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Insurance Mergers: Efficiencies and Monopsony Power

The Anthem-Cigna Litigation

Jon B. Jacobs[1]
Perkins Coie LLP
700 13th Street, NW, Suite 600
Washington, DC 20005-3960

Laura K. Hennessey
Perkins Coie LLP
1201 Third Avenue, Suite 4900
Seattle, WA 98101-3099

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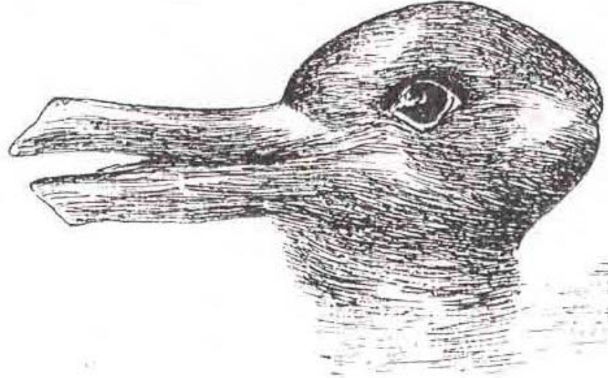
[1] Jon Jacobs was lead trial counsel for the United States in the *U.S., et al. v. Anthem, Inc.* litigation in the district court.

I. The conundrum: Is it a duck? Or is it a rabbit?

A popular kind of optical illusion allows you to see two very different things in the same image. For example, the following can be seen as both a duck and a rabbit:



An "optical illusion" of sorts arose in the litigation challenging Anthem Inc.'s proposed $54 billion acquisition of Cigna Corporation. Anthem's primary defense was that it would achieve over $2 billion in medical network savings by negotiating lower reimbursement rates with hospitals and doctors. All of these savings would pass through to self-insured employers that pay directly for the medical expenses of their employees, resulting in lower health care expenses that would benefit consumers. Anthem looked at these lower reimbursement rates and saw them as an "efficiency."

The Department of Justice looked at these lower rates and saw something completely different. It had challenged the merger to protect competition not only in markets for the sale of health insurance, but also in markets for the purchase of healthcare services from hospitals and doctors. It believed that Anthem and Cigna, by merging and acquiring more bargaining leverage over healthcare providers, would have the market power to decrease reimbursement rates and cause harm to hospitals, doctors, and the quality of care provided to patients. DOJ looked at these lower reimbursement rates and saw them as an exercise of "monopsony power."

When looking at the image above, it is easy to answer the question, "is it a duck or a rabbit?" It is both. When looking at the purchasing cost savings at issue in the *Anthem* litigation, it was much harder to answer the question, "are they an efficiency or evidence of monopsony power?" This article describes how each side argued their case on this issue and how it was handled by both the District Court and the Court of Appeals. It concludes by discussing four questions for future cases in which this issue may arise.

II. Factual background of the Anthem/Cigna transaction

On July 24, 2015, Anthem announced its acquisition of Cigna. It represented a merger between the second and third largest health insurance carriers in the country. Just three weeks earlier, on July 3, 2015, Aetna had announced its proposed acquisition of Humana for $37

billion. Together, these transactions would have reduced the number of nationwide health insurers from five to three.

The relevant markets affected by the two deals, however, were very different. The Aetna/Humana transaction was challenged because of alleged harm in markets for the sale of health insurance to individuals—specifically, Medicare Advantage plans and those sold on the exchanges established under the Affordable Care Act ("ACA").[2] The challenge to the Anthem/Cigna merger focused on the sale of group health insurance to employers. Commercial group sales are made to either "small group" or "large group" employers. Small group employers are often defined as those with 50 or fewer employees, and the market to sell health insurance to small groups is more highly regulated by state departments of insurance. The *Anthem* case focused on the sale to large groups, as well as to "national accounts"—large group employers with employees located in more than one state.

Anthem and Cigna competed vigorously against each other to sell health insurance to large group employers, including national accounts. Both Anthem and Cigna offered broad networks of hospitals and doctors across the country. Like other health insurers, they pre-negotiated reimbursement rates that providers agreed to accept in exchange for the provision of medical services. A very high percentage of their large-group employer customers were self-insured, meaning they paid the medical expenses for their employees directly. Self-insured employers paid an Administrative Services Only (or "ASO") fee to the carrier to compensate the carrier for processing the medical claims incurred by its customers' employees.

Anthem itself was not a nationwide health insurer like Cigna. But it was a member of the Blue Cross Blue Shield Association ("BCBSA"), which licenses different companies to sell health insurance under the Blue trademarks in specified geographic territories around the country. Anthem was the largest Blue licensee, selling under the Blue Cross or Blue Shield trademarks (or both) in 14 different states. Through the so-called "Blue Card" network, which included not only the medical networks in its 14 states but the networks of all other Blue licensees, it was able to offer employers access to a nationwide network of doctors and hospitals.

In general, Anthem and its affiliated Blue plans had negotiated lower reimbursement rates than had Cigna. Blue Cross and Blue Shield plans are typically among the largest health plans in their respective markets, and that size gives them the ability to obtain lower rates in exchange for bringing higher volumes of patients to doctors and hospitals. By contrast, though Cigna operates nationwide, its enrollment is often much smaller in each individual market.

This pre-merger disparity in reimbursement rates was important to how Anthem calculated its purported $2 billion in savings. Using what it called a "best-of-best" approach, it assumed that, post merger, it could apply the lower of the two reimbursement rates in each market (usually Anthem's, but sometimes Cigna's) to all of the members of the merged company.

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[2] Complaint, *United States, et al. v. Aetna, Inc., et al.*, No. 1:16-cv-01494, ECF No. 1 (D.D.C. July 21, 2016), available at https://www.justice.gov/atr/file/878196/download.

Shortly after the transaction was announced, the DOJ began its investigation. On July 21, 2016, almost exactly one year later, DOJ filed its lawsuit. Twelve states joined DOJ on the complaint. Plaintiffs alleged competitive harm in several markets:

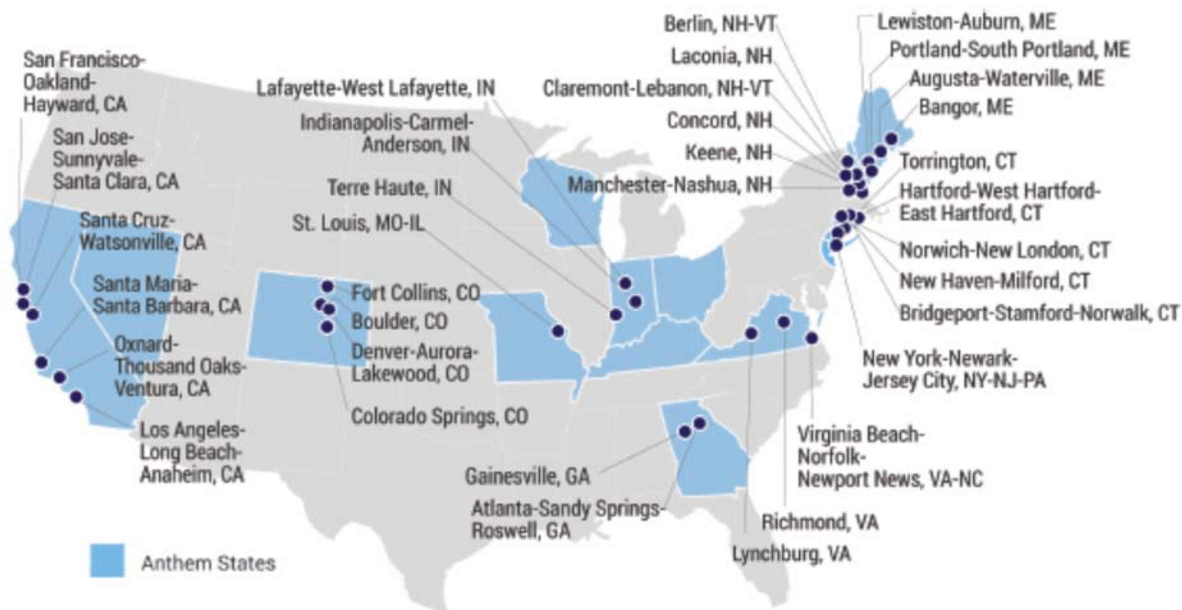
(i) the sale of health insurance to national accounts, both nationwide and in a separate geographic market composed of the 14 states in which Anthem held a BCBSA license;

(ii) the sale of health insurance to large group employers in 35 different local markets around the country;

(iii) the sale of health insurance to individuals in St. Louis and Denver through the ACA public exchanges (a claim Plaintiffs later dropped to streamline the case); and

(iv) the purchase of healthcare services by commercial health insurers in the same 35 local markets alleged with respect to the sale of insurance to large group employers.[3]

Plaintiffs' monopsony case focused on the fourth market, claiming that the transaction would enhance Anthem's leverage over doctors and hospitals and result in lower reimbursement rates for healthcare services. The 35 local markets in which Plaintiffs alleged harm both to large-group employers and to healthcare providers were identified by this map in the Complaint:



[3] Complaint ¶ 8, *United States, et al. v. Anthem, Inc., et al.*, No. 1:16-cv-01493, ECF No. 1 (D.D.C. July 21, 2016) ("Complaint"), available at https://www.justice.gov/atr/file/903111/download.

Anticipating the fight over how to characterize these lower rates, the Complaint alleged that "[t]o the extent the merging parties anticipate cutting the reimbursement rates paid to doctors and hospitals for their services as a result of the merger, these reductions stem from a reduction in competition and may not be treated as efficiencies."[4]

III. Arguments in the district court

Trial began on November 21, 2016 before U.S. District Court Judge Amy Berman Jackson. Judge Jackson bifurcated the presentation of the evidence into two phases. In Phase I, she heard evidence relevant to Plaintiffs' national accounts case. In Phase II, she heard evidence on the two claims arising in the 35 local markets.

Shortly after testimony began on Plaintiffs' monopsony case in Phase II, Judge Jackson asked the parties to brief the legal standards for proving a monopsony case. On December 19, 2016, both sides filed their briefs on this issue.[5] Much of their arguments on the issue of how to characterize the lower reimbursement rates (as an efficiency or as evidence of monopsony power) are included in those filings.

A. Anthem's argument: it's an efficiency

Anthem argued that Plaintiffs could prevail on their monopsony claim only if they proved two things: (i) that the lower reimbursement rates fell below providers' long-run marginal costs; and (ii) that the lower rates reduced the output of healthcare services. Otherwise, Anthem contended, the lower reimbursement rates represented an efficiency and a benefit to consumers.[6]

To support its argument about long-run marginal cost, Anthem relied primarily on predatory pricing and predatory bidding cases.[7] These cases, Anthem argued, provide the best guidance on when prices are considered to be "too low" under the antitrust laws. The First Circuit's opinion in *Kartell* is particularly instructive, it stressed, because that case addressed monopsony purchasing by a Blue Shield licensee. In that opinion, Judge (now Justice) Breyer emphasized that Congress had "enacted the Sherman Act . . . as a way of protecting consumers against prices that were too *high,* not too low."[8] Citing the below-cost predation tests of those

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[4] *Id.* ¶ 77.

[5] Anthem's Memorandum on the Role of Rates and Output Evidence in Plaintiffs' Monopsony Case, *United States v. Anthem, Inc.*, No. 1:16-cv-01493, ECF No. 411 (D.D.C. Dec. 19, 2016) ("Anthem's Buy-Side Memorandum"); Plaintiffs' Supplemental Memorandum on the Buy-Side Case, *United States v. Anthem, Inc.*, No. 1:16-cv-01493, ECF No. 410 (D.D.C. Dec. 19, 2016) ("Plaintiffs' Buy-Side Memorandum").

[6] Anthem's Buy-Side Memorandum at 1-2.

[7] Anthem Buy-Side Memorandum at 2 (citing *Brooke Grp. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209 (1993); *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lumber Co.,* 549 U.S. 312 (2007); *Kartell v. Blue Shield of Mass.,* 749 F.2d 922 (1st Cir. 1984)).

[8] *Kartell,* 749 F.2d at 931.

cases, Anthem argued that the test should be the same in assessing monopsony claims in a merger case.

For Anthem, the proxy for marginal cost in this industry was the level that Medicare reimbursed doctors and hospitals. In fact, the parties stipulated that Medicare, in setting its reimbursement rates, at least intended to cover the costs that "reasonably efficient providers would incur in furnishing care."[9] Because it was undisputed that Anthem's reimbursement rates, even after the merger, would remain well above the level of Medicare's rates, Anthem argued that its anticipated savings should be characterized as a procompetitive efficiency and not as an exercise of monopsony power.

The second test that Anthem posited for distinguishing between efficiency and monopsony related to the effects on output. It argued that the essential harm to the exercise of monopsony power was that a buyer with additional market power would reduce the level of its purchases below the competitive level. Therefore, in this case it argued that its medical network savings should be considered a monopsony only if purchases of medical services would fall after the merger.[10] Anthem argued that the exact opposite would occur if reimbursement rates fell. If that happened, medical care would become cheaper and employees would likely seek out more care instead of less.[11]

Anthem also made a public policy argument, noting that prices for medical care services had more than doubled since 1999 and that there was tremendous inefficiency and waste in the operation of hospitals and doctors.[12] These rising costs were an additional reason why the court should allow the merger to go through, so that Anthem could achieve lower health care costs for consumers.

B. Plaintiffs' argument: it's an exercise of monopsony power

Plaintiffs countered with their own arguments. First, with respect to Anthem's public policy argument, they argued that it was "irrelevant as a matter of law."[13] Plaintiffs argued that antitrust law was grounded in a "faith in the value of competition" and that arguments about whether competition was good or bad in a particular industry were irrelevant.[14] Anthem's efficiencies defense, in Plaintiffs' view, was nothing more than a suggestion by Anthem "that it

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[9] Plaintiffs' Buy-Side Memorandum at 8.

[10] Anthem's Buy-Side Memorandum at 9-10 (*quoting Kartell,* 749 F.2d at 927 ("the single harm most likely to accompany the existence of market power on the buying side of the market" is "lower seller output")).

[11] *Id.*

[12] *Id.* at 2.

[13] Plaintiffs' Buy-Side Memorandum at 2.

[14] *Id.* at 2 (quoting *Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 695 (1978)).

will cure rising healthcare costs by supplanting competition and replacing the judgment of Congress with its own promise to lower prices."[15]

Plaintiffs' test for distinguishing between efficiency and monopsony was very different from Anthem's tests. It had nothing to do with marginal costs, or any specific price levels, or the effects on output. For Plaintiffs, the key was market power. They claimed that all they needed to prove to win their monopsony claim was that Anthem would acquire enhanced market power and leverage over doctors and hospitals in the market to purchase their medical services. "It is the creation or enhancement of market power, and the resulting risk of anticompetitive harm, that makes a merger unlawful under Section 7."[16] "Because monopsony is the mirror image of monopoly, similar legal standards apply to antitrust claims involving buy-side markets."[17] Therefore, proof that the merger would significantly increase Anthem's share of the market for the purchase of health insurance to anticompetitive levels would be sufficient to state a prima facie case.

The fact that Anthem would obtain more bargaining leverage over doctors and hospitals was not at issue in the case. Anthem's principal expert economist testified at his deposition that "Anthem and these providers are pushing against each other in these negotiations as hard as they can. And the merger changes the outcome of the pushing."[18]

Plaintiffs argued that they need not prove that reimbursement rates would fall below the marginal costs of providers or below any other predetermined price point. Relying again on the "mirror image" principle, they argued that there is no requirement to show that prices will likely increase by a certain amount when litigating sell-side cases. Rather, the test is whether prices would increase by an amount greater than they would *but for* the merger. Therefore, the same should be true in buy-side cases; the test should be whether prices in the upstream market "are likely to be 'lower than they would have been but for' the challenged act."[19]

Plaintiffs also argued they need not prove a reduction in output—or, indeed, any harm to consumers in the downstream market. They cited case law supporting the view that "suppliers . . . are protected by antitrust laws even when the anti-competitive activity does not harm end-users."[20] Plaintiffs argued that they would offer evidence of downstream harm in the form of

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[15] *Id.*

[16] *Id.* at 4-5.

[17] *Id.* at 5 (quotation omitted).

[18] Transcript of Bench Trial at 21:19-23, *United States, et al. v. Anthem, Inc., et al.*, No. 1:16-cv-01493, ECF No. 444 (D.D.C. Jan. 13, 2017) (Plaintiffs' Opening Statement, made on November 21, 2016).

[19] Plaintiffs' Buy-Side Memorandum at 6-7 (quoting *Todd v. Exxon Corp.*, 275 F.3d 191, 214 (2d Cir. 2001)).

[20] *Id.* at 10 (quoting *Telecor Commc'ns v. Sw. Bell Tel.*, 305 F.3d 1124, 1133 (10th Cir. 2002)).

lower output and lower quality of medical care, but asserted that they had no legal obligation to do so.

In sum, the parties differed sharply on the issue of how to distinguish efficiency from monopsony when looking at reduced provider reimbursement rates. According to Anthem, Plaintiffs had to prove a decrease in rates below marginal cost and a reduction in output in order to prove monopsony. According to Plaintiffs, they only needed to prove what they would have to prove in a comparable sell-side case: a sufficient increase in market power and market concentration, and an effect on pricing that would not occur "but for" the merger.

IV. The District Court opinion

On February 8, 2017, Judge Jackson issued a permanent injunction against the merger. In her opinion, however, she did not address Plaintiffs' monopsony case or this characterization issue head on. Instead, she found for the Plaintiffs based on two other relevant markets— the sale of health insurance to national accounts, and the sale of insurance to large group employers in Richmond, Virginia. With that, she concluded that she "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."[21]

Though Judge Jackson did not directly pass judgment on whether Anthem's claimed purchasing cost savings were an efficiency or an exercise of monopsony power, she rejected Anthem's efficiencies arguments on other grounds.

First, she found Anthem's claimed efficiencies were not merger specific because they involved applying "pricing that one or the other of the companies *has already achieved* alone" and were "not dependent upon the delivery of new members to the providers."[22] She found that the bulk of the claimed savings would come from the mere "rebranding" of Cigna customers forced to switch to an Anthem-branded Blue Cross offering.[23] The Horizontal Merger Guidelines define merger-specific efficiencies as ones that are "unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects."[24] Because most of the savings would come from applying Anthem's generally lower reimbursement rates to Cigna customers acquired through the merger, those lower rates already existed in the market and the merger was not necessary to achieve them. As Judge Jackson noted, "[n]ot one penny of these savings derives from anything new, improved or different that

[21] *United States v. Anthem, Inc.*, 236 F.Supp.3d 171, 179 (D.D.C. 2017).

[22] *Id.* at 237-43.

[23] *Id.* at 239-41. The BCBSA requires its licensees to derive a certain percentage of its revenue from Blue-branded business. Because Anthem would violate those guidelines upon its acquisition of Cigna, it was very likely that Anthem would try to rebrand at least some of Cigna's members as Blue Cross members to come back into compliance. *Id.*

[24] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 10 (2010), *available at* https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf.

the combined company would bring to the marketplace that neither company can achieve alone."[25]

Second, Judge Jackson concluded that Anthem's claimed savings were not verifiable. Citing internal Anthem documents, the court found that Anthem's integration plans had not progressed very far, and that many within Anthem were concerned about its ability to extract lower rates from some of its providers, especially at a time when Anthem was also seeking to develop a closer relationship with those providers. Because the chance of provider resistance was high, Judge Jackson concluded that Anthem had not verified its medical network savings claims.[26]

However, her opinion is not completely silent on the characterization issue. She noted that it was "questionable" and that she had "serious doubts" about whether these medical cost savings were "efficiencies at all."[27] They were not tied to "either company doing anything better, or from the elimination of duplication or the creation of new demand."[28] Instead, the savings largely resulted from the mere transfer of Anthem's already-negotiated lower rates to Cigna's customer base. Moreover, the savings were not the result of operating or administrative efficiencies the merged company would gain, nor were they tied to "increased output" or "enhanced quality."[29] Thus, although Judge Jackson did not decide the issue, she signaled some sympathy with Plaintiffs' view that the medical cost savings should not be considered efficiencies at all.

V. <u>The Court of Appeals opinion</u>

Anthem appealed the District Court's injunction solely on its rejection of the purchasing cost savings defense. Anthem argued that Judge Jackson erred by rejecting a "consumer welfare standard."[30] Anthem asserted that "the District Court's decision furthers the faulty 1960's logic that 'big is always bad' even when it concerns a transaction that all parties acknowledge is likely to lower costs for American businesses and make healthcare more affordable for U.S. employers and their employees."[31] Anthem also argued that its medical cost efficiencies were merger

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[25] *Anthem,* 236 F.Supp.3d at 238.

[26] *Id.* at 243-45.

[27] *Id.* at 249-51.

[28] *Id.* at 251.

[29] *Id.*

[30] *See* Brief for Defendant-Appellant Anthem, Inc. at 10-16, *United States v. Anthem, Inc.*, Case No. 17-5024 (D.C. Cir. Feb. 13, 2017).

[31] *Id.* at 15.

specific, notwithstanding the District Court's conclusion to the contrary. The merger was necessary, it said, to achieve a combination of "the best of both companies."[32]

On April 28, 2017, a three-judge panel of the U.S. Court of Appeals for the D.C. Circuit affirmed the injunction by a 2-to-1 vote.[33] Writing for the Court, Judge Judith Rogers limited her opinion to the issues of merger specificity and verifiability, finding that the District Court had not abused its discretion in rejecting Anthem's claimed efficiencies on those grounds.[34] Therefore, like Judge Jackson below, the majority did not specifically reach the characterization issue.

But Judge Patricia Millett did in her concurring opinion. She emphasized that "to have any legal relevance, a proffered efficiency cannot arise from anticompetitive effects," and instead "must at least neutralize if not outweigh the harm caused by the loss of competition and innovation."[35] Second, Judge Millet pointed out that buying a product at a lower cost due to greater bargaining power is not a procompetitive efficiency when the only effect is to transfer income from a seller (here, doctors and hospitals) to a buyer (Anthem) without any resource savings.[36] "Ultimately, the judicial task here is not to favor cost redistribution or any other economic agenda for its own sake," Judge Millett concluded, "[o]ur task is to enforce [the] legislative judgment" to enjoin mergers that substantially lessen competition.[37]

Judge Brett Kavanaugh dissented, contending that the District Court committed clear error in rejecting Anthem's efficiencies defense.[38] Finding that the purchasing cost savings were "merger-specific by definition" and "sufficiently verified" at trial, he would have remanded to the District Court for determination of the characterization issue.[39] In his view, if the claimed purchasing savings were correctly classified as an efficiency, then the merger's benefit would clearly outweigh the harm. If, however, Plaintiffs were correct that the purchasing savings would stem from the merged entity's monopsony power in the upstream market, then the decision to enjoin the merger should be upheld.[40] But Judge Kavanaugh gave very little guidance on how he would distinguish between the two. For him, the key was whether

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[32] *Id.* at 24-35.

[33] *United States v. Anthem, Inc.*, 855 F.3d 345 (D.C. Cir. 2017).

[34] *Id.* at 356-64.

[35] *Id.* at 369 (Millet, J., concurring).

[36] *Id.* at 371.

[37] *Id.*

[38] *Id.* at 374-75 (Kavanaugh, J., dissenting).

[39] *Id.* at 374-75, 377-78.

[40] *Id.* at 377-78.

Anthem's post-merger provider rates would fall "below competitive levels,"[41] but he did not define how that competitive level should be determined.

VI. Takeaways for future cases

We conclude with four questions for future cases.

1. So which is it, a duck or a rabbit? Will we ever know?

We may not. This characterization issue was not decided in *Anthem*, and it may never be decided. There are multiple ways a court can dismiss an efficiencies defense. It can decide that efficiencies are not merger specific, not verifiable, or not likely to be passed through to consumers in the relevant markets. In *Anthem,* that last factor was not a significant issue because the affected customers, self-insured employers, pay the medical expenses of their employees directly. But merger specificity and verifiability were still issues, and the District Court elected to dismiss Anthem's efficiencies on those grounds only.

2. What effect, if any, will the Anthem opinions have on future cases?

Although neither the District Court nor the Court of Appeals decided the characterization issue, the opinions are friendlier to plaintiffs than defendants on the issue. Judge Jackson's opinion included very strong dicta questioning whether Anthem's purchasing cost savings were "efficiencies at all."[42] And Judge Millett made it clear that she does not believe true efficiencies can result from an exercise of market power.[43] Judge Kavanaugh agreed with Anthem's arguments on merger specificity and verifiability, but deferred on the characterization issue. Because the only two judges expressing a view on the issue agreed with Plaintiffs, the opinions may influence future courts (if they choose to decide the issue) to characterize purchasing cost savings as evidence of monopsony power instead of an efficiency.

3. Should defendants forego a purchasing savings defense?

Merging parties may fairly ask whether it is worth proffering purchasing cost savings as an efficiency. Will doing so merely cause plaintiffs to add a monopsony count to their complaint?

The answer to that question, like most answers to questions about antitrust risk, is "it depends." But Plaintiffs' arguments in *Anthem*, as well as a passage in the Merger Guidelines, provide guidance on a possible safe harbor. For Plaintiffs, the key was market power. In both a sell-side case and a buy-side case, it is "the creation or enhancement or market power, and the resulting risk of anticompetitive harm, that makes a merger unlawful under Section 7."[44] And

[41] *Id.*

[42] 236 F.Supp.3d at 251.

[43] 855 F.3d at 369 (Millett, J., concurring).

[44] Plaintiffs' Buy-Side Memorandum at 4-5.

the Merger Guidelines, in the section on mergers of competing buyers, recognize that a "[r]eduction in prices paid by the merging firms not arising from the enhancement of market power can be significant in the evaluation of efficiencies from a merger."[45]

Therefore, perhaps the only safe harbor is one in which the combined purchasing shares of the two firms in the upstream market, properly defined, fall below the level that raise competitive issues under the Merger Guidelines and the case law. All other claims about purchasing cost savings will face varying degrees of risk.

4. What factors are future courts likely to use in deciding this issue?

Again, there are no clear cut rules of law in this area. But different tests and guidelines offered by the litigants and judges in *Anthem* may provide guidance for courts in future cases. Relevant questions to consider include:

- Would the merging parties' combined share of purchases in the upstream market, properly defined, create a presumption of harm, under the "mirror image" principle?
- Would the merger likely cause upstream prices to fall?
- Would those prices fall below the upstream suppliers' (long-run) marginal costs?
- Would the merging parties reduce the amount of their purchases post-merger, causing output to fall?
- Why would upstream prices fall? Because:
  - The merging parties would be able to exercise greater bargaining leverage?
  - The merging parties would qualify for a volume discount offered by the sellers?
  - The costs of selling to the merging parties would decrease due to some resource savings?
- Would the price effect simply be a transfer of money from upstream suppliers to the merged firm, with few other effects?

[45] HORIZONTAL MERGER GUIDELINES § 12.