT: That's helpful.

Let me ask you a couple questions before I go to Mr. Savitt.

Assuming that I were to give you a TRO today, one would normally think we'd have to come back relatively soon for some type of preliminary injunction. What would be your preference for when that would occur?

MR. KURTZ: Well, we are prepared to move on any schedule, light speed or otherwise, as the Court would like to see, or CIGNA would like to see. We're sort of protected with a TRO. It may be that CIGNA would have a bigger interest.

If I were going to make a suggestion on my own, it would probably be if we got ourselves to April 30, then we could deal with at a preliminary injunction stage the issue about whether or not CIGNA has any right to terminate in light of the breaches.

But we're also prepared to move next

week or any other time, if CIGNA wants it or Your Honor wants it.

THE COURT: All right. That's probably enough of an answer on that, then.

Let me hear from Mr. Savitt.

MR. KURTZ: Thank you.

MR. SAVITT: Thank you, Your Honor. And thank you for hearing us.

We are digesting this morning's filings from our good friends on the other side. I think I can, in summary, respond, however, to the information that's been put before the Court and the parties.

The remedy that's been sought, as the Court, of course, knows, is an extraordinary one, not readily granted, notwithstanding my friends' suggestion to the contrary. It requires a showing on the merits. It requires a showing as to harm. And the short answer for why a TRO ought not be entered here is that there has been no showing on the merits and no showing as to harm.

As to the merits -- and I will, with fidelity, Your Honor, respect your suggestion that we not litigate the facts. It is for sure that there is

a significant disagreement with respect to how the events over the past 18 months plus have unfolded. We register our disagreement with what's been said on the other side of it, and particularly with respect to what's been suggested about the impact for the insurance market, the health insurance markets and health insurance industry and health care industry in the United States as a whole, but will not use the Court's time to litigate that matter except to register our disagreement.

The folks on the other side seeking a TRO have to make a showing, and what they have to make a showing of is that they haven't breached the agreement. The allegations in our verified complaint are detailed and extensive and we think will be abundantly supported by massive evidence at trial.

I'm not litigating that now, of course, Your Honor, but the question is whether there's been a showing that that hasn't happened. And there has been no showing. Literally nothing. Zero. They haven't even tried to make such a showing, and there is nothing before the Court in the nature of evidence that could support a restraining order.

It's not as though Anthem has been

taken by surprise with respect to this situation, what with a 55-page brief. It seems rather more that they were waiting for this to happen.

You can't do a TRO without a showing on the merits, and there hasn't been one. And by that, to be express, Your Honor, I mean there hasn't been a showing that CIGNA does not have a right to terminate.

And it's not as though this is a new issue that cries out for resolution right now or -- for the love of Mike, the issue of the parties' dispute was front and center in the litigation in the District of Columbia, and it figured in Judge Berman's decision, which I believe the Court now has.

As to the harm, the irreparable harm piece of it, we don't think there's been any showing on that either, Your Honor.

Now, some of what my friends said I think confuses the issue whether there would be irreparable harm with respect to an ultimate judgment that the merger was terminated, that is to say whether the remedy of an injunction is an adequate substitute for an award of damages. That is an irreparable harm question, but it's not the precise irreparable harm

question we're dealing with now.

What we're dealing with now is the irreparable harm question whether, absent a restraining order, the extraordinary device that Anthem proposes, it will suffer irreparable harm. We think there's been no showing there either.

We are struggling to define with precision what even is alleged to be the irreparable harm. Reference was made in my friend's presentation to the loss of a valuable transaction, but that's not the irreparable harm here.

At the end of trial, if the Court believes that Anthem is correct, then it can order specific performance and the transaction will proceed, assuming that it's able to clear the other conditions necessary for consummation, which we think is exceedingly unlikely, but that's another matter.

The irreparable harm that is on issue here, that's on offer here, seems to be the argument that without an order of this Court, Anthem won't be able to proceed with its appeal, and Anthem won't be able to take steps to continue to get regulatory approval.

We don't see a showing that that's so.

They can prosecute their appeal without us. Anthem indeed took its appeal without CIGNA as a participant in that appeal.

What they can tell the District of Columbia Circuit is the truth, which is perfectly clear, not just from today's filings but what has come before, which is the parties dispute whether there has been a breach and whether there are termination rights.

They can say that that issue is before Your Honor, and they can tell the D.C. Circuit that the parties to that dispute, to the dispute we are presently on the phone about, agree -- at least we do -- that we should try to ensure that whatever ruling this Court ultimately makes can be given proper effect. A principle that we think is important in the context of evaluating a motion for a TRO which we're happy to say we clearly agree with.

To the extent there is an argument regarding whether Vice President Pence thinks that the merger ought to be approved, well, it's not in any papers as far as we can tell.

Their arguments regarding new DOJ, the fact is there is no new DOJ. There is only old DOJ.

No new DOJ personnel has been appointed or approved.

And the idea that we are doing anything on the CIGNA side of things to impair any discussions there is without any basis, as is the suggestion that there is some new DOJ to talk to.

I did want to address the question why what's happened happened now because my friend adverted to it with a suggestion -- false -- that it was driven by their motion to expedite. What's happened, Your Honor, is that Anthem has only now, recently, in the past number of days, made clear that it believes CIGNA has no right to terminate the merger agreement, not to January 31st, not on April 30th, as my friend suggested, but ever.

Their position is that Anthem is -- is that CIGNA can't terminate the merger agreement because it's breached the merger agreement in ways that precluded regulatory approval. If that's right, then by Anthem's light, CIGNA is on the hook indefinitely.

That rendered the dispute presently before the Court utterly inevitable, because it is as certain as the day is long that April 30th will come and go and regulatory approval for this transaction

will not be had. I doubt I will even hear my good friend on the other side dispute it.

It is Anthem's own words that it's 120 days from Court approval until regulatory approval can be had. From today, that takes us into June. And we're not going to start today. We're going to start only after an appeal on whatever calendar is decided by the D.C. Circuit, and in the event of a favorable ruling for the transaction in the D.C. Circuit, a remand for further proceedings in the District Court. There isn't any question that April 30th is not going to see regulatory approval.

But what's fundamental now is Anthem's position that CIGNA is precluded from escaping the merger agreement, terminating the merger agreement, even then. This isn't a circumstance where Anthem said, Well, give us until April 30th and we'll see where we are. Anthem has taken precisely the opposite position.

And even then, so the Court understands, it's very difficult for CIGNA to continue to perform this contract even if it was otherwise able to. We are being asked to approve of filings in the District of Columbia Circuit Court that we believe are

legally misguided and are factually inaccurate.

We've navigated this tension as best we could in the District Court but we couldn't continue to be bound by any obligation to cooperate in the Circuit Court, given the increasingly irresponsible litigating positions Anthem has taken, especially when balanced against the literally zero percent chance of success on the regulatory front by April 30th.

And in few of all this -- and I'm coming to a point, Your Honor, that we believe is important for purposes of responding to what the folks on the other side have said -- we've concluded that what's happening here is Anthem wants to keep CIGNA on ice. It wants to continue to keep a competitor from competing. It wants to continue exploiting the merger agreement for its own narrow gain. That's what they've done for over a year and a half. We've been tied up for over a year and a half. And they aren't entitled to do it anymore.

CIGNA has a right to terminate. It has obligations to stockholders and to customers and the people it serves to move to put a deal behind it that cannot be done when a termination right is ripe,

which it is.

My friend made reference to -- I think he said that there was no harm because CIGNA would just be basically sitting around while the months ran off the clock and Anthem pursued increasingly hopeless regulatory strategy. But large public companies worth many tens of billions of dollars with obligations to stockholders and constituencies don't basically sit around. There is a strategy to be deployed. There are capital deployments to be made. There are any number of initiatives that each of these companies, CIGNA and Anthem, need to get to if they're going to go about their business.

The idea that an ongoing temporary restraining order is cost-free to CIGNA is false, just plain false. There's no showing of it. And handcuffs of the sort that Anthem proposes to continue to bind CIGNA are not justified on the facts, not justified on the contract, and not at all cost-free.

Now, it's our position that we've complied with our obligations under the merger agreement, and I think the evidence will show that. I know the Court doesn't want to hear about it and, candidly, I don't want to talk about it now.

I do want to say that we are keen on the CIGNA side to continue to conduct ourselves so as to ensure that any relief the Court orders will be capable of being given effect.

What we are not trying to do here is to short-circuit the ability of this Court or any other to have its rulings enforced. Candidly, we don't think, ultimately, an order of specific performance can happen here because we don't think there's any way this transaction can ever be approved, given the self-interested way in which Anthem has gone about seeking regulatory approval.

But we have no interest in doing anything to impair this Court's remedial authority. If anything, candidly, Your Honor, it's the Anthem side of the equation that is ignoring the merger agreement.

As an illustration, both companies have covenants in the merger agreement that restrict their ability to deploy capital for share repurchases. As the Court knows, this is an important issue from a governance and capital management perspective.

CIGNA announced to Wall Street in the past number of days that it would undertake

repurchases this year only within the tolerance permitted by the merger agreement, attempting to live within the boundaries of the merger agreement so as to ensure the capacity of the Court to order effective relief. That's a company that's trying to remain compliant.

Anthem, on the other hand, announced to Wall Street that they'll undertake buybacks this year that will exceed the amount permitted by the merger agreement. That is a company that is not coloring within the lines of the merger agreement.

There are all sorts of other matters pertinent to integration that evince Anthem's failure to do its contractual duty, and it just can't be said, Your Honor, that the situation is cost-free or that either party should be put in the position of having to indefinitely comply with the restrictions of the agreement.

Finally, I think I heard the other side say that CIGNA has conceded that the contract could be extended to April 30th, and I think that was in their papers as well. That just is not true.

Anthem, to be sure, argued before Judge Jackson in the D.C. Circuit that the trial

schedule needs to be compressed to hit an April 30th deadline, but among other things, they told the Court that it needed to be finished 120 days before April 30th so they could have time to appeal so they could have time to implement a favorable ruling.

So all that does is confirm that April 30th is no longer even remotely in prospect. It doesn't do anything to support the idea that anyone on the CIGNA side made such a concession.

Anthem cites in page 3 of its papers a statement from the District Court's opinion enjoining the merger that the parties are bound by their merger agreement through April 30th, but all the Court was citing there was a unilateral filing of Anthem in which Anthem made the point that expedition was necessary.

I mean, it's kind of worth noting that Anthem doesn't think that the statement is true because Anthem thinks that CIGNA is bound well beyond April 30th, as it has made perfectly clear.

These issues come together, Your Honor, in our response to the temporary restraining order because we submit that what has not been shown is, on the merits, a sufficient likelihood of success

to allow the extraordinary remedy ordered, or on the irreparable harm, to justify the extraordinary relief that's been requested.

I've said it a couple of times and I'll say it again, and it's in Mr. Ross' letter, we believe that we should get this case tried. We believe we should get it tried promptly. It's complicated, and it's going to be very fact-intensive. We want to make sure the Court has an adequate record, but we are ready to get to work on it. And we're also ready to do that in a way that will ensure the Court's ultimate ability to do substantial justice as it sees fit. And we're happy to cooperate with our friends on the other side of the caption to see to it.

Having said all that, the idea that a sufficient record has been submitted to justify a temporary restraining order, we would submit, Your Honor, is inaccurate and ought not be countenanced.

So I'll stop there and, of course, be delighted to take any questions that the Court might have.

THE COURT: Thank you, Mr. Savitt.

Mr. Kurtz, do you have anything you want to reply?

MR. KURTZ: Yes. Thank you, Your Honor. I'll be brief, but let me take the big issues on, at least.

On the merits, I think I accurately described the standards, which is colorable claim, which is, in fact, a low threshold.

I also walked through and we briefed that breach -- and that's the only basis on which CIGNA says that the extension is improper, that there was a breach. I walked through in the brief and we walked through today, Your Honor, that 7.1(b) extensions are not attached to breaches; that, instead, it just has to be a condition that's capable of being satisfied. And my brethren didn't respond to that, but that's a legal issue. Your Honor can look at the words and decide yourself.

Also, the notion, factually, that Anthem is in breach is not supported even by the complaint. We have proof by Your Honor in the form of our verified complaint that Anthem, in fact, incurred $520 million, which may be a record -- I don't know -- in trying to get through regulatory clearance.

We've walked through -- and I won't repeat the facts -- obviously, just tireless work.

And we continue to work. And a lot of times, I think when you're trying to figure out who really did what they were supposed to do, maybe you look at parties' interests, because people tend to act in their own interests. And you can see our interest has been at the outset to merge. We reinitiated it over resistance. And here we are, later in the game, and we're fighting for it. And we're reaching out to DOJ, which is new, by the way. There is a confirmed Attorney General, Sessions. And CIGNA is fighting to terminate it.

So I think on the merits, which is a low threshold, I don't know if it had to be an overwhelming likelihood of success on the merits, but I think we have met it.

And on that April 30 date, you can look to our brief on pages 30 and 31 and you can get the quotes. It's not just Anthem that was at April 30. It was also CIGNA that stood up and said, We agree. And the Court, of course, established that date as the foundational basis for a trial schedule and reiterated that in the recent decision. So it's only CIGNA that's trying to change the timing rules as they got here.

In terms of harm, I'm not sure how it could credibly be argued that the loss of a transformative merger is not irreparable harm. It's textbook irreparable harm.

The appeal, which I'm not sure my friend responded to, likewise, the loss of an appellate right is irreparable harm. I think the response was, Oh, it's okay, you can argue your position, but, unfortunately, our position is compromised in the event of a termination.

And I'll quote from a DOJ filing today, where DOJ said CIGNA's termination "gut" Anthem's argument for expedited appellate review. "Since CIGNA has already terminated the agreement, expedited review and perhaps any appellate review" -- any appellate review -- "would be futile." So I don't really think we can argue about the harm this is discussing.

CIGNA says, Well, the harm isn't the loss of the transaction because we're still available, but there is no way to make progress on the transaction if you don't have a merger agreement that purports to still be in place. No one will talk with you. Nobody will -- we can't negotiate divestitures

or approvals, and we may not be able to take an appeal.

And counsel says, Well, look, this is not painless. There's a cost. I don't dispute there's a cost for all parties. That's the cost that they undertook when they entered into an agreement that, in fact, had an extension date for the asking, unilaterally, through April 30.

And that became the cost also when they chose to attack the merger instead of support it, because under the terms of the agreement between these sophisticated commercial parties, that breached it. If you breach, you don't get to terminate. So we're not asking them to do anything outside the agreement.

And it is indefinite. We don't dispute it's indefinite. It's indefinite because we're where we are, based on the conduct of CIGNA.

But having said that, as I said before, nobody is looking to delay this. We're going to try to get it through, which is going to create enormous benefit for everyone. And if it doesn't get through, we have the same interest as CIGNA has in terminating.

And I'll tell you, we had I think it

was a $120 million commitment fee payment due on our extension. Our financing only went through January 31st. That's real dollars spent in support of trying to clear a merger with a real belief that we have an opportunity to do so. Companies don't undertake extended financing commitment fees in the nine figures lightly.

And we're certainly not trying to keep CIGNA on ice. I don't know how CIGNA is on ice. Maybe they have an equity repurchase interest that I don't know about. But they're out competing and trying to get more work and operating their businesses and making various flowery and optimistic statements into the marketplace about their abilities to continue on in business.

And any ice that is involved in remaining tied to the agreement that the parties signed, it applies both ways. And, obviously, Anthem isn't looking to put itself on ice either, which is why we're moving diligently and tirelessly to get to a result here.

The idea -- the conspiracy theory that Anthem spent $520 million, including a $120 million commitment fee, just to extend and is pursuing

settlement and appeal somehow to harm CIGNA really is a little offensive. It also doesn't make any sense. There is no harm attendant to efforts to continue to clear the merger or to take an appeal. It's a little bit fantasy, and there is no way that it actually could be happening. There's no handicuffs at all.

So we think that this is a TRO that doesn't hurt CIGNA, even with respect to the matters that they've identified, because they say they'll come right back. They'll come right back if we win at the trial. But the problem is we'll have lost all the time between now and then, because we have an agreement that by all public accounts has been terminated and not reinstated through our TRO.

And so talk about being on ice. The progress of the deal is on ice. And there's no way, then -- when we get to a hearing, if we win, you're starting from scratch, but you've lost your appeal right, potentially. The D.C. Circuit doesn't get to play the game that we start and stop whenever we feel like it because we can put the genie back in the bottle. It's a public termination.

And CIGNA's statement that it didn't make that to coincide at all with the motion to

expedite is at least a little suspect, given that we only had to get through tomorrow before we could have seen if we got an expedited motion before feeding the DOJ juicy quotes for their opposition.

But at the end of the day, all we're trying to do here -- we're not asking to require them to sign over shares or sign stock certificates or provide due diligence, which we'll need at some point in order to divest assets, if a divestiture of assets is required to remediate in order to get a settlement.

All we're saying now is the termination is stayed, the invalid piece of paper that got sent across the wire is stayed, and that CIGNA can't interfere with our efforts to get it cleared, at least through April 30th, pending Your Honor's determination of the next step, trial or preliminary injunction, however people want to proceed. Which, as I said, maybe makes sense to do sometime before April 30, by which time Your Honor will have more record.

And, obviously, my friend over there says the record indisputably is going to undermine me, so that will help him. I'm not nearly as convinced. I think that we have the ability to make progress, and

we'll be in a position to report into that over time.

So we believe we're entitled to a TRO, and we would ask for it.

THE COURT: All right. Thank you both for your eloquence.

MR. SAVITT: Your Honor, I apologize for interrupting. If I may make a couple points. And I will be still briefer than my good friend on the other side.

THE COURT: Very quickly.

MR. SAVITT: One is to observe -- and this is in Mr. Ross' letter -- but the matter of breach, the short of it is that if there's been a breach of obligation on Anthem's part, its right to extend is terminated. That is a function of the interplay of Section 6.3(b) and Section 7.1(b) of the merger agreement.

As to this business about being on ice, we have been, and as long as we're subject to the merger agreement, are trying to comply with that. We doubt Anthem is. It's not a trivial matter in the least.

Conspiracy theory. Well, it only takes -- you need two to conspire. So there is no

conspiracy theory. It's all Anthem. But what doesn't make a lot of sense is that CIGNA would throw down -- would file a complaint and terminate if it didn't need to escape the deal for legitimate purposes, if it didn't need to invoke its rights for legitimate purposes.

If it was as simple as waiting for April 30th to come and go, then there's no reason we wouldn't have done that. We couldn't do it because we were being put in an impossible legal and business position by the conduct of Anthem.

And as to the relief with respect to not interfering with their efforts, no one is interfering with their efforts. It's not even alleged. The question of whether it's an invalid piece of paper, that's not a fit subject for a TRO or preliminary injunctive, frankly. It's essentially final relief in the case and requires a trial.

I apologize, Your Honor, and I appreciate the indulgence.

THE COURT: All right. Thank you.

I'm going to go ahead and give you all my ruling now. I am granting the TRO. Here's my reasoning.

I won't go into the details of the situation that the parties have presented except to say that Anthem and CIGNA are parties to a detailed merger agreement. There has been an injunction issued by the District Court of the District of Columbia blocking the merger.

Anthem desires avidly to appeal that injunction. It has argued, and I think it has the better reading of the merger agreement on this point, that CIGNA is required to support it in its appeal.

Notwithstanding that fact, CIGNA has issued a termination notice purporting to terminate the agreement and has filed a lawsuit seeking to establish that it complied with its obligations and that Anthem, in fact, breached its obligations under the agreement.

We are technically here on Anthem's countersuit which seeks, in the first instance, to hold CIGNA to its agreement and, in the second instance, should that not be possible, to recover damages.

The relief that is sought today is a temporary restraining order that would preserve the status quo so that this case can be litigated and this

Court can indeed grant final relief, if appropriate, enforcing the merger agreement through a decree of specific performance.

It is also a TRO that is designed to preserve the status quo pending April 30, 2017, which is the drop-dead date for the merger agreement, assuming that neither party establishes a breach that would prevent the other party from terminating as of April 30th.

A status quo order that would keep the merger agreement in place pending that date is critically important because, otherwise, without that type of temporary restraining order, CIGNA can claim, as it has, to have terminated the merger agreement.

That obviously has real-world consequences, notwithstanding the suggestion by CIGNA's counsel to the contrary. One of those real-world consequences is that if the merger agreement is terminated, then the injunction issued by the District Court is arguably moot. That, in turn, would prevent the Court of Appeals for the District of Columbia from reviewing that injunction.

I can tell you, as a trial judge, that while it seems highly likely, having read the District

Court's opinion, that the government has the strong hand going into that appeal, I have been reversed on many occasions where I had thought I had gotten it right, and so it is certainly possible that the Court of Appeals could reverse that decision and result in the elimination of an impediment to the closing.

It's also possible that with the merger agreement still in place, impediments to the closing could be addressed through other ways. Mr. Kurtz has cited several of them.

This brings us to the analysis of the TRO application. It requires, in the first instance, a colorable claim. It requires, in the second instance, a showing of irreparable harm. And then the Court, as it always must, has to take into account the balancing of the hardships.

CIGNA's counsel starts from the proposition that this is an extraordinary remedy. It is an extraordinary remedy but in the sense of a non-ordinary remedy. It is an out-of-the-ordinary remedy. It is not an extraordinary remedy in the sense of "The League of Extraordinary Gentlemen" or extraordinary superpowers or things that a Court just never does.

It is out of the ordinary in the sense that cases normally do not proceed at an expedited pace and normally do not involve preliminary injunctive relief, whether as a temporary restraining order or otherwise, to preserve the status quo. We normally proceed in a nonexpedited fashion to a trial. So in that sense and only that sense is preliminary injunctive relief extraordinary.

But preliminary injunctive relief including a TRO is quite common, particularly in this Court, which deals with a lot of similar and, using the word in the same sense, extraordinary situations where it is necessary to preserve the status quo so that effective legal relief can be granted.

This is an extraordinary transaction. And I say that not in the sense of whether I believe it's a great deal, as Mr. Kurtz cleverly put it, but in the sense that it is an out-of-the-ordinary transaction. It is quite large. It involves two major companies. It is quite detailed. It is the type of thing that, while it is in place, creates a very different state of play than if it is purportedly terminated.

Preliminary injunctive relief of the

TRO variety or the preliminary injunction variety also becomes less extraordinary where, as here, the parties have agreed to its availability by stipulating in the merger agreement that irreparable harm will arise from breach.

If parties don't want that, don't put it in your merger agreement. If you want to be able to come in later and say that there's no irreparable harm, don't agree in your merger agreement that there is irreparable harm. It's credibility impairing to say that there's no irreparable harm when there is a provision in the agreement where you stipulated that there is irreparable harm.

So in terms of the TRO standard, the first question is whether a colorable claim has been asserted. As I see it, the first aspect of the colorable claim is whether the merger agreement remains in existence as of now but for the termination because of the extension of the drop-dead date through April 30, 2017.

In my view, Anthem's arguments on that are not only colorable but are, at least on a preliminary basis, more persuasive.

The termination date provision gives

Anthem the right to extend to April 30th not only if the conditions to closing are satisfied as of that date but if they are capable of being satisfied.

What CIGNA would like to say is that Anthem had already breached as of the time when the time for extension came and therefore could not exercise its extension right. There are several problems with that argument.

The first is that CIGNA's claims of breach themselves have to be proven. It is not established. And Anthem has countered that, in fact, it did not breach and that it did what it was supposed to do under the merger agreement. That is contested.

The second is that it is colorable for purposes of today that Anthem could establish that if it had failed to or was not then able to satisfy one of the conditions, that it was capable of satisfying the conditions by April 30, 2017. It's not clear to me that because of that language, an actual breach would prevent you from exercising your extension right to April 30 if that breach, to the extent it existed, was curable.

There's a third reason why I think Anthem has the better of the argument on the

extension, and that's the dialogue with the District Court in the District of Columbia about the timing of the merger agreement and how long it would be in place. Nowhere in that dialogue is there any indication of CIGNA taking the position that it's taking now about the extension right not being able to be exercised. To the contrary, CIGNA appeared to be on all fours with Anthem and with the District Court in believing that the drop-dead date had been extended and was then April 30, 2017.

What that means, then, is that this agreement, but for CIGNA's purported termination, remains in place. And CIGNA's purported termination is a change in the status quo that has consequences for Anthem.

As I see it, Anthem has more than cleared the low hurdle for a colorable claim in terms of the agreement remaining in effect. It remains in effect subject to the District Court's order enjoining the parties from proceeding, but that is the current state of play, a binding merger agreement that the parties are not allowed to proceed with because of the District Court's order. That is a very different state of play from what CIGNA would like to achieve,

which is a terminated merger agreement that moots the District Court's order and the prospect of any appeal.

The second claim that I think is in play in this case is whether, because of the allegations of breach, the merger agreement can remain in place after April 30, 2017. That possibility arises because if a party has breached, then a party cannot exercise its termination right.

I don't think I have to express any view on that today because the question for me today is whether I preserve the status quo through a TRO pending a preliminary injunction hearing later, when we can determine whether the status quo should be continued.

I think in connection with the later preliminary injunction hearing, we will have to deal with the arguments about which sides breached -- maybe both sides breached -- and what the consequences of that are for an April 30th termination. But I think for purposes of today, the fact that the merger agreement would be in place but for CIGNA's attempt to terminate is enough to establish a colorable claim.

I then get to the issue of irreparable harm. And this is the one where I find that CIGNA's

eloquent arguments are somewhat astounding.

Clearly, the loss of a major transaction is irreparable harm. If Anthem is in a position to close this deal or otherwise hold CIGNA to the merger agreement, it is in a very different position than if the agreement is terminated. Those two states of the universe are literally universes apart. They're fundamentally different.

Second, in terms of irreparable harm, not only is the deal potentially lost, but the opportunity to pursue things in the interim, such as the appeal, such as potential alternatives to regulatory approval, are also lost.

CIGNA's counsel took the strong position that he thought it was certain as the day is long that it would be impossible for Anthem to achieve regulatory approval. This is a year in which we've seen the Cavaliers come back from a 3-1 deficit for the first time in NBA history. This is a year where we've seen the Cubs come back from a 3-1 deficit to win their first World Series in over a century. This is a year where we've seen the Patriots come back from a 28-3 deficit to win the Super Bowl for the first time in overtime. This is a year where the new

Administration that Mr. Kurtz wants to deal with was not predicted by virtually any political pundit to be the Administration that Mr. Kurtz would be dealing with. I don't think that, given that, this is the year in which someone can reasonably posit and be certain as the day is long that there is no chance for this merger to get approved.

Yeah, there might be no chance for it to get approved in a traditional fashion, but there are untraditional things that are available, and Mr. Kurtz has identified some routes short of a full-blown appeal followed by state-by-state approval that he thinks theoretically could get him there.

At least for purposes of today, I am not going to deny relief and allow the status quo to be fundamentally changed based on overconfidence about what is certain not to happen.

We, finally, get to the balancing of the hardships on this issue. I think it's foreshadowed by my analysis of the irreparable harm. If no TRO issues, then CIGNA gets to claim that the merger agreement is terminated, and any ability to go forward with the transaction is lost.

By contrast, if the status quo is

maintained, then that is all that happens. The status quo is maintained. The agreement remains in place. The parties continue to comply with it. They're still in a situation where they have a binding merger agreement that they have been enjoined from proceeding with. Anthem can pursue its appeal. And CIGNA simply has to live by the agreements that it voluntarily undertook when it signed up the transaction.

So for all these reasons, I'm granting the TRO.

I think what you all need to target is a preliminary injunction hearing during the week of April 10th. At that preliminary injunction hearing, I would be inclined to consider not only the question of whether Anthem validly extended in January, which is what I've given you a preliminary and tentative view on today, but also the question of whether there was a sufficient basis to believe that a breach occurred and that the breach was by CIGNA such that the merger agreement would need to stay in place beyond April 30th.

And then we can go from there as to what proceedings we need from that point on in terms of a trial for specific performance or damages or

whatever has to happen.

Now, let me give you a couple caveats. Nothing I say today presages how I view the case as a whole. I've obviously ruled in favor of Anthem. I've obviously expressed some skepticism about some of the arguments that CIGNA has advanced, particularly on the absence of irreparable harm, when we're talking about an agreement governing a front-page *Wall Street Journal* headline deal that contains an irreparable harm provision.

Yeah, I'm skeptical that there's no irreparable harm from the loss of that, and I'm surprised that that argument was made, but that doesn't translate into the idea that Anthem wins the case. It means that for purposes of today, they have cleared the relatively lenient standard for a TRO, which requires only a colorable claim and a threat of irreparable harm and the balancing of hardships, to maintain the status quo pending further proceedings.

Certainly, once there is a more developed record in terms of a preliminary injunction, things could be different. And when we ultimately get to the merits in terms of deciding what actually has happened, things could be very different.

I also will say that in terms of the form of temporary restraining order that I'm granting, I am striking the words that appear in the single sentence from "or" to the end.

So, in other words, I am enjoining CIGNA from terminating the merger agreement. I am not going further than that. Because once I have enjoined CIGNA from terminating the merger agreement, CIGNA is bound by the provisions under the merger agreement. So is Anthem.

But for purposes of any additional restriction on taking any action to prevent or impede regulatory approval on consummation of the merger, the actions that CIGNA is expected to take, is obligated to take, and the things it's obligated not to do, are set forth in the merger agreement. By keeping the merger agreement in place, those restrictions stay in place.

I'm not going to substitute for what sophisticated parties agreed to. I'm not going to replace that with whatever this is, a dozen words. You all are going to have to stick with what your sophisticated deal lawyers worked out for you in terms of the obligations relating to transactional approval

and regulatory approval.

All right. I've talked almost as long as you all did, for which I apologize.

Mr. Kurtz, you were the movant. What questions do you have?

MR. KURTZ: I have no questions, Your Honor. And we appreciate your immediate attention.

THE COURT: All right.

Mr. Savitt, what questions do you have?

MR. SAVITT: No questions, Your Honor. Thank you.

THE COURT: All right. I will sign the order in the form that I've suggested, and you all can go from there in terms of pursuing what other issues you want to pursue.

Thank you, everyone.

(Conference adjourned at 5:08 p.m.)

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CERTIFICATE

I, JEANNE CAHILL, RDR, CRR, Official Court Reporter for the Court of Chancery of the State of Delaware, do hereby certify that the foregoing pages numbered 3 through 51 contain a true and correct transcription of the proceedings as stenographically reported by me at the hearing in the above cause before the Vice Chancellor of the State of Delaware, on the date therein indicated.

IN WITNESS WHEREOF I have hereunto set my hand at Wilmington, Delaware, this 15th day of February, 2017.

/s/ Jeanne Cahill

Jeanne Cahill, RDR, CRR
Official Chancery Court Reporter
Registered Diplomate Reporter
Certified Realtime Reporter