HALL RENDER
KILLIAN HEATH & LYMAN

HEALTH LAW NEWS

MARCH 23, 2017

U.S. DISTRICT COURT BLOCKS SECOND INSURANCE MEGA-MERGER; COURT NOT IMPRESSED WITH ANTHEM'S PLAN TO "DROP THE HAMMER" ON PROVIDERS

On February 8, 2017, the U.S. District Court for the District of Columbia (the "Court") blocked the proposed $54 billion merger between Anthem, Inc. ("Anthem") and Cigna Corp. ("Cigna"). This ruling comes on the heels of the Court's decision to block the other insurance mega-merger ($37 billion) between Aetna Inc. and Humana Inc. Anthem has already appealed the decision to the United States Court of Appeals for the District of Columbia ("DC Circuit"), which is scheduled to hear the appeal on March 24, 2017.

BACKGROUND

Eleven states and the District of Columbia joined the U.S. Department of Justice ("DOJ") in challenging Anthem's acquisition of Cigna, a deal that would have combined two of the "big four" largest health insurers and two of the few remaining commercial health insurance options in the individual and employer markets throughout the country. Valued at $54 billion, this transaction would have been the largest merger in the history of the health insurance industry. In its complaint, the government argued that the merger would substantially lessen competition in numerous markets throughout the country, raise prices, reduce benefits and deprive consumers and health care providers of the ability to improve care outcomes. The government further argued that, post consolidation, the "big four" would become the "big three" and each would have twice the revenue of the next largest insurer.

The DOJ's case against Anthem/Cigna focused on three distinct areas.

National Accounts. National accounts are those employer plans with more than 5,000 employees across multiple states (i.e., those that require national coverage to insure their employees). The DOJ argued that the proposed merger would harm national accounts in two geographic markets: (1) the 14 states where Anthem sells under a Blue Cross Blue Shield Association ("Blue") license; and (2) the United States, generally. According to the DOJ, the merger would eliminate a substantial competitor for Anthem, further consolidating an already consolidated market, resulting in market shares exceeding 50 percent in the relevant geographic markets. In addition, since Blue affiliates each enjoy an exclusive license to market insurance under the Blue brand within their individual territories, no two Blue companies will ever bid on the same large group or national account and no Blue licensee may bid on an account headquartered in another licensee's state without receiving a "cede" from that carrier.

Large Group Employers. The DOJ argued that the proposed merger would harm competition in 35 metropolitan areas across the United States. In these areas, Anthem and Cigna are either the only or two of the very few large group employer insurance options, where they compete based on reimbursement rates, customer service and innovation, all of which would presumably be affected by the proposed merger. Indeed, the record revealed that Anthem's business model was to compete on the basis of low price (the "Walmart" model according to one witness). In contrast, the Cigna model was to compete on the basis of lowering employer medical spend through innovative provider collaboration and population health management programs.

Monopsony Claim. The DOJ claimed that the proposed merger would result in a monopsony[1] whereby Anthem would be able to dictate market terms, resulting in lower reimbursement rates, reduced access to medical care, reduced quality and fewer value-based provider collaborations. The government argued that, post-merger, Anthem would gain significant leverage in rate negotiations with physician practices, hospitals and physician groups, allowing Anthem to impose "take-it-or-leave-it" terms. These lower rates would, in turn, force physician groups to reevaluate their employment and operations practices, effectively reducing patients' access to care and dis-incentivizing physicians to engage in collaborative, value-based care.

ANALYSIS

In reaching its decision, the Court primarily focused on the anticompetitive harm to national accounts in the 14 states where Anthem operates as the Blue licensee. While the Court did not directly address the monopsony claim (which would have been of keen interest to providers) during its detailed discussion of Anthem's claimed $2 billion of efficiencies, the Court did address the harm the merger would have caused to providers, even noting that Anthem's own witness offered his view that the merged company would ultimately be able to achieve

even larger discounts from providers. In addition, the Court noted Anthem's efficiency claims were premised upon its ability to exercise the muscle it had already obtained by virtue of its size, so with no corresponding increase in value or output, the Court found the "efficiency" claims were better characterized as an application of market power rather than a cognizable beneficial effect of the merger.

National Accounts. The Court found that the merger would likely result in an anticompetitive impact on the market for the sale of national accounts within the 14 states where Anthem operates as a Blue licensee. According to the Court, the evidence demonstrated that the merger is likely to result in higher prices to employers and individuals, eliminate competition between the two companies for national accounts, reduce the number of national carriers available to respond to solicitations and diminish innovation.

After confirming the relevant geographic and product markets, the Court used the Herfindahl-Hirschman Index ("HHI") metric to measure market concentration in the 14 states in question. The government argued, and the Court found, that the market concentration resulting from the merger would be presumptively anticompetitive as it eliminated the existing head-to-head competition between Anthem and Cigna and reduced the number of national accounts carriers from four to three. Further, the resulting entity's market power would not be mitigated by new market entrants, the expansion of the markets in question or the sophistication and bargaining power of the surviving competitors.

Efficiencies.

- **$2 Billion in Medical Cost Savings**. In an effort to rebut the DOJ's case, Anthem argued that national account customers would enjoy over $2 billion in medical cost savings. Because many national accounts are self-insured and sign "administrative services only" ("ASO") contracts, Anthem argued these $2 billion in medical cost savings would flow directly to large employers. In order to recognize these medical cost savings, Anthem's plan post-merger was to unilaterally invoke the "affiliate clause" provision in its provider contracts to require providers to extend Anthem's discounted fee schedules to the newly acquired Cigna accounts. But the Court was not impressed with this argument, stating the medical cost savings were primarily the result of increasing market power and were not even necessarily an "efficiency" at all. In addition, the Court specifically pointed out that Anthem's internal documents reflected that the company had been actively considering ways to capture the medical cost savings for itself, including by raising ASO fees.
    - *Not Merger-Specific*. Because Anthem's plan was to use the "affiliate clause" and merely provide lower Anthem reimbursement to the Cigna accounts, the Court found that "[n]ot one penny of these savings derives from anything new, improved, or different . . . to the contrary, the medical network calculation is specifically based on pricing that one or the other of the companies *has already achieved* alone." In addition, the Court found that Anthem's own witness specifically opined that Anthem had already achieved the benefits of scale in its dealings with providers and that increased volume would not enable it to obtain greater discounts, stating, "Anthem's already past the threshold of having enough size to do what it needs to do in terms of offering volume to providers." Essentially, the Court found national accounts could already obtain the lower Anthem rates if they wanted to by simply switching carriers, so the medical cost savings were not merger-specific.
    - *Not Verifiable*. Interestingly, the Court also found that the medical cost savings were not verifiable. Citing internal Anthem memos and emails, the Court found that Anthem was expecting strong provider push back in moving Cigna members to the lower Anthem rates. In one internal email, an Anthem executive stated, "I would expect strong provider resistance, as they view this as an incremental discount with no corresponding incremental value (no new members)." Additionally, even Cigna's CEO testified that Anthem's predicted medical cost savings were unreliable because they were based on an unproven assumption that providers will not react and negotiate their fee schedules upwards.
    - *Not Even a True "Efficiency."* The Court also doubted whether the medical cost savings were even a true "efficiency" at all. Finding that the medical cost savings do not result from either company doing anything better, or from the elimination of duplication or the creation of new demand, the Court was reticent to even call the medical cost savings an "efficiency."
- **Anthem and Cigna's Differentiated Product Offerings**. Additionally, the Court made particular effort to point out that Anthem and Cigna offer different products and utilize different strategies in the health insurance market. Anthem's strategy of leveraging its market power to command substantial discounts in provider contracts is directly opposed to Cigna's value-based strategy of collaborating with providers to reduce costs through innovation. As part of its "affiliate clause" strategy, Anthem's post-merger plan would force providers to increase collaboration (similar to Cigna's pre-merger strategy) but do so at lower rates (similar to Anthem's pre-merger strategy). Internal emails between Anthem executives showed the conflict between Anthem's stated plans to increase provider collaboration and to

"drop the hammer" on providers with lower rates. Additionally, Cigna's CEO testified that imposing lower fee structures post-merger would unravel the collaborative relationships with providers that are essential to accountable care and better clinical outcome, leading to the destruction of the Cigna value proposition. The Court noted that Anthem's own experts found that people "like something Cigna offers." Further, the Court noted that providers have been very clear that one cannot ask them to do more but pay them less at the same time.

- **The Elephant in the Courtroom**. In a rather bizarre twist, the Court noted the "elephant in the courtroom" - that Anthem and Cigna's relationship had deteriorated throughout the merger and that the two were clearly not aligned. Not only did Cigna's executives provide compelling testimony that undermined the medical cost savings, but Cigna's counsel cross-examined Anthem's 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's witnesses." All of this led the Court to question whether the medical cost savings could be achieved and whether there is any basis to "believe in the rosy vision being put forward by Anthem."

AFTERMATH

Almost immediately following the Court's decision, Anthem appealed the decision to the DC Circuit, asking for and receiving an expedited hearing. The DC Circuit is set to hear the appeal on March 24, 2017. On February 14, 2017, Cigna ended the merger agreement with Anthem and filed suit against Anthem in the Delaware Court of Chancery. Cigna is seeking $13 billion in damages for its shareholders on top of a break-up fee outlined in the transaction agreement, alleging that Anthem "willfully breached" the merger agreement in a way that made it unlikely the deal would be approved. Anthem subsequently sought and received a restraining order against Cigna in the Chancery Court, alleging that Cigna had been attempting to "sabotage" the deal throughout the process. Much of this procedural fallout may be in anticipation of the pending litigation over the $1.85 billion break-up fee Anthem is required to pay to Cigna in the event the transaction is not consummated.

PRACTICAL TAKEAWAYS

The proposed merger between Anthem and Cigna and the Court's subsequent decision provide a number of practical takeaways for providers to consider moving forward.

- Anthem's plan to invoke its "affiliate clause" post-merger would have had a very large and negative financial impact on many providers. Anthem's strategy serves as a good reminder that providers should pay particular attention to "affiliate clauses" when negotiating managed care agreements. Where possible, providers should attempt to remove or revise these clauses to limit the payer's ability to pass along a negotiated discount in the event of a merger or the addition of new affiliates. For example, the inclusion of a notice and acceptance process allows the provider to have greater control over whether the agreement can be passed on to new affiliates.

- A key focus of the decision was on the difference between the products and strategies utilized by Anthem and Cigna in the health insurance market. The Court was keenly aware that collaboration with providers is a key part of Cigna's strategy and was therefore hesitant to allow a merger that might destroy this differentiated product. As more care moves to the value-based model, providers should be mindful of the various products and services offered by payers and understand how these various products and services affect a provider's payer strategy. Recognizing in many markets providers cannot simply walk away from the dominant payer, providers should carefully consider the financial risks and rewards of the various payer products and services.

- Although the Court did not directly address the "monopsony" (buyer market power) claim, it noted that even according to Anthem's own experts, Anthem has already attained the benefits of scale over providers and can already force providers to accept lower rates. That being said, interestingly, Anthem's internal documents showed concern that providers would push back against lower rates and that Anthem would not be able to force rates down any further (and even if it could, it would take years to come to fruition).

- In reaching its decision, the Court addressed what it referred to as the "elephant in the courtroom" - that before and during the trial, Cigna provided testimony that undermined the efficiencies claimed by Anthem. For providers considering a potential merger or other transaction, this emphasizes the importance of ensuring proper intent and alignment between the parties, particularly as the DOJ and Federal Trade Commission depose leadership and review ordinary course documents in an attempt to determine the competitive impact.

- Looming in the background of this trial, and not lost on the Court, was the ever-present policy discussion surrounding rising health care costs. The Court even noted that all sides offered testimony related to the high and unsustainable cost of medical care. While Anthem

claimed the customer's pocketbook was its number one concern and the merger would help bring down the cost of health care in America, the Court specifically rejected this claim and rejected the notion that the Court should make a policy decision related to health care costs. The Court stated, "[w]hat [Anthem] is asking the Court to do is to elevate Anthem's ability to sustain its margins over the need or ability of physicians and hospitals to do the same, and Supreme Court precedent indicates that courts should not be in the business of making policy determinations about the appropriate allocation of health care dollars; those are value judgments that are better directed to the legislature." Not surprisingly, in this era of the Affordable Care Act (and its potential repeal and replacement), courts are cautious about wading into the policy discussion of rising health care costs even though certain cases might be squarely on point, deferring instead to the legislature to make such policy determinations.

If you have any questions or would like additional information about this topic, please contact one of the following members of Hall Render's Antitrust Practice Group or Managed Care Group:

- William E. Berlin at (202) 370-9582 or wberlin@hallrender.com;
- Clifton E. Johnson at (317) 977-1430 or cjohnson@hallrender.com;
- Michael R. Greer at (317) 977-1493 or mgreer@hallrender.com;
- Amy L. Mackin at (919) 447-4963 or amackin@hallrender.com;
- Laetitia L. Cheltenham at (919) 447-4968 or lcheltenham@hallrender.com;
- John F. Bowen at (317) 429-3629 or jbowen@hallrender.com; or
- Your regular Hall Render attorney.

[1] A monopsony, sometimes referred to as a buyer's monopoly, is a market condition similar to a monopoly except that a large buyer, not a seller, controls a large proportion of the market and drives prices down.

View this article and other health law-related posts by visiting the Hall Render Blog at: http://blogs.hallrender.com or click here to sign up to receive Hall Render alerts on topics related to health care law.