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By Email and Courier

February 29, 2016

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

Dear Assistant Attorney General Baer:

I am writing to follow up on concerns raised in the American Hospital Association's (AHA) correspondence with the Antitrust Division of the Department of Justice (Department) regarding the proposed Anthem acquisition of Cigna. In that letter, AHA detailed the anticompetitive potential of a number of aspects of the deal, including Anthem's affiliation with the Blue Cross Blue Shield System (Blue system or plan).[1] We elaborated on the Blue plan affiliation concerns in congressional testimony, pointing out that "Cigna['s entry] into the overall Blue System . . . may augment the already considerable power of the Blue plan in every state."[2] In this letter, we further elaborate on these concerns and discuss why, when added to those raised in our previous letter, we believe this acquisition would irreparably harm competition and consumers.

Because the likely resulting harm cannot reliably be remedied by structural means, such as divestitures, or by conduct agreements, such as limits on price hikes or network adequacy promises, we urge that the Department challenge the deal. [3]

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[1] Letter from Melinda Reid Hatton, Senior Vice President & Gen. Counsel, Am. Hosp. Ass'n, to the Honorable William Baer, Assistant Attorney Gen., U.S. Dep't of Justice Antitrust Div., (August 5, 2015), http://www.aha.org/advocacy-issues/letter/2015/150805-let-acquisitions.pdf.

[2] *E.g., Healthy Competition? An Examination of the Proposed Health Insurance Mergers and the Consequent Impact on Competition: Hearing Before the H. Subcomm. on Regulatory Reform, Commercial and Antitrust Law*, 114th Cong. 5 (2015) (testimony of Thomas Nickels, Exec. Vice President, Am. Hosp. Ass'n), http://www.aha.org/advocacy-issues/testimony/2015/150929-tes-nickelscompetition.pdf.

[3] The transaction violates Section 7 of the Clayton Act, 15 U.S.C. §18, and Section 2 of the Sherman Act 15 U.S.C. §2.

INTRODUCTION AND OVERVIEW

We urge the Department to challenge Anthem's acquisition of Cigna. The acquisition threatens to both reinforce existing barriers to entry and raise new ones, further entrench dominant Blue plans, and exacerbate conditions conducive to abuse of market or monopoly power. The Blue Cross Blue Shield Association (Association) rules reinforce and compound these competitive concerns. Specifically, the acquisition is likely to: (1) reduce the ability of other health insurers to compete with Blue plans or even exclude Blue plans' competitors in some markets; and (2) raise prices paid by Blue plans' competitors, which will, in turn, raise the cost of health insurance premiums paid by consumers.

Blue plans currently dominate the health insurance market in most states.[4] Collectively, Anthem and the other Blue plans control 105 million lives.[5] The addition of Cigna adds 14.7 million more lives; this represents a 14 percent increase in the lives controlled by Blue plans nationwide.[6] That is more than one-third of the entire U.S. population.[7] Blue plans compete with other health insurers but, in many states, are many times larger than their next largest competitor. In many states, a Blue plan has market power in the sale of commercial health insurance.

Blue plans, including Anthem, belong to the Association and are expected to abide by the rules and bylaws of the Association. Under the Association's BlueCard program, ***all*** Blue members in a state (for ***all*** insurance products) are allocated to the resident Blue plan for purposes of contracting with providers. That means that the addition of up to 14.7 million Cigna lives would give the Blue plan in virtually every state greater power to demand disproportionately larger discounts from providers and dictate other restrictive terms and conditions harmful to consumers.

The Department is aware based on previous investigations that plans with market power, such as the Blues, have used it to raise their competitors' costs in order to defeat entry or

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[4] *E.g.*, Complaint at ¶ 1, United States v. Blue Cross Blue Shield of Michigan, No. 2:10-cv-14155 (E.D. Mich. Oct. 18, 2010) ("Blue Cross is by far the largest provider of commercial health insurance in Michigan and has been for many years."), available at http://www.justice.gov/atr/case-document/complaint-43; Am. Med. Ass'n, *Competition in Health Insurance, A Comprehensive Study of U.S. markets*, (2015); Molly Gamble, *153 Statistics on Dominant Payers in Each State*, BECKERSHOSPITALREVIEW.COM (Aug. 28, 2013), http://www.beckershospitalreview.com/finance/153-statistics-on-dominant-payers-in-each-state.html.

[5] Blue Cross Blue Shield Ass'n, About Blue Cross Blue Shield Association, www.bcbs.com, http://www.bcbs.com/about-the-association/ (last visited Feb. 10, 2016).

[6] Oppenheimer, Industry Update with Changes: ANTM Acquiring CI, July 27, 2015, at 4, available at http://www.achp.org/wp-content/uploads/Effect-of-Cigna-Anthem-Merger.pdf. Although 11.7 million of Cigna's 14.7 million members are ASO lives, the market segment is immaterial for analyzing the anticompetitive effects of provider contracting barriers to entry.

[7] The U.S. population on July 4, 2015 was 321,442,019. United States Census Bureau, U.S. and World Population Clock, CENSUS.GOV, http://www.census.gov/popclock/ (last visited Feb. 10, 2016).

expansion in their markets.[8] This tactic should be particularly concerning because new insurance plans, including those hoping to use the health insurance marketplaces or exchanges as a launching pad to establish or grow their business, are the most vulnerable.

Previous investigations also suggest that increased Blue plan market power will raise, not lower, premiums to consumers.[9] We would expect that same impact on premiums in any state with a dominant or near-dominant Blue plan that gains *any* additional market power as a result of this acquisition. And, no speculative claim of efficiency gains put forward by the parties to this deal can offset the likelihood that premiums will increase for consumers as a result of this transaction.

Finally, the temptation for dominant plans to abuse their market power will only increase as a result of this acquisition. Some dominant Blue plans already have the financial and other means to undermine or defeat entry or expansion by other plans, even established plans. Eliminating a national competitor better able to withstand the onslaught of a variety of anticompetitive tactics will almost certainly embolden this conduct, thereby harming, perhaps irreparably, any chance of increasing competition and consumer choice.

I. ANTHEM'S ACQUISITION OF CIGNA CREATES HIGHER BARRIERS TO ENTRY AND EXPANSION

a. Barriers Identified by the Department's 'Entry Project'

The Department has repeatedly recognized the barrier to entry and expansion created by dominant insurance plans, such as the Blue plans that currently dominate in at least 40, and perhaps more, states.[10] In its study of entry into health plan markets, referred to as the "Entry Project," the Department cited control over a significant volume of commercial lives as a significant barrier to entry.[11] The addition of Cigna lives will reinforce these existing barriers to entry, which, among other things, likely contributed, at least in part, to the demise of 12 health plan co-op entrants last year and discouraged countless other potential new entrants.[12]

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[8] *E.g.*, Complaint, United States v. Blue Cross Blue Shield of Michigan, No. 2:10-cv-14155 (E.D. Mich. Oct. 10, 2010), available at http://www.justice.gov/atr/case-document/file/489536/download.

[9] In Michigan, Blue Cross charged consumers higher, not lower, premiums. *Id.*

[10] Am. Med. Ass'n, *Competition in Health Insurance, A Comprehensive Study of U.S. markets*, (2015).

[11] Christine Varney, Assistant Attorney Gen., U.S. Dep't of Justice Antitrust Div., Antitrust and Healthcare: Remarks as Prepared for the ABA/AHLA Antitrust in Healthcare Conference 4-5 (May 24, 2010), available at http://www.justice.gov/atr/speech/antitrust-and-healthcare.

[12] "To review: 12 of the 23 nonprofit startups seeded with $2.4 billion in Obamacare loans have collapsed, forcing 600,000 exchange customers to find new plans during the current enrollment season." Paul Demko, et al, *Slavitt Faces Senate Scrutiny Over Failed Co-ops*, POLITICO, Jan. 21, 2016, http://www.politico.com/tipsheets/politico-pulse/2016/01/pulse-slavitt-faces-senate-scrutiny-over-failed-co-ops-hhs-wont-turn-over-cost-sharing-docs-the-shkreli-show-coming-to-a-congressional-hearing-near-you-212276.

The Entry Project contained a number of important findings that are relevant here:

- "[T]he biggest obstacle to an insurer's entry or expansion in the small or mid-sized-employer market is scale."[13]
    - "New insurers cannot compete with incumbents for enrollees without provider discounts, but they cannot negotiate for discounts without a large number of enrollees."[14]
    - Entry is easier in less concentrated insurance markets.[15]
        - "[N]ew entrants or niche players are more likely to receive provider discounts comparable to their competitors' in less concentrated markets than they are in markets dominated by one or two plans. This is because *no one plan provides such a large number of enrollees that it can demand, and likely receive, disproportionately larger provider discounts than other incumbents or possible entrants.*"[16]

This provider discount disparity deprives new entrants of the "economies of scale that will allow them to compete with incumbents."[17] These findings are in accord with statements and actions by both Anthem and Cigna. Anthem, for example, has explicitly acknowledged that "[s]ize and scale matters."[18] In Securities and Exchange Commission filings, Cigna identified the importance of comparable provider discounts to its ability to compete: "Our results of operations are substantially dependent on our ability to contract for … services [from physicians, hospitals and other health care providers] at competitive prices."[19] Provider discounts are the "primary competitive factors affecting our business …."[20]

b. Blue Brand Barriers Thwarted Anthem's Attempt to Enter New Markets

Anthem itself provides a real-life example of the impact of this barrier to entry. Specifically, Anthem's inability to negotiate comparable provider discounts for non-Blue branded plans sold outside its assigned Blue territory appears to be responsible for Anthem

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[13] Varney, *supra* note 11, at 9.

[14] *Id.*

[15] *Id.*

[16] *Id.* (emphasis supplied).

[17] *Id.*

[18] WELLPOINT, 2014 INVESTOR CONFERENCE 63 (Mar. 21, 2014), http://ir.antheminc.com/phoenix.zhtml?c=130104&p=irol-EventDetails&EventId=5086658 (follow "Presentation" hyperlink).

[19] CIGNA CORP., FORM 10-K, Dec. 31, 2014, at 21, available at http://www.cigna.com/assets/docs/about-cigna/Investor%20Relations/cigna-fourth-quarter-2014-form-10-k.pdf.

[20] *Id.* at 7.

transferring its UniCare individual and group insured business to the dominant Blue plan in Illinois and Texas – Health Care Service Corporation (HCSC). The relevant chronology is as follows:

- In 1994, Anthem (then WellPoint)[21] acquired UniCare, which was then a workers' compensation underwriter;
- In 1996, Anthem (then WellPoint) bought health insurance units of John Hancock and Massachusetts Mutual companies and operated them under the UniCare brand in an attempt to compete outside of its Blue assigned service areas in individual and group health insurance;[22]
- In 2002, Anthem acquired the Methodist Health Care System in Texas and rebranded it as UniCare, presenting it as an expansion of its existing business;[23]
- In 2009, Anthem transferred the UniCare business in Illinois and Texas to HCSC.[24]

Despite its size and business acumen, Anthem's effort appear to have failed because it could not compete effectively outside its assigned territories against another Blue. Anthem cited the lack of adequate provider discounts as "critical" to the strategic decision to transfer UniCare lives in Illinois and Texas to HCSC. Citing "scale" and "the best discounts in the market" as "the fundamental drivers that are important to this business no matter what happens," the then President and CEO said:

> Marketplace dynamics made it increasingly difficult for UniCare to provide affordable, high-quality products to Commercial customers in [Illinois and Texas]. We know from our . . . 14 Blue states that a plan must have sufficient scale to obtain optimal provider arrangements and deliver maximum value to Commercial and individual customers. . . . the fundamental drivers that are important to this business . . . . [n]amely scale; we need to have scale; we need to have the best discounts in the market. And those are characteristics that we as Blue plans can share together. That, as well as the UniCare transaction for us was a strategic one. We transitioned the membership in Texas and Illinois to another Blue plan. So we really think we are working really well with our Blue plan partners ….. *But it was a strategic decision to transfer that membership. We*

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[21] WellPoint changed its name to Anthem, Inc. in December 2014. http://www.antheminc.com/AboutAnthemInc/CompanyHistory/index.htm.

[22] WellPoint, WellPoint Across the Nation, http://media.corporate-ir.net/media_files/irol/82/82476/reports/ar95/nation.html (last visited Jan. 12, 2016); Funding Universe, WellPoint Health Networks Inc. History, FUNDINGUNIVERSE.COM, http://www.fundinguniverse.com/company-histories/wellpoint-health-networks-inc-history/ (last visited Jan. 12, 2016).

[23] Press Release, Anthem, Inc., WellPoint Completes Acquisition of MethodistCare; Strengthens UNICARE Commitment to Growth in the Texas Marketplace (Apr. 30, 2002), available at http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-newsArticle&ID=736697.

[24] WELLPOINT, WLP – Q4 2009 WELLPOINT, INC. EARNINGS CONFERENCE CALL 16 (Jan. 27, 2010), available at http://seekingalpha.com/article/184862-wellpoint-inc-q4-2009-earnings-call-transcript.

don't have the scale. We don't have the depth of the provider discounts that we have in other geographies. And that was really critical.[25]

c. Blue Brand Barriers Strengthened by the Acquisition

The Department has recognized that another entry barrier to health insurance markets is firm reputation, *e.g.*, brand.[26] Plans that use Blue in their name have the highest brand familiarity of all health insurers, dwarfing others in comparison.[27] This "most recognized brand in the industry" Anthem asserts "provides us with an advantage over our competition."[28] The Blue brand is a barrier to entry generally into health insurance, and also specifically into individual health insurance.[29] For example, one study found "brand familiarity is likely to play a key role in consumer choice on the exchanges. Consumers . . . will not pick their hospital, physician, and specialist . . . they will pick an insurance product."[30] The proposed acquisition adds up to 14.7 million lives to the Blue brand barrier to entry.

d. Blue Brand Barriers Already Widespread

The Department's findings and Anthem's experience illustrate the formidable barriers to entry that dominant health insurance plans present to would-be competitors. And, it is the Blue plans that dominate most insurance markets:

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[25] *Id.* at 4, 11, 16 (Angela Braly, President & CEO (emphasis supplied)).

[26] "Entry barriers to the health insurance industry may include: . . . firm reputation." FTC & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION Ch.6 p.8 (July 2004), available at https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

[27] Blue Cross is at 81%, the next nearest is UnitedHealth at 55%. Harris Poll, EquiTrend 2014.

[28] ANTHEM, INC., FORM 10-K 2014 7 (Dec. 31, 2014), available at http://www.sec.gov/Archives/edgar/data/1156039/000115603915000003/antm-20141231x10k.htm; *see* "One in five customers actually was willing to pay more—about seven percent, on average—to have the Blue Cross and Blue Shield brand name." J.K. Wall, Anthem-Cigna Mega Deal Might Snag on Blue Cross, IBJ.COM (Aug. 8, 2015), http://www.ibj.com/articles/54338-blue-cross-may-snarl-anthem-cigna-mega-deal.

[29] The "Blue Cross emblem has proved a potent marketing tool in the health insurance market. . . . and may complicate or retard the entry of new firms." D. ANDREW AUSTIN & THOMAS HUNGERFORD, CONG. RESEARCH SERV. THE MARKET STRUCTURE OF THE HEALTH INSURANCE INDUSTRY 33 (Nov. 17, 2009), available at https://www.fas.org/sgp/crs/misc/R40834.pdf.

[30] NOAM BAUMAN ET AL., MCKINSEY & CO., WINNING STRATEGIES FOR PARTICIPATING IN NARROW-NETWORK EXCHANGE OFFERINGS 10 (July 2013), http://www.mckinsey.com/ (search "Winning Strategies Participating"; then click on link).

- Blue plans have the largest membership of any insurer.[31] The Blues cover more than 105 million Americans.[32] That is "nearly one in three Americans."[33] Collectively, the Blues are three times bigger than any other health plan.[34]
- Blue plans command the largest share of the commercial fully insured (FI) segment in at least 45 states and the District of Columbia (D.C.); in 35 states, a Blue plan holds 50 percent or more FI market share; in some states, 85 percent of all FI members belong to a Blue plan.[35]
- Blue plans rank first in total membership in at least 43 states and D.C., with a high market share of 97 percent.[36]
- In the Federal Employees Health Benefits Program, the Blue plans command 66 percent of total membership,[37] and control 50 to 90 percent of the membership in 48 states and D.C.
- In the public exchanges, Blue plans dominate.[38] In at least one state, the Blue plan enrolled 100 percent of the exchange membership in 2015, and other Blue plans acquired membership shares in the forties through nineties in many states.[39]
- Blue plans collectively are significantly larger than any of their rivals on a consolidated basis. Indeed, collectively Blue plans had $244 billion in revenue in 2013, making them larger than all companies on the Fortune 500 except for Walmart and Exxon Mobil.[40] With the addition of Cigna, Blue plans will have close to $300 billion in revenue.

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[31] WELLPOINT, 2014 INVESTOR CONFERENCE 34 (Mar. 21, 2014) ("Our STRENGTH is UNPARALLELED 3x larger total Blue membership than next closest competitor").

[32] About Blue Cross Blue Shield Ass'n, *supra* note 5.

[33] Def. Blue Cross & Blue Shield Ass'n Answer & Affirmative Defenses to Corrected Consol. Second Am. Provider Compl. at 2, 3, 67, 135, *In re* Blue Cross Blue Shield Antitrust Litig., No. 2:13-cv-20000-RDP (N.D. Ala. Dec. 22, 2014) [ECF No. 289] hereinafter Association Answer].

[34] WELLPOINT, *supra* note 31 at 34 ("Our STRENGTH is UNPARALLELED 3x larger total Blue membership than next closest competitor").

[35] Interstudy, Health Leaders data.

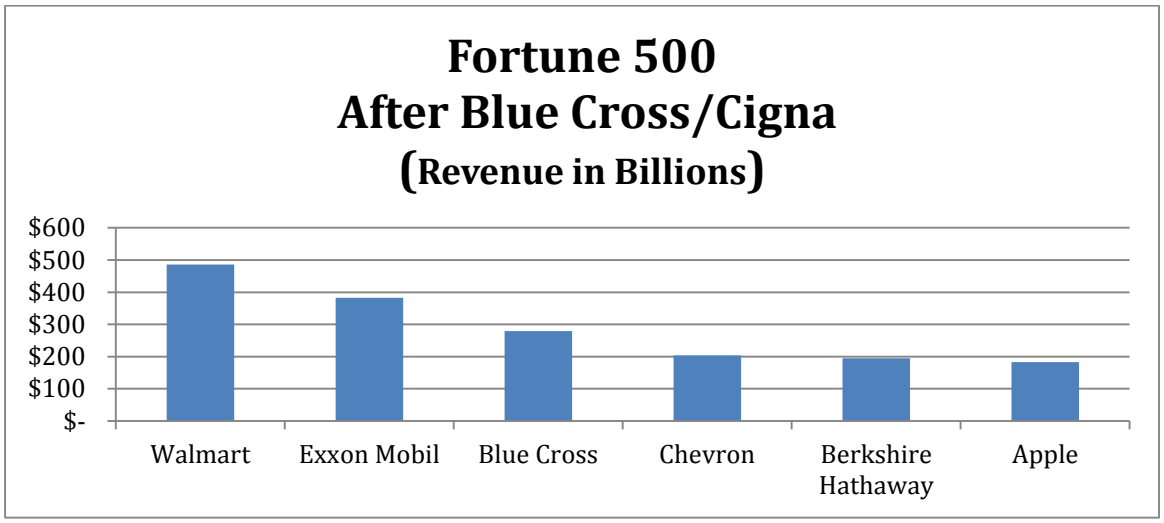
[36] *Id.*; *see also* Gamble, *supra* note 4.

[37] KIRSTIN B. BLOM & ADA S. CORNELL, CONG. RESEARCH SERV., FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM: AN OVERVIEW 7 (Feb. 25, 2015), available at https://www.fas.org/sgp/crs/misc/R43922.pdf.

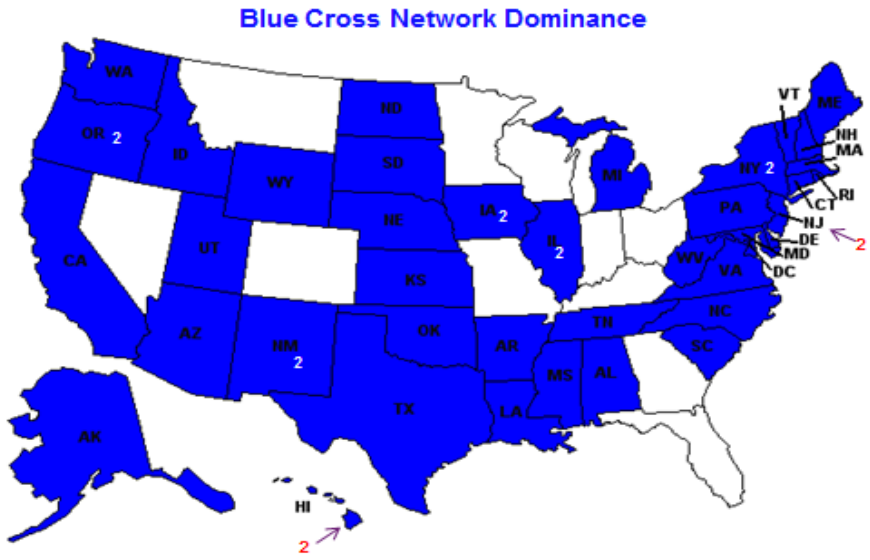
[38] *E.g.*, Eugene Wang & Grace Gee, *Larger Issuers, Larger Premium Increases: Health Insurance Issuer Competition Post-ACA*, TECH. SCI., Aug. 11, 2015, at 11-14, available at http://techscience.org/a/2015081104/; Caroline F. Pearson, AVALERE ANALYSIS: WELLPOINT, BLUES CAPTURE GREATEST PERCENTAGE OF 2014 EXCHANGE MARKET SHARE (Sep. 10, 2014), available at http://avalere.com/expertise/managed-care/insights/avalere-analysis-wellpoint-blues-capture-greatest-percentage-of-2014-exchan.

[39] Wang & Gee, *supra* note 38, at 11-13. West Virginia is 100% Blue Cross. *Id.* at 13.

[40] Analysis based on Fortune 500, Blue Cross Blue Shield Association, 10-Ks, company reports, and regulatory filings.



- The Blue plans of Alabama, Florida, Illinois, Kansas, Minnesota, Montana, Nebraska, New Mexico, North Dakota, North Carolina, Oklahoma, Texas and Wyoming through their jointly owned pharmacy benefit manager acknowledge their "market dominance."[41]
- Blue plans dominate provider networks. In 32 states and D.C., Blue plans have the largest provider networks and, in seven more states, Blue plans have the second-largest provider networks.



[41] Prime Therapeutics, Fact Sheet: Ingredient Cost per Prescription 1 (Dec. 2013) ("Prime works with several leading Blue Cross and Blue Shield Plans across the nation. These plans hold strong positions within their regional health care markets. Prime focuses this market dominance . . . ."). http://cdn2.content.compendiumblog.com/uploads/user/220a4eb2-dd7f-4520-ab96-7cfb9e87326b/8e648f20-2a6c-4610-9b15-849b37ce4f51/File/76d12b0eba57c5ac8e7f8779974bec92/fact_sheet_ing_cost_per_rx_12_17_13.pdf.

- Blue plans contract with 96 percent (more than 5,100) of U.S. hospitals and 92 percent of professional providers, which is more than any other insurer.[42]

As the Department's Entry Project predicted, such dominance already enables Blue plans, on a nationwide basis, to "demand, and likely receive, disproportionately larger provider discounts" that creates a formidable barrier to new entry. This is vividly illustrated by the facts that Blue plans have a:

- 12.8 percent ($47) per member per month (PMPM) total cost of care advantage nationally at the three-digit zip code level based on historical claims data;[43]
- 20 percent PMPM outpatient surgery cost advantage;[44]
- 28.2 percent cost advantage in outpatient radiology;[45] and
- 33 percent cost advantage in the average cost of Emergency Room professional services.[46]

"No other carrier even comes close."[47]

e. Blue Brand Barriers Reinforced by Blue Association Rules

The Blue system operates as a single firm. According to the Association, "The . . . Association and the Blue Plans . . . are a single entity with respect to the licensing and related governance of the Blue Marks, in competing against national insurance companies, and in offering an integrated product to customers across the United States . . . ."[48] Each Blue plan signs a license agreement with the Association. The license agreement and the rules, standards, and bylaws of the Association enforce cooperation and link all the Blue plans together economically.[49] The license agreement requires plans to "effectively and efficiently participate

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[42] About Blue Cross Blue Shield Ass'n, *supra* note 5.

[43] MILLIMAN, 2015 TOTAL COST OF CARE PLACEMENT, 1-2 (Jan. 2015) ("Blue Cross Blue Shield has a significant and measurable advantage over the average cost of national competitors and the best national competitor.").

[44] *Id.* at 2.

[45] *Id.*

[46] *Id.*

[47] *Id.* Anthem recognizes these advantages: One official referred to its provider discounts as giving it a "leading cost of care position" and another called it "a great network discount program." Anthem, Inc. and Cigna Corp. Joint Conference Call to Discuss the Definitive Agreement of Anthem, Inc. to Acquire Cigna Corp. (July 24, 2015) [hereinafter Anthem Jt. Conf. Call July 24, 2015], at 2, 15 (statements of Joseph Swedish and Wayne DeVeydt), available at http://www.sec.gov/Archives/edgar/data/701221/000095015915000211/cigna425.htm.

[48] Association Answer, *supra* note 33, at 2.

[49] The Association continually monitors and enforces compliance with its rules and bylaws, resulting in the Blue single economic enterprise. Br. in Supp. of Defs.' Mot. to Dismiss Pls.' Antitrust Conspiracy Claims at 34, *In re* Blue Cross Blue Shield Antitrust Litig., No. 2:13-cv-20000-RDP (N.D. Ala. Sep. 30, 2013) [ECF No. 120] [hereinafter Association MTD Brief]. The Association conducts on-site reviews and semi-annual audits to ensure plan compliance, and plans regularly furnish financial reports, risk-based capital reports, budgets, audit reports,

in each national program," including the BlueCard program, National Account programs, and others.[50]

The BlueCard program is the mechanism that ties the Blue plans together allowing them to share provider networks, provider pricing, claims, revenues, membership, and other proprietary information.

> The BlueCard program allows subscribers of each local Blue Plan to use sister Plans' networks and negotiated rates, and provides a single network for . . . processing of claims. BlueCard also allows multi-state employers to gain access to multiple Plans' networks in a single transaction . . . . With this cooperation, Blue Plans are able to collectively provide health insurance coverage to 100 million Americans …[51]

An Internal Revenue Service document describes the BlueCard program in detail.[52] Under the BlueCard program, a member enrolls with a Blue plan, called the Home Plan. That member may receive care outside of the Home Plan's service area, through another Blue plan's provider network (Host Plan). Rather than file a claim with the member's Home Plan, Blue plan contracts require the provider to file a claim with the Host Plan. The Host Plan sends its proprietary provider negotiated discount information and provider charges to the Home Plan. It also charges a network access fee (up to $2,000 per claim in 2013) computed as a percentage of the savings between a provider's standard rate and the Host Plan's contracted rates, and an administrative expense allowance, typically $9 per transaction. The Home Plan determines the member's eligibility and coverage for the claim and approves or denies it. The Host Plan pays the provider and settles the accounts receivable from the Home Plan through the Association's Central Finance Agency.

The volume of lives consolidated for provider contracting through the BlueCard program is significant. And, the BlueCard program allows a local Blue plan to count non-member lives as its own in determining provider contract discounts, thereby allowing the local Blue plan to earn larger network access fees (potentially in the billions of dollars) and to lower its cost of doing

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insurance department records, enrollment reports, and member indices for each geographic market to the Association. Ass'n License Agreement, Ex. 2; Internal Revenue Service, Memorandum POSTF-111423-12, IRS.GOV 10 (Mar. 7, 2013), http://www.irs.gov/pub/irs-lafa/20133701f.pdf [hereinafter IRS Memo]. **Plans are forbidden from contacting providers outside of their Blue service area.** Ass'n License Agreement, Ex. 4. Competitive decisions made by the Association include rules for the BlueCard program, National Account program, strategic reserves, and "best efforts" rules limiting competitiveness of non-Blue branded subsidiaries.

[50] Ass'n License Agreement, Ex. 2 Membership Standards, Standard 5.

[51] Association MTD Brief, *supra* note 49, at 30-31.

[52] IRS Memo, *supra* note 49, at 4-8.

business. The amount of lives accounted for by the BlueCard program range from more than 14 percent for Anthem[53] to more than 35 percent for other Blue plans.[54]

The BlueCard program also enables local Blue plans to obtain the "disproportionately larger provider discounts than other incumbents or possible new entrants" about which the Department has been concerned.[55] According to Anthem officials, it intends to incorporate Cigna's lives into the Blue system. It expects to do this in its own states by transitioning Cigna's lives to Anthem, and, outside of its states, it expects to incorporate Cigna lives (insured under national-employer arrangements) into the network of Blue plans, through the BlueCard program.

> [W]e would rebrand in our current Blue states that [Cigna] business . . . . We would obviously fully expect to take advantage of the Blue network. And in these situations in our non-Blue states for national accounts we'd be able to Blue brand it on a premium equivalent basis and use the Blue Card system . . . . [56]

Through the BlueCard program, each Blue plan will have "control" over Cigna lives in its territory for provider contracting if Anthem acquires Cigna.[57] While Anthem's plan seemingly leaves Cigna lives insured through local employers or other means available to compete with local Blues plans, Anthem's professed desire to strengthen the "Blue world"[58] and the limits on the revenue attributable to non-Blue plan products (discussed below) will at least stifle and potentially eliminate that competitive possibility as well.

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[53] ANTHEM, INC., FORM 10-K 2014, *supra* note 28, at 50.

[54] It accounted for 5,000,000 lives or over 36% of HCSC's membership. A.M. BEST, A.M. BEST'S RATING REPORT: HEALTH CARE SERVICE CORP., 3 (July 10, 2014) [hereinafter BEST 2014 HCSC Report]. It accounted for close to 1,000,000 members—more than 25% of Blue Cross Blue Shield of North Carolina's membership. BLUE CROSS BLUE SHIELD OF NORTH CAROLINA, FACT SHEET 1 (2015), available at http://mediacenter.bcbsnc.com/internal_redirect/cms.ipressroom.com.s3.amazonaws.com/49/files/20154/2014CorporateFactSheet.pdf. Although information on total BlueCard claims is not publicly available, in 2014 NASCO processed 116.7 million BlueCard claims out of the 261 million claims it processed for 22.1 million Blue members. NASCO, 2014 ANNUAL REPORT 26 (June 2015), available at http://www.nasco.com/nascowordpress/wp-content/uploads/2015/06/2014-NASCO-Annual-Report.pdf. So, for about 20% of total Blue membership, 45% of their claims are BlueCard claims. If each claim processed was subject to a $2000 access fee, BlueCard claims for 1/5th of total Blue membership accounted for $233 billion to the Blues for consolidating provider contracting.

[55] Varney, *supra* note 11, at 9.

[56] Wayne DeVeydt, EVP & CFO, Conference Call Regarding Proposal to Acquire Cigna, 14 (June 22, 2015) [hereinafter Anthem Conf. Call June 22, 2015].

[57] When asked at an investor conference discussing the merger if Anthem would feed Cigna's Florida membership to the local Blue, the CEO expressed optimism that they "will develop a model that works for all of Blue." Joseph Swedish, President & CEO, Anthem, Inc., Anthem Jt. Conf. Call July 24, 2015, *supra* note 47. He stressed the "incredibly collaborative" relationship that the Blues enjoy, and that "the Blue relationship will get stronger" as a result of the transaction. *Id.* at 8, 15. Earlier, he had said he thinks the other Blues "will view this as an opportunity to make the Blue, call it the Blue world, even stronger with respect to being able to leverage the assets and resources that will come to bear in the marketplace." Anthem Conf. Call June 22, 2015, *supra* note 56, at 15 (Joseph Swedish, President & CEO); *see also id.* at 14 ("I think there is will be [sic] general agreement that this transaction will strengthen the Blue organization, the Blue Association.").

[58] *Id.*

f. Competition Harmed by Blue Rules

The majority of Blue plans do not compete in the sale of their products.[59] Outside their assigned territories Blue plans have little or no *financial* incentive to contract with a separate provider network when the rates for another Blue plan's network are likely to be the lowest available (given Blue plans' widespread dominance).[60] Likewise, Anthem would have little or no incentive to ensure that an acquired Cigna contracted separately for a provider network when a Blue plan network is available to it because, as explained below, it too would have a severely limited opportunity to make sales outside of its territory and would likely face higher contracting costs. The absence of sales opportunities is a product of both the Association's rules and the terms of the Blue licensing agreements. The rules restrict each Blue plan to sales within a specific geographic territory. The license agreement prevents a Blue from selling or advertising Blue products and from contracting with providers outside of its assigned territories, called a Service Area.[61] While Blue plans may own non-blue subsidiaries, Association rules prevent those subsidiaries from growing large enough to pose a competitive threat to another Blue plan. That is because:

> Best efforts rules require that "at least 80% . . . of a licensee's annual combined local net revenue . . . attributable to health care plans and related services . . . must be sold . . . under the Blue Cross and Blue Shield names and marks . . . ."[62] Those rules also require that "at least 66 2/3% of a licensee's annual combined national net revenue . . . attributable to health care plans and related services must be sold . . . under the Blue Cross and Blue Shield names and marks . . . ."[63]

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[59] In Pennsylvania, California, Oregon and Washington, for example, different plans hold the "Cross" and the "Shield" licenses thereby allowing those plans some latitude to compete if they wish to do so. But even if they do compete in selling health plans, it's not clear to what degree they contract separately for their provider networks. Indeed, unless there is some modification to the BlueCard system, that system would seem to provide a template for the exchange of information regarding provider reimbursement rates between the Home and Host plans that could undermine the Home and Host Blues plans incentive to compete to establish separate networks. In any event, it appears that in the vast majority of territories, the "Cross" and "Shield" are unified in one licensee's hands and there are not separate networks.

[60] According to the Association License Agreement, plans are forbidden from contracting with providers outside their Blue Service Area, *supra* note 49, Ex. 4.

[61] Ass'n License Agreement, ¶ 1 (Association grants to the Plan the right to use Blue Cross name and marks in the sale, marketing and administration of health care plans (defined) in the Service Area defined in paragraph 5); *id.* ¶ 5 (The rights granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is defined as the Service Area, except to the extent the Service Area may overlap areas served by one or more other licensed Blue Cross Plans as of said date or subsequent license, as to which overlapping areas the rights granted are nonexclusive as to such other Plan or Plans only.); ¶ 6 (Except as provided with respect to National Accounts, Government Programs and certain other necessary uses, the Plan may not use the Licensed Marks and Names outside the Service Area.). *See also* Ass'n License Agreement, Ex. 1, ¶ 3; Ex. 4, ¶ 2.2; Ex. 3, ¶ 9.

[62] ANTHEM, INC., FORM 10-K, *supra* note 28, at 33.

[63] *Id.*

Notwithstanding congressional testimony suggesting otherwise, it is difficult to imagine a scenario in which Cigna would vigorously compete against non-Anthem Blue plans:[64]

- Anthem's statements that Cigna's membership will be Blue branded and deployed in collaboration with other Blue plans, combined with the Association's "best efforts" rules clearly belie that suggestion; [65]
- The real world example of Anthem's strategic decision to withdraw its non-blue branded products in Illinois and Texas because it could not garner sufficient provider discounts to compete successfully against the resident Blues, appears to make it even less likely that a non-blue branded product, even one with a more recognizable name, will continue to compete vigorously against Blue plans;[66]
- A combined Anthem/Cigna will share with other Blue plans proprietary provider network information through the pre-existing BlueCard system; this will likely result in less vigorous, if any, competition. That was the Department's conclusion in a similar case, *United States v. UnitedHealth Group*.[67] In that case, it found that, as the result of an acquisition, two large health insurers that had competed in the sale of commercial health insurance and the purchase of provider services would be able to share proprietary provider network information through a pre-existing joint venture.[68] The Department determined this would result in less vigorous competition, enjoined the exchange of non-public information relating to the two provider networks, and required the joint venture to dissolve.[69]

Even if Cigna did jockey against other Blue plans for some opportunities when the deal was closed, that would not introduce significant or assured new competition or mitigate the negative impact of increased barriers to entry and expansion for new or existing health plans.

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[64] "[I]n our … non-Blue states … Cigna will compete." *Examining Consolidation in the Health Insurance Industry and its Impact on Consumers: Hearing Before the S. Judiciary Subcomm. on Antitrust, Competition Policy and Consumer Rights*, 114th Cong. (Sep. 22, 2015) (statement of Joseph Swedish, President & CEO, Anthem, Inc.), available at http://www.c-span.org/video/ ?c4552279/swedish-best-efforts-rule-cigna.

[65] Anthem Conf. Call June 22, 2015, *supra* note 56.

[66] Indeed, Blue Cross asserted in federal court that it is "dubious … that, but for the challenged [Blue Cross] license agreements, other Blue plans would enter other service areas and compete . . .." Defs.' Reply to Pls.' Supplemental Submissions Regarding Case Mgmt. at 10, *In re* Blue Cross Blue Shield Antitrust Litig., No. 2:13-cv-20000-RDP (N.D. Ala. Sep. 22, 2015) [ECF No. 432].

[67] Complaint, No. 1:05-cv-02436 (D.D.C. filed Dec. 20, 2005) [ECF No. 1], available at http://www.plainsite.org/dockets/download.html?id=2833776&z=d3cb1301.

[68] *Id.* at ¶ 53.

[69] Final Judgment at VII, United States v. UnitedHealth Grp., No. 1:05-cv-02436 (D.D.C. May 23, 2006) [ECF No. 13], available at http://www.plainsite.org/dockets/download.html?id=2833776&z=d3cb1301. The United States required United to discontinue use of the Blue provider network entirely after a one-year transition period. *Id.*

II. INCREASING BARRIERS TO ENTRY RAISE MONOPOLIZATION CONCERNS

a. Small Group and Individual Plans Particularly Vulnerable

The Department's Entry Project raised concerns about provider network barriers to entry or expansion in the small or mid-sized employer market. These are the markets where it appears Blue plans dominate.[70] The Blue brand is an additional entry barrier in these markets. By increasing the number of lives that the Blue plans control, the acquisition not only increases the network and brand barriers to entry, it also raises concerns about monopolization.

The market segments for health insurance that the Department has targeted for enforcement actions have evolved with time and experience; however, it has consistently included small group and fully insured market segments, finding them to be particularly vulnerable to anticompetitive transactions.[71] For example, when a Blue plan paid the owners of a new entrant to stop competing, the Department focused on commercial group and commercial individual health insurance as the relevant product markets.[72] And, when the Department sued a Blue plan for preventing competitors from obtaining discounts that would allow them to compete more effectively, it named "commercial group" and "commercial individual" health insurance, "including access to a provider network," as relevant product markets.[73]

While all sized groups are sensitive to price increases, small groups are particularly sensitive to them:[74]

> [S]mall employers are less able to provide health coverage . . . because of the greater risk associated with small groups. Furthermore, such firms generally do not have the necessary administrative capacity to negotiate with multiple provider groups and handle all the day-to-day operational functions.[75]

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[70] While publicly available information does not disclose the precise shares of the Blue Cross plans in these segments, general information and the Blues' history of anticompetitive behavior support the widely-held belief that the Blues dominate these segments.

[71] The Division appears to always include small group fully insured customers in its market definition but to state a market that is no larger than all commercially fully insured customers.

[72] Complaint, at ¶ 20, United States v. Blue Cross & Blue Shield of Montana, No. 1:11-cv-00123 (D. Mont. Nov. 8, 2011) [ECF No. 1] [hereinafter U.S. v. BCBS-MT Compl.], available at http://www.justice.gov/atr/case-document/file/489571/download.

[73] Complaint, at ¶¶ 20, 22, United States v. Blue Cross Blue Shield of Michigan, No. 2:10-cv-14155 (E.D. Mich. Oct. 18, 2010) [ECF No. 1] [hereinafter U.S. v. BCBS-MI Compl.], available at http://www.justice.gov/atr/case-document/complaint-43.

[74] *See generally* Margot Sanger-Katz, *Medical Debt Often Crushing Even for Insured*, N.Y. TIMES, Jan. 6, 2016 at A1, available at http://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html?_r=0.

[75] BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., HEALTH INSURANCE: A PRIMER, 10 (Mar. 17, 2009), available at

To "help keep premiums affordable, small firms tend to offer coverage with higher deductibles."[76]

Similar observations may be made about individual health insurance: "Because individual health insurance is not subsidized by employers, each consumer pays the entire cost, deciding whether the coverage justifies the premiums. As a result, consumers in this market tend to be very price sensitive."[77] Yet, "individual insurance is expensive for what one gets . . . ."[78]

The Blue plans' dominance in these insurance markets appears to be corroborated by their success in the health insurance marketplaces, or exchanges. In the exchanges' first year of operation, Blue plans "account[ed] for almost half [48 percent] of all exchange products."[79] That initial lead will undoubtedly widen in the wake of the failure of a number of co-op competitors. To date, 12 of the 23 co-ops subsidized by the federal government have failed and two capped enrollment for 2016.[80] The only money-making co-op last year is now losing millions.[81] This is especially concerning because the exchanges were expected to provide a platform for new entry

https://www.jacksonhewitt.com/uploadedFiles/JacksonHewitt2014com/Content/Resource_Center/Healthcare_and_Taxes/Small_Employers/CRS-12-02-16-Health-Insurance-Primer-RL32237.pdf.

[76] AM.'S HEALTH INS. PLANS, SMALL GROUP HEALTH INSURANCE IN 2010: A COMPREHENSIVE SURVEY OF PREMIUMS, PRODUCT CHOICES, AND BENEFITS 3 (July 2011), available at http://www.ahip.org/AHIPResearch/.

[77] AM.'S HEALTH INS. PLANS, INDIVIDUAL HEALTH INSURANCE 2009: A COMPREHENSIVE SURVEY OF PREMIUMS, AVAILABILITY, AND BENEFITS 3 (Oct. 2009), available at https://webcache.googleusercontent.com/search?q=cache:eWLTugE40MMJ:https://www.ahip.org/Individual-Market-Survey-2007/+&cd=3&hl=en&ct=clnk&gl=us.

[78] Mark Pauly & Allison Percy, *Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets*, JOURNAL OF HEALTH POLITICS, POLICY AND LAW, 21 (Feb. 2000).

[79] MCKINSEY & CO., EXCHANGES GO LIVE: EARLY TRENDS IN EXCHANGE DYNAMICS 3-4 (Oct. 2013), available at http://healthcare.mckinsey.com/sites/default/files/Exchanges_Go_Live_Early_Trends_in_Exchange_Filings_October_2013_FINAL.pdf.

[80] Sabrina Corlette et al., *Why Are Many CO-OPs Failing?* COMMONWEALTHFUND.ORG 7 (Dec. 2015), http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf?la=en.

[81] Tom Murphy, *Lone Profitable ACA Insurance Co-Op Losing Millions*, ABCNEWS.GO.COM (Dec. 10, 2015, 4:41 PM ET), http://abcnews.go.com/Business/wireStory/lone-profitable-aca-insurance-op-losing-millions-35700296.

and greater competition.[82] Recent experience with the exchanges appears to reinforce the findings of the Entry Project that scale is crucial to successful entry and expansion.[83]

It is not only new entrants that will be impacted by this deal. Blue plan dominance makes it difficult even for established insurance companies to compete. For example, Aetna sued a Midwest Blue plan over its most favored nations (MFNs) contracts charging that the dominant local Blue plan[84] had "purchased protection from competition" through contracts that constrained "its competitors' ability to negotiate with hospitals."[85] The complaint explained that the dispute began when Aetna acquired HMS Healthcare and began to threaten the Blue plan's dominance.[86] The Blue plan sought to increase its rivals' costs by depriving Aetna of provider discounts.[87] Essentially, the Blue plan agreed to pay providers more if the providers increased their rates to competing health plans like Aetna.[88] Some contracts required that charges be at least as high as those for the Blue plan, while others required a 39 percent surcharge.[89] Providers acknowledged that they didn't "have a choice" and complied with Blue plan demands because it represented approximately one-third of their business.[90] To pay for this scheme, Aetna claimed the Blue plan increased premiums to consumers.[91]

We expect that the acquisition would increase the Blue plans' incentive and ability to pressure providers to raise their competitors' costs, thereby making it more difficult for those

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[82] *E.g.*, "I can help . . . a little bit on the background of the CO-Ops. One of the things—the problems we face and we are drafting legislation was that in certain states the availability of private insurance was limited to one provider or—I think in Alabama there was Blue Cross-Blue Shield dominated 90—over 90% of the market. In many states that was the situation, . . . but the idea was to create competition." Examining the Costly Failures of Obamacare's Co-Op Insurance Loans: Hearing Before the H. Energy & Commerce Subcomm. on Oversight and Investigations, 114th Cong. 53 (Nov. 5, 2015) (statement of John Yarmuth, Member, Subcomm. on Oversight and Investigations); "Congress established the CO-Ops to do a number of things that the private market had not done, and specifically, CO-Ops were created to compete with large . . . insurance companies, and hopefully put downward pressure on premium prices and certain parts of the country that have fewer or no insurance options. . . . particularly in rural – rural regions." *Id.* at 29 (statement of Rep. Pallone, Jr., Member, H. Energy & Commerce Committee), available at http://docs.house.gov/meetings/IF/IF02/20151105/104146/HHRG-114-IF02-Transcript-20151105.pdf.

[83] Varney, *supra* note 11, at 9; *see also*, Corlette et. al, *supra* note 80, at 19.

[84] Blue Cross controls at least 60% of the commercial health plan population in Michigan. Complaint, at ¶ 41, Aetna Inc. v. Blue Cross Blue Shield of Michigan, No. 2:11-cv-15346 (E.D. Mich. Dec. 6, 2011) [ECF No. 1][hereinafter Aetna Compl.], available at http://www.kslaw.com/Library/publication/HH121211_Aetna.pdf.

[85] *Id.* at ¶ 19.

[86] *Id.* at ¶ 2. Aetna grew its small group membership from 1500 to 27,000 and its fully insured membership from 4600 to 17,600 in two years. *Id.* at ¶ 25.

[87] *Id.* at ¶ 2.

[88] Rather than seek lower rates from providers, Blue Cross agreed to pay higher rates if the hospitals entered the exclusionary contracts, and threatened to pay lower rates if the hospitals declined. *Id.* at ¶ 4.

[89] *Id.*

[90] *Id.* at ¶ 21.

[91] *Id.* at ¶ 3.

competitors to maintain or grow their insurance business. Absent that pressure, we would expect premiums for consumers to increase, particularly in the small group and individual segments

b. Some Blue Plans' Marketing Practices Raise Competitive Concerns

There are other examples of contracting practices by dominant Blue plans that illustrate how they can abuse their dominance to limit entry, raise rivals' costs and harm consumers and providers:

- The Department accused a Blue plan of using MFN terms to exclude or reduce "the ability of other health insurers to compete" and to raise "prices paid by Blue Cross' competitors";[92]
- The Department investigated the anticompetitive use of MFNs by Blue plans in seven other states.[93] Following that investigation, at least 20 states passed legislation restricting insurer use of MFNs in provider contracts; and
- The Department sued a Midwest Blue plan to prevent its acquisition of a local health plan because it would have harmed "the quality of health care delivered to consumers" by giving the Blue plan "the ability to control physician reimbursement rates."[94]

c. Excessive Capital Reserves Backstop Abuses of Market Power

As dominant firms, Blue plans have strong incentives to foreclose rivals because they have more to lose than any other plan from entry or expansion that introduces competition. And many Blue plans may have the financial ability to defeat new or expanding competitors by employing what appear to be excessive capital reserves. The National Association of Insurance Commissioners developed a model for minimum surplus levels, and set it at 200 percent of risk-based capital authorized control level (RBC-ACL). The Association, however, requires 800 percent or greater ACL and liquidity of two months or greater if a Blue plan does not participate in a state guaranty fund.[95] In 2013, at least 17 Blue plans maintained a surplus in excess of 1,000 percent of RBC, for a total of $57.8 billion and an average of 946 percent RBC.

Blue plans appear to have exploited their excess capital in some known instances. For example, in one western state, six hospitals started a health insurance company to compete directly against the Blue plan.[96] The new company put pressure on the Blue plan to offer lower

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[92] U.S. v. BCBS-MI Compl., *supra* note 73.

[93] Jeff Bliss & Tom Schoenberg, *Blue Cross Blue Shield Probe Expanded by Justice Department*, BLOOMBERG BUSINESS (Mar. 26, 2011 12:01 AM EDT), http://www.bloomberg.com/news/articles/2011-03-26/u-s-expands-antitrust-probe-of-blue-cross-blue-shield-hopital-contracts.

[94] Press Release, U.S. Dep't of Justice, Blue Cross Blue Shield of Michigan and Physicians Health Plan of Mid-Michigan Abandon Merger Plans 1 (Mar. 8, 2010), http://www.justice.gov/sites/default/files/atr/legacy/2010/03/08/256259.pdf.

[95] IRS Memo, *supra* note 49 at 10.

[96] U.S. v. BCBS-MT Compl., *supra* note 71.

prices and provide better service. The Department charged that the Blue plan, rather than compete on the merits, paid the company $26.3 million and gave it two board seats to secure its cooperation in limiting competition.[97] The new company was expected to buy Blue Cross insurance for its own employees and otherwise cease competition with the Blue plan.[98] The Blue plan was presumably able to do this because its parent Blue held $10.3 billion in RBC, or 1,228 percent more than required.[99]

d. Market Power Drives Higher Rate Increases

A recent study looking at pricing changes on 34 state exchanges found that the "largest insurance company in each state on average increased their rates 75 percent more than smaller insurers in the same state," and increases did not appear to be related to higher medical costs.[100] "In most states insurers with large market share [overwhelmingly Blue plans] have proposed rate increases in excess of 20 percent for next year."[101] These studies seem to suggest that Blue premiums are higher in states where they are dominant and any network efficiencies they enjoy as a result do not translate into lower premiums for consumers.

- New Mexico ─ the Blue plan requested a 52 percent increase.[102]
- North Carolina ─ the Blue plan sought an average increase of 26 percent and the Blue plan's individual rates are increasing by 32.5 percent for 2016.[103]
- Illinois ─ the Blue asked for an average increase of 29 percent for its HMO plan and 38 percent for its PPO plans.[104]
- Pennsylvania and Maryland ─ the Blue plan asked for 30 percent increases.[105]

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[97] *Id.*

[98] *Id.*

[99] BEST 2014 HCSC Report, *supra* note 54, at 2.

[100] Wang & Gee, *supra* note 38, at 1.

[101] Republican Policy Committee, *Cost of Obamacare Plans Skyrocketing*, Factiva, June 2, 2015, at 1, available at https://medium.com/@Senate_RPC/cost-of-obamacare-plans-skyrocketing-b1a7630683b0#.dftd7pdow.

[102] Grace-Marie Turner, *Families brace for steep hikes: Opposing view*, USA TODAY, Aug. 11, 2015, available at

http://www.usatoday.com/story/opinion/2015/08/11/affordable-care-act-health-insurance-premiums-editorials-debates/31480355/.

[103] *North Carolina Rate Review Submissions*, HEALTHCARE.GOV, https://ratereview.healthcare.gov/ (click on "search aca-compliant products" box; then choose "North Carolina" as the state; then click "submit search"; sort by "effective date" 2016; scroll down to "Blue Cross and Blue Shield of NC" to see final rate increase) (last visited Jan. 13, 2016).

[104] Wes Venteicher and Ameet Sachdev, *Some steep increases in health premiums expected in Illinois in 2016*, CHICAGO TRIBUNE, June 1, 2015, available at http://www.chicagotribune.com/news/local/breaking/ct-obamacare-insurance-rates-20150601-story.html.

[105] Gail R. Wilensky, *2016 Exchange Rate Hikes: How Big Will They Be?*, HEALTHCARE FIN. MGMT., July 1, 2015, at 2, http://www.hfma.org/Content.aspx?id=31859.

- Alabama ─ the Blue plan asked for average increases of 28 percent.[106]
- Alaska ─ the Blue plan requested 39 percent average increases.[107]
- Arizona ─ the Blue plan requested a 21 percent increase.[108]
- Idaho ─ the Blue plan requested a 24 percent increase.[109]
- Kansas ─ the Blue plan asked for average increases of 38 percent.[110]
- Montana ─ the Blue plan requested a 23 percent increase.[111]
- Oklahoma ─ the Blue plan requested increases from 23 to 44 percent.[112]
- Tennessee ─ the Blue plan was approved for a 36.3 percent average increase.[113]

Anthem requested exchange premium increases of more than 10 percent in California, Connecticut, Georgia, Kentucky, New York, and Virginia.[114] Despite its higher premiums in the individual market, and despite losing some share to lower-priced competitors, Anthem declared that "we will not chase price to buy membership."[115]

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[106] Amy Yurkanin, *Health insurance rates could rise substantially in Alabama*, AL.COM, June 2, 2015, available at http://www.al.com/news/index.ssf/2015/06/alabama_health_insurance_compa.html.

[107] *Individual Plan Holders in Alaska Will See Higher Premium Rates in 2016*, PREMERA NEWS, June 1, 2015, available at http://premeranews.com/2015/06/01/individual-plan-alaska-higher-rates-2016/.

[108] Ken Alltucker, *Health insurers seek rate increases of up to 27 percent*, THE ARIZONA REPUBLIC, June 5, 2015, available at http://www.azcentral.com/story/money/business/consumer/2015/06/06/health-insurers-seek-rate-increases/28587791/.

[109] Samantha Wright, *Blue Cross Of Idaho Asks For Rate Hike, Says More People Are Using Health Care*, BOISE STATE PUBLIC RADIO, June 10, 2015, available at http://boisestatepublicradio.org/post/blue-cross-idaho-asks-rate-hike-says-more-people-are-using-health-care.

[110] Dave Ranney, Insurance department predicts jump in 2016 health premiums; official says insurers seeking rate increases in wake of new Affordable Care Act requirements, KHI News Service, May 26, 2015, available at http://www.khi.org/news/article/insurance-department-predicts-jump-in-2016-premiums.

[111] Eric Whitney, *Daines Misstates Obamacare Price Increases*, MONTANA PUBLIC RADIO, June 7, 2015, available at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjg--OhrJbLAhXBHB4KHZUtCZgQFggcMAA&url=http%3A%2F%2Fmtpr.org%2Fpost%2Fdaines-misstates-obamacare-price-increases&usg=AFQjCNEs3x8uYdPtGs06r4Y30WGEzH1WLw&bvm=bv.115339255,d.dmo.

[112] Republican Policy Committee, *supra* note 101, at 1-2.

[113] Holly Fletcher, *ACA Rate Hikes May Not Cover Losses*, THE TENNESSEAN (Aug. 21, 2015), http://www.tennessean.com/story/money/industries/health-care/2015/08/21/aca-health-insurance-rate-decision/32059577/

[114] HEALTHCARE.GOV, https://ratereview.healthcare.gov (search by state, then sort by year).

[115] Joseph Swedish, President & CEO, Anthem, Inc., Q3 2015 Anthem Inc. Earnings Call 8 (Oct. 28, 2015) (Anthem lost 99,000 individual lives in Q3, does not predict that to slow down in Q4, and expects it to continue into 2016). Wayne DeVeydt emphasized that "we are still making money in our individual book and making margins that we think are sustainable margins." *Id.* at 16. Available at http://seekingalpha.com/article/3614856-anthem-antm-joseph-r-swedish-q3-2015-results-earnings-call-transcript?all=true&find=joseph%2Bswedish.

CONCLUSION

We fully expect that the Department will examine the impact of Anthem's acquisition on competition, including the increase in barriers to competition described in this letter, in the states where Anthem is the Blue plan and its control over the Cigna lives post-acquisition would be absolute. It is also important that the Department investigate the potential impact of this transaction on states and localities where Anthem is not the Blue plan. That is because the goal of reforming the health care system cannot be met "if dominant insurers use exclusionary practices to blockade entry or expansion by alternative insurers."[116] This deal, in particular, threatens to undermine reform by, among other things, discouraging or blocking entirely new entry and entrenching already dominant insurers across the nation. For those reasons, and those previously detailed in our letter, we urge the Department to challenge it.

Sincerely,

/s/

Melinda Reid Hatton
Senior Vice President & General Counsel

[116] Varney, *supra* note 11, at 3.