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January 2016

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States Launch Hearings on Major Insurance Company Mergers

By James M. Burns

This summer, in the space of only a few weeks, Aetna announced an intention to acquire Humana, followed by an announcement by Anthem that it was planning to merge with Cigna. As was widely reported at the time, if consummated, the deals would transform the current "Big Five" national health insurers into a "Big Three" of Aetna, Anthem and United Healthcare. However, as the parties acknowledged, before the deals could be completed regulatory approvals at both the federal and state levels would be required. For this reason, the parties announced a targeted date of late 2016 for closing the deals.

Since the announcements, the parties have been hard at work seeking the necessary regulatory approvals, in addition to gaining shareholder approval for the transactions, which has now been obtained. This past fall most of the early attention was focused at the federal level. Congress held hearings on the mergers in October, calling the CEOs of the merging parties to Washington to testify about the transactions, even though Congress plays no formal role in the review process. The Department of Justice (DOJ) Antitrust Division, which is the federal regulator that will ultimately approve or challenge the deals, issued "second requests" to the parties in each deal, requiring them to produce additional information so that the Antitrust Division could

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further study the potential competitive implications of the transactions. Since then, the Antitrust Division has quietly continued its work, providing little indication – at least so far – of where their analysis is leading, when it may be completed and, most significantly, how the Antitrust Division will ultimately come out on either of the transactions.

As activity at the federal level appears to have quieted (at least publicly-reported activity), activity at the state level has begun to fill the void. The Aetna/Humana deal requires approval in all 50 states, and the Anthem/Cigna deal requires approval in approximately 25 states, so there is clearly much work to be done by the parties before they may be in a position to close the deals. Ramping up of activity on the state level began in November, with the Florida Department of Insurance announcing that it would be the first state to hold public hearings on the deals.

Notably, unlike the Antitrust Division's review, which focuses solely upon whether the transactions are likely to lessen competition and create a monopoly, the scope of state insurance regulatory review of a proposed insurance merger includes other factors as well, including – most significantly – a general assessment of whether the transaction is "in the interests of policyholders and the general public." In addition, the "lessening competition" standard that is typically applied by the states is also somewhat less well-defined than that applied by the Antitrust Division, which applies a test set forth in its 2010 Horizontal Merger Guidelines.

Given the wider scope of review at the state level, and the fact that the review is not limited solely to competition issues, the Florida Insurance Department held separate hearings on each deal. On December 7, a hearing was held on the Aetna/Humana deal, which would create Florida's largest insurer (albeit with only a somewhat modest 31 percent market share). The very next day a hearing was held on the Anthem/Cigna transaction, even though Anthem's combined market share of the commercial insurance market in Florida, post-merger, would still be less than seven percent. (Notably, Anthem does not offer commercial insurance products in Florida; another Blue, Blue Cross Blue Shield of Florida, is the Blue Cross Blue Shield licensee in the state.) Consistent with the testimony that Aetna and Anthem had offered at the Congressional hearings, at the Florida hearings the merging parties expressed the view that the transactions would permit them to operate more efficiently, creating substantial benefits for Florida consumers.

Perhaps not surprisingly, the American Medical Association (AMA), which has urged the Antitrust Division to block both deals on competitive grounds, filed comments in Florida (in conjunction with the Florida Medical Association), urging the Florida Insurance Department to block the Aetna/Humana deal. Somewhat more surprisingly, the AMA did not take the same approach with respect to the Anthem/Cigna deal, notwithstanding the AMA's opposition to that deal on a national level, perhaps in recognition of the very modest combined Anthem/Cigna market share in Florida.

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Nevertheless, this small combined share did not dissuade several other groups from filing comments opposing the transaction, focusing principally on the contention that the transaction was generally not in the public interest. The Florida Insurance Department's ruling on both deals is not expected until the end of the first quarter of 2016.

Several other states, including New Hampshire and Kentucky, have now also announced that they will be holding public hearings on the deals in the coming months, and other states are likely to follow suit. (Many state regulatory schemes affirmatively require a public hearing prior to approval). Whether these hearings will ultimately lead to state-level opposition to either deal remains to be seen; typically, state decisions on insurance mergers have followed the Antitrust Division's decisions, particularly with respect to the assessment of the potential competitive implications of such deals. Where insurance mergers have faltered, most often it has been federal opposition that has been the cause. For example, in 2010, plans by Blue Cross Blue Shield of Michigan to acquire in-state rival Physicians Health Plan of Mid-Michigan were derailed by an announcement by the Antitrust Division that it would challenge the deal. Similarly, in 2012, Anthem's acquisition of Amerigroup was temporarily halted by the Antitrust Division until the parties agreed to divest Amerigroup's Northern Virginia operations to a third party. Thereafter, both the Antitrust Division and Virginia regulators approved the deal.

However, this general rule has not been absolute. On occasion, insurance mergers that have gained federal regulatory approval have been held up, even prevented, by state regulators. Most notably, in 2009, Highmark and Independence Blue Cross gained approval for a proposed deal from the DOJ, without the necessity of any concessions at all, only to see their plans derailed by an inability to gain approval from the Pennsylvania Insurance Department. Similarly, in 2004, after Anthem and Wellpoint had gained federal approval for their deal (by agreeing to a number of divestitures and other concessions), they were forced to offer additional benefits to consumers in California and Georgia to gain approval from regulators in those states before the deal was able to close.

What will the regulatory response be to the Aetna/Humana and Anthem/Cigna transactions, at both the federal and state levels? Only time will tell. However, what is certain is that the potential impact of the deals on competition and consumers will be the focus of considerable attention and debate at both the federal and state levels throughout the first half of 2016. Stay tuned.

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Antitrust Division May Name Individual Employees as Defendants in Civil Actions Brought Against Corporations

By James M. Burns

In September, Department of Justice (DOJ) Deputy Attorney General Sally Yates announced that, going forward, when the DOJ brings an action against a corporation, it will give more serious consideration to asserting claims against the corporate employees responsible for that conduct as well. Not surprisingly, the announcement got the attention of corporate officers and board members serving on corporate boards all across America.

The subsequently issued "Yates Memo" provided further details on the DOJ's intentions, including the fact that, henceforth, individual actions would be considered in both criminal and civil matters. Notably, with respect to antitrust claims, this would constitute a radical departure from traditional practice; while the Antitrust Division has long considered, and occasionally brought, parallel actions against corporate defendants and their culpable employees in criminal matters, it has traditionally not done so in civil matters. This policy decision was based upon the view that many civil actions involve conduct that can have uncertain competitive effects, and thus imposing personal liability on those making such decisions was viewed as being unfair and unwarranted. Accordingly, some uncertainty lingered after the Yates announcement regarding how the Antitrust Division would respond to the Yates Memo.

In late November, corporate America got its answer, as DOJ Assistant Attorney General William Baer, who leads the Antitrust Division, made clear that the Antitrust Division supported the principles set forth in the Yates Memo. Moreover, Baer expressly confirmed that the Antitrust Division would consider bringing claims against individuals in civil antitrust matters, stating, "We will be looking, going forward, at whether there ought to be individual accountability" in such matters. He continued, "It doesn't mean we're going to do it, but it is, I think, a fair thing for the Deputy Attorney General to ask all components [of the DOJ] to look at [whether] there is an additional deterrent effect that comes with holding responsible the individuals who adopt a policy that is in violation of the antitrust laws."

It remains uncertain at this point whether Assistant Attorney General Baer's statement was intended to be little more than a show of support for Deputy Attorney General Yates's announcement, or a signal that individual actions against corporate employees in civil matters are on the way. In any event, Deputy Attorney General Yates and Assistant Attorney General Baer have likely already accomplished a large part of what they intended with their announcements: they appear to have gotten the attention of corporate officers all across the nation, with many corporations resolving to put antitrust compliance training at the top of their "to do" lists for 2016. Stay tuned.

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Quest Defeats Claims that It Conspired with Health Insurers

By James M. Burns

On November 25, District Court Judge William Orrick (N.D. Cal.) dismissed all claims in *Eastman v. Quest Diagnostics*, finding that the plaintiffs, a class of Northern California consumers who had utilized Quest's services, had failed adequately to allege that Quest had engaged in unlawful monopolization of the Northern California clinical laboratory services market.

Specifically, the plaintiffs' claims in the case centered around the allegation that they paid higher prices for lab services than those paid by consumers in other markets, which the plaintiffs attributed to Quest's alleged "market dominance" in Northern California. However, to succeed on such a claim, the antitrust laws also require a plaintiff to plead, and ultimately prove, that the alleged monopolist gained market dominance through improper means. In an effort to meet this requirement, the plaintiffs alleged that Quest had induced Aetna and Blue Shield to terminate Quest's competitors from the insurers' respective networks, permitting Quest to achieve "dominant" status. In further support of that contention, the plaintiffs also alleged that "approximately 1.54 million persons are enrolled in Aetna and Blue Shield plans in California – ten percent of the available enrollees in the relevant market."

However, Judge Orrick held that the plaintiffs' factual allegations were insufficient as a matter of law. Judge Orrick stated that "pleading the percentage of available enrollees 'in California' that are enrolled in Aetna and Blue Shield does not tell [the Court] the percentage for Northern California," and that "even if it did [provide facts to support plaintiffs' market dominance assertions], alleging that ten percent of available enrollees in Northern California are enrolled in Aetna or Blue Shield, without providing more information regarding the players in and dynamics of the relevant market, is not enough to plausibly establish foreclosure of a substantial share." Foreclosure of "30 to 50 percent" of the market "is generally required to plead an exclusive dealing claim," Judge Orrick noted, and "plaintiffs do not cite to any case holding that a claimant that affirmatively pleads foreclosure of only ten percent of the relevant market states a claim for violation of the Sherman Act." Accordingly, because the plaintiffs had failed to allege sufficient facts to suggest that Quest had achieved a "dominant" share of the relevant market through improper means, the claim was properly subject to dismissal.

Despite the fact that the plaintiffs had already amended their complaint once before, Judge Orrick granted them leave to amend their complaint a second time. However, rather than attempting to do so, on December 11 the plaintiffs announced that they would be appealing Judge Orrick's ruling to the Ninth Circuit. Stay tuned.