STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

IN THE MATTER OF:

FORM A STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH CIGNA HEALTHCARE OF NEW HAMPSHIRE, INC., BY ANTHEM, INC.; FORM E PRE-ACQUISITION NOTIFICATION FORM REGARDING THE POTENTIAL COMPETITIVE IMPACT OF A PROPOSED MERGER OR ACQUISITION BY ANTHEM, INC., OF CIGNA CORPORATION

Docket No: Ins. 15-054-AP

STATUS REPORT OF THE ANALYSIS TEAM AS OF FEBRUARY 15, 2017

The Analysis Team of the Insurance Department ("Analysis Team")[1] submits this fourth status report to the Insurance Commissioner ("Commissioner") concerning the status of the Form A Statement Regarding the Acquisition of Control of Cigna Healthcare of New Hampshire, Inc., by Anthem, Inc. ("Anthem"), filed with the Insurance Department ("Department") on September 2, 2015 ("Form A Statement"), and the related Form E Pre-Acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-Domiciliary Insurer Doing Business in this State or by a Domestic Insurer concerning Anthem, Inc., and Cigna Corporation ("Form E Statement") filed with the Department on December 11, 2015.

1. As the regulator of insurance in New Hampshire, the Commissioner has authority to approve or disapprove a proposed merger or other acquisition of control involving insurance

[1] As described in the Analysis Team's status report of March 11, 2016, the Department has assigned staff to be involved in the review of Anthem's application to two "teams": (1) the Adjudicative Team, led by the Commissioner, who bears ultimate responsibility for making a decision in this matter; and (2) the Analysis Team, led by the Deputy Commissioner, which will review and evaluate the application and present a recommendation to the Commissioner at the public hearing in this matter.

companies operating in the state under the Insurance Holding Companies law, NH RSA chapter 401-B. The state's insurance company merger review is separate from any review of the merger in which the federal government or other state regulators may be engaged, and the Department's exercise of its authority is not contingent on action by the federal government or any other state regulator.

2. As explained in the second status report of June 2016, the statute lays out a clear standard for the review: the Commissioner "shall approve" a proposed merger unless he or she finds, after a public hearing, that the merger would create one or more of six specified conditions harmful to the public or the state's insurance markets. The specified conditions include a substantial lessening of competition in insurance in the state or tendency to create a monopoly, a standard similar to that at issue in the federal trial regarding the merger, United States of America, et al. v. Anthem, Inc. and Cigna Corp., , No. 1:16-cv-01493-ABJ (United States District Court for the District of Columbia) ("federal suit"). The Commissioner is not a party to the federal suit.

3. By statute, the state review process includes additional insurance-specific considerations that go beyond the antitrust analysis in the federal suit. These include review of factors including whether the merger will result in a financial condition that might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders; material changes in business or corporate structure that are unfair and unreasonable to policyholders of the insurer and not in the public interest; and other likelihood of hazard or prejudice to the insurance-buying public. See NH RSA 401-B:3, VI(a).

4. Trial in the federal suit was held from November 21, 2016 until January 4, 2017. During the trial the Analysis Team continued to engage in collecting information that it may

present to the Commissioner at the public hearing in this matter. In particular, Anthem worked cooperatively with the Analysis Team to provide in a timely fashion the public transcripts in the federal suit.

5. On February 8, 2017, the District Court issued an Order in the federal suit enjoining the merger of Anthem and Cigna. A copy of the Order is attached as Exhibit A.

6. On February 9, 2017, Anthem appealed from the Order to the United States Court of Appeals for the District of Columbia Circuit. The appeal was docketed as United States of America, et al. v. Anthem, Inc., Appeal No. 17-5024 (D.C. Cir.). On February 13, 2017, Anthem filed an emergency motion requesting expedited consideration of its appeal.

7. The Order would moot this matter if upheld, and the merger agreement between Anthem and Cigna presently has a termination date of April 30, 2017. Accordingly, the timing and result of the appeal will have a bearing on the need to continue with this matter.

8. The Analysis Team will file a further status report once the Appeals Court rules on the motion regarding expedited consideration of the appeal.

Respectfully submitted,

Alexander K. Feldvebel

Alexander Feldvebel
Deputy Commissioner

February 15, 2017

Certificate of Service

I hereby certify that a copy of this Status report of the Analysis Team as of February 15, 2017, is being served this 15th day of February, 2017, by email and mail on counsel for Anthem, Inc.

Alexander K. Feldvebel

Alexander K. Feldvebel

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, *et al.*, Plaintiffs, v. ANTHEM, INC., *et al.*, Defendants.	Civil Action No. 16-1493 (ABJ)

ORDER

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

Judgment will be entered in favor of the plaintiffs on their first claim, and the merger will be enjoined due to its likely impact on the market for the sale of health insurance to "national accounts" – customers with more than 5000 employees, usually spread over at least two states – within the fourteen states where Anthem operates as the Blue Cross Blue Shield licensee. So the Court does not need to go on to decide the question of whether the combination will also affect competition in the sale to national accounts within the larger geographic market consisting of the entire United States. The Court also does not need to rule on the allegations in plaintiffs' second

claim that the merger will harm competition downstream in a different product market: the sale of health insurance to "large group" employers of more than 100 employees in thirty-five separate local regions within the Anthem states. But the evidence has shown that the proposed acquisition will have an anticompetitive effect on the sale of health insurance to large groups in at least one of those markets: Richmond, Virginia. Finally, given the ruling against the merger, the Court need not reach the allegations in the complaint that the merger will also harm competition upstream in the market for the purchase of healthcare services from hospitals and physicians in the same 35 locations.

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

The evidence demonstrated that large national employers have a unique set of characteristics and needs that drive their purchasing processes and decisions, and that the industry as a whole recognizes national accounts as a distinct market. Witness after witness agreed that there are only four national carriers offering the broad medical provider networks and account management capabilities needed to serve a typical national account. Notably, both Anthem and Cigna have established business units devoted to national accounts, and these separate profit and loss centers each have their own executives, sales teams, and customer service personnel. While various brokers and insurance carriers may draw differing lines to define the boundaries of a "national account," the government's use of 5000 employees as the threshold is consistent with how both Anthem and Cigna identify the accounts within their own companies. Moreover, when

measured against the appropriate legal standard, the government's definition was sufficient to include reasonable substitutes and to fairly capture the competitive significance of other products.

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

Next, the Court finds that plaintiffs have established that the high level of concentration in this market that would result from the merger is presumptively unlawful under the U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, which courts regularly consult for guidance in these cases. The evidence has also shown that the merger is likely to result in higher prices, and that it will have other anticompetitive effects: it will eliminate the two firms' vigorous competition against each other for national accounts, reduce the number of national carriers available to respond to solicitations in the future, and diminish the prospects for innovation in the market.

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

superior discounts, the two companies are competing head-to-head with respect to many of the other aspects of their offerings, all of which can factor into the employer's total cost per employee for medical benefits.

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

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

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

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

But the claimed medical cost savings are not cognizable efficiencies since they are not merger-specific, they are not verifiable, and it is questionable whether they are "efficiencies" at all. And the projected G&A efficiencies suffer from significant verification problems as well.

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

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

It is also questionable whether Anthem's ability to drive a hard bargain with providers by virtue of its size can be characterized as an "efficiency" at all. The Guidelines define an efficiency as something that would enable the combined firm to achieve lower costs for a given quantity and quality of product. Here, the combined firm will not be selling healthcare. Its "product" in the national accounts market – as Anthem has emphasized since the first day of the trial – is "ASO" or "administrative services only" contracts, which include claims administration, claims adjudication, and access to a network of health providers. So there is no evidence that the claimed

network savings will arise because the cost of what the merged firm produces, and what it sells in the relevant market, will go down.

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

Anthem is asking the Court to go beyond what any court has done before: to bless this merger because customers may end up paying less to healthcare providers for the services that *the providers* deliver even though the same customers are also likely to end up paying more for what the defendants sell: the ASO contracts that are the sole product offered in the market at issue in this merger. It asks the Court to do this because it is the insurers that negotiate the in-network provider discounts, access to those rates is part of what the customers are buying when they buy health insurance, and medical costs account for the overwhelming portion of any customer's total healthcare expenditure. In short, Anthem is encouraging the Court to ignore the risks posed by the proposed constriction in the health insurance industry in the relevant market on the grounds that consumers might benefit from the large size of the new company in other ways at the end of the day. But this is not a cognizable defense to an antitrust case; the antitrust laws are designed to protect competition, and the claimed efficiencies do not arise out of, or facilitate, competition. Moreover, Anthem's own documents reveal that the firm has considered a number of ways to

capture the network savings for itself and not pass them through to the customers as it insisted in court that it would.

Anthem argues that even if expanding access to provider discounts does not technically qualify as an antitrust efficiency that can offset anticompetitive effects on a dollar-for-dollar basis, it is a factor to be taken into consideration in assessing the overall impact of a merger in a market where it is universally acknowledged that growing costs must be controlled. In short, the Court should decide that the pressure the merger would place on providers would be beneficial to consumers in general. But the record created for this case did not begin to provide the information needed to reveal whether all providers, no matter their size, location, or financial structure, are operating at comfortable margins well above their costs, as Anthem's expert suggested, or whether Anthem's use of its market power to strong-arm providers would reduce the quality or availability of healthcare as the plaintiffs alleged. And the trial did not produce the sort of record that would enable the Court to make – nor should it make – complex policy decisions about the overall allocation of healthcare dollars in the United States.

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

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

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

The documentary record and the testimony reflect that the pre-merger integration planning that is necessary to capture any hoped-for synergies is stalled and incomplete. Much of the work has not proceeded past the initial stage of identifying goals and targets to actually specifying the steps to be taken jointly to implement them. Moreover, the relationship between the companies is marked by a fundamental difference of opinion over the effect the Anthem strategy to impose

lower rates on providers and move members away from Cigna's network will have on the collaborative model of care that is central to the Cigna brand. Both Cigna witnesses and providers have testified that effective collaboration requires more of the physicians and hospitals, and they expect to be paid for it, and the engagement with members to improve behaviors that can affect wellness requires an investment of resources on the part of the insurer. All of this raises serious questions about when, how, and whether the medical savings can be achieved, whether the G&A savings can be verified, and whether there is any basis in the record to believe in the rosy vision being put forward by Anthem of a new national carrier that delivers the Cigna product at the Anthem price.

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

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

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

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

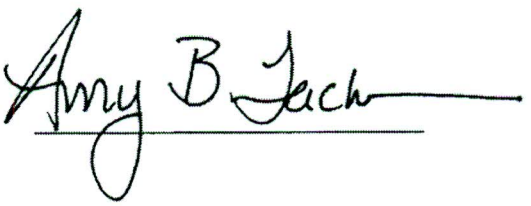
It is therefore

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

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

FURTHER ORDERED that each party shall file notice with the Court by close of business February 9, 2017 of whether it has any objection to the Court unsealing the Memorandum

Opinion docketed on this date in its entirety and if so, specifying what portions it believes should remain under seal and why.



AMY BERMAN JACKSON
United States District Judge

DATE: February 8, 2017