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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

IN RE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION MDL 2406	:	**Master File 2:13-cv-20000-RDP**
	:	**This document relates to Subscriber Track cases**

SUBSCRIBERS' POST-HEARING BRIEF IN SUPPORT OF FINAL APPROVAL OF CLASS SETTLEMENT

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INTRODUCTION

In accordance with this Court's request during the final approval hearing held on October 20 and 21, 2021, Settlement Class Counsel for Subscribers submit this post-hearing brief in support of final approval of the settlement reached between Subscribers and Defendants. We address below (1) the legality of the Defendants' system as it will exist after the settlement becomes effective; (2) the treatment of the Second Blue Bid relief as relief available to the Self-Funded Sub-Class included in the certification under Rule 23(b)(3); (3) the allocation of settlement funds between Self-Funded Sub-Class and the Fully Insured Claimants;[1] (4) the objection that the settlement somehow violates contractual rights to arbitrate claims (it does not); and (5) certain objections filed after the hearing relating to the Plan of Distribution.

As shown below, the objections fail to show that the Settlement is unfair, unreasonable, or inadequate. Accordingly, the Court should overrule the objections and approve the Settlement.

ARGUMENT

I. The Settlement's Structural Relief Creates A Post-Settlement System That Is Procompetitive And Not Clearly Illegal.

At the hearing on final approval of the proposed settlement, challenges were raised that it is improper to have a settlement that does not eliminate the Exclusive Service Areas ("ESAs") Rule because, even standing alone, it is a per se violation of the Sherman Act. Transcript of Final Approval Hearing dated October 20, 2021 at 134:10 to 139:15 and 145:1 to 146:9.[2] As Subscriber Plaintiffs explained both in their brief in support of final approval, (Final Approval

[1] Capitalized terms not otherwise defined herein shall have the meaning given them in the Settlement Agreement, ECF No. 2610-2.

[2] The transcript of the Final Approval Hearing is cited as "Tr. I" for October 20, 2021 and "Tr. II for October 21, 2021.

Br., ECF No. 2812-1 at 64-68), and at the fairness hearing, (Tr. I at 52:1 to 73:20), the Court need only satisfy itself that the arrangement that is being left intact under the Settlement is not "clearly illegal" or "per se illegal." Here, ESAs and the going-forward Blue system, with the significant procompetitive benefits created by the Settlement, easily satisfies this standard. The Objectors do not consider these changes, and essentially ignore the Court's ruling on standard of review in *In re Blue Cross Blue Shield Antitrust Litig.*, 308 F.Supp. 3d 1241 (N.D. Ala. 2018), *interlocutory certification granted*, 2018 WL 3326850 (N.D. Ala. June 12, 2018), *leave to appeal denied*, 2018 WL 71522887 (11th Cir. Dec. 12, 2018) ("*BCBS*").

The conduct that the Court deemed potentially subject to a *per se* rule of antitrust liability in *BCBS* was composed of the combination of each Blue plan agreeing, as a condition of licensing the Blue Marks, "to not sell health insurance plans and services with the Blue Marks outside of their respective geographic service areas" and each Blue Plan "limit[ing] the output of non-branded health insurance and related health financing products by the licensees nationwide [the National Best Efforts ('NBE') Rule]." 308 F.Supp. 3d at 1269. The Court in *BCBS* emphasized that it was the *combination* of these practices *operating together* that was subject to potential *per se* treatment:

> Today, the court faithfully applies *Sealy* [*United States v. Sealy, Inc*., 388 U.S. 350 (1967) ("*Sealy*")] and *Topco* [*United States v. Topco Associates., Inc*., 405 U.S. 596 (1972) ("*Topco*")] to the Rule 56 record before it and determines that, in navigating the antitrust landscape in this case, those decisions and their progeny remain polestars. Thus, the court concludes that Defendants' aggregation of a market allocation scheme together with certain other output restrictions is due to be analyzed under the per se standard of review.

308 F.Supp. 3d at 1279 (emphases added). *See* ECF No. 2812-1 at 65-66. The Court noted this fact at the final approval hearing. Tr. I at 85:11 to 85:22.

The proposed settlement eliminates this aggregation and includes acknowledged procompetitive relief. Pursuant to it, the NBE Rule is banned. Pursuant to it, Blue Plans will be able to compete on a non Blue-branded basis (*i.e.,* on a "green" basis) in the ESAs of other Blue Plans. And pursuant to it, Qualified National Accounts are able to solicit a Second Blue Bid from Blue Plans located outside the geographic region where the account is headquartered. Thus, while ESAs may remain, they function under the proposed settlement in a radically changed competitive environment. The Court made this point explicitly in its order granting preliminary approval of the proposed settlement, where it explained why the marketplace going forward if the proposed settlement is approved will be quite unlike the marketplaces deemed to be anticompetitive in *Sealy* and *Topco*:

> In any event, however, this court's decision was based on the aggregation of restraints that existed during the class period. The proposed Settlement currently under consideration alters Defendants' business model.
>
> Where there are many pro-competitive benefits to a settlement -- such as here where the resolution abolishes National Best Efforts, makes available a second Blue bid in certain circumstances, removes restrictions on acquisitions, and when the "ultimate outcome on the merits [of the legality of the conduct as modified by the settlement is] uncertain" --undetermined legal issues will not bar a fair and reasonable settlement. *See Swaney* [*v. Regions Bank*, No.] 2020 WL 3064945, at *3 [(N.D. Ala. June 9, 2020) (quoting *Parsons* [*v. Brighthouse Networks, LLC*,] 2015 WL 13629647, at *2 [(N.D. Ala. Feb. 5, 2015)]). Here, the court believes it has sufficient experience with the practices at issue in this case that were challenged by Subscribers (and Providers) to say, again preliminarily, that these structural changes, when implemented, likely will move the Blues' system from the Per Se category into the Rule of Reason category and that procompetitive benefits will flow from these negotiated changes.

In re Blue Cross Blue Shield Antitrust Litig., 2020 WL 8256366, at *24-25 (N.D. Ala. Nov. 30, 2020).

There is no basis therefore to conclude that the competitive world created by the proposed settlement is in any way perpetuating a *per se* violation of the antitrust laws by allowing ESAs to continue in use. The Eleventh Circuit has stressed that "unless the illegality of an arrangement under consideration is a legal certainty, the mere fact that certain of its features may be perpetuated is no bar

to approval." *Bennett v. Behring Corp*., 737 F.2d 982, 987 (11th Cir. 1984). *See* ECF No. 2812-1 at 68-70. In doing so, the Eleventh Circuit relied on the Eighth Circuit's *Grunin* decision, which equated that legal standard with whether the go-forward conduct is per se illegal. *Id.*; *Grunin v. Int'l House of Pancakes*, 513 F.2d 114, 124 (8th Cir. 1975). No objector at the final approval hearing convincingly demonstrated that this stringent standard is satisfied here.[3] As they have previously stated, Settlement Class Counsel believe that ESAs in the go-forward system are not clearly illegal and instead that any future challenge would be tested under the Rule of Reason, taking into account the procompetitive benefits of the go-forward system.[4]

Since *BCBS* was decided, only one reported case has addressed it substantively and then only in passing on a different topic: *In re Delta Dental Antitrust Litig*., 484 F.Supp.3d 627 (N.D. Ill. 2020) ("*Delta Dental*"). The Court at the final approval hearing asked the proponents of the settlement to address the significance, if any, of that opinion in the present context. Tr. I at 66:20 to 67:20. We believe that the *Delta Dental* decision should have little if any significance for the Court's resolution of the questions that are before it as it determines whether to grant final approval to the Settlement. To begin with, the court in that case was not called upon to assess, and did not assess or purport to assess, the legality of the pre-Settlement Blue system, much less the legality of the Blue system as it will operate in the event the Court approves the Settlement. The *Delta Dental* decision thus does not assess whether that post-Settlement Blue system is "clearly illegal" within the meaning of the caselaw governing the

[3] As Subscriber Plaintiffs have already explained, Final Approval Br., ECF No. 2812-1 at 66, the Court also expressly declined to resolve the question whether the Blues acted as a single entity with respect to their management of the Blue marks, finding that affirmative defense depended on facts that were in genuine dispute and required a trial. *BCBS*, 308 F. Supp. 3d at 1266.

[4] At the Final Approval hearing, Subscribers' counsel explained: "if we did not believe--we, class counsel, did not believe that there is no per se violation in this settlement agreement that will be perpetuated either in the aggregate or looking at any of its features--if we did not believe that, if we thought there was, we could not place it before you conscientiously for approval". Tr. I at 53:17 to 53-22. .

Court's inquiry at the final approval stage. And even had the court ruled that the Delta Dental system is unlawful under Section 1—and, make no mistake, it did not—the *Delta Dental* decision would still have virtually no bearing on the Court's determination of whether the going forward Blue system would be clearly illegal because there is no indication that the court considered the Delta Dental system to be indistinguishable, in all relevant respects, from the post-Settlement Blue system that is now before this Court.

This point is itself sufficient to address *Delta Dental*'s significance to the questions before the Court. But *Delta Dental's* significance is further reduced for two additional reasons: The opinion was handed down in the completely different context of resolving a motion to dismiss under Fed. R. Civ. P. 12(b)(6), and the court hedged its bets by also analyzing the alleged practices under the Rule of Reason. First, the *Delta Dental* decision addresses only the threshold question whether the complaint stated a claim under the Sherman Act. The court ruled only that plaintiffs had adequately alleged a plausible *per se* claim based on *Sealy* and *Topco* "[p]rior to any factual development." 484 F.Supp. 3d at 635. The court also declined to dismiss claims that Delta Dental's exclusive territories for branded competition led to collusive artificially low reimbursement rates for dentists, noting that "[a]lthough the factual basis for plaintiffs' belief that defendants have agreed to restrict their non-Delta Dental branded business is indeed modest, they have alleged facts that, if proven, may entitle them to relief." *Id*. at 639. In a footnote, it added that "[t]he basis for plaintiffs' belief that a revenue restriction agreement exists seems to be largely inferential. Plaintiffs allege that Delta Dental State Insurers in fact conduct little to no competing business despite having the wherewithal to do so, and they point to 'broad language' governing defendants' relationship that they construe as giving [Delta Dental of Pennsylvania] the authority to impose and police the revenue restriction mechanism. This is perhaps a slim reed on which to base their claim, but in the context of their allegations as a whole, I conclude that

it is enough to entitle them to discovery." *Id*. at 639 n.4 (citations omitted). This is quite unlike the situation now before the Court.

Second, the court in *Delta Dental* also separately examined the challenged conduct under a Rule of Reason theory. It said, in connection with its analysis of whether the complaint had adequately stated a claim for a violation under the Rule of Reason, that "Plaintiffs will undoubtedly have to develop the record to define more precisely the geographic market that is relevant to their claims, but given that they seek to represent a nationwide class and claim that defendants insure patients across the country, their identification of the United States and the respective territories in which defendants participate in the market as buyers of dental goods and services is sufficient at this stage." *Id*. at 641. Likewise, it rejected defendants' assertion that market shares were inadequately pled, saying that "Defendants' remaining arguments do not convince me that Rule 8 requires more detailed factual allegations than those plaintiffs articulate concerning defendants' market power." *Id*. at 642.

Thus, because the lawfulness of the Blues' exclusive service areas was not at issue, and given both the procedural posture in *Delta Dental* and that court's application of the lenient standard of pleading, the decision denying defendants' motion to dismiss is not useful in addressing the adequacy of the proposed settlement here.

II. The Settlement Provides The Second Blue Bid To Eligible Members Of The Proposed Self-Funded Sub-Class To Be Certified Under Rule 23(b)(3).

Subscriber Plaintiffs have proposed certification of two classes and one sub-class: an Injunctive Relief Class under Rule 23(b)(2), and a Damages Class under Rule 23(b)(3), which includes a Self-Funded Sub-Class. Initially, in support of our preliminary approval motion, we described the second Blue bid ("SBB") relief provided under Paragraph 15 of the Settlement Agreement as relief provided to the members of the Injunctive Relief Class being certified under Rule 23(b)(2). We believed then, and still believe now, that the SBB relief both addresses

anticompetitive conduct that applies generally to the (b)(2) Injunctive Relief Class and provides procompetitive relief that "will drive innovation and price reductions that will benefit the entire health insurance market generally and ASOs[5] in particular." Tr. I at 25:25 to 26:2.[6] For the reasons set forth below, however, and as discussed at length at the final approval hearing, Subscriber Plaintiffs have concluded that the SBB relief is more properly classified as divisible relief that is being provided to the Self-Funded Sub-Class that is being certified under Rule 23(b)(3).

By way of background, as we negotiated the terms of this Settlement with the Blues, counsel for Subscriber Plaintiffs and counsel for the Self-Funded Sub-Class sought to obtain as many additional Blue bids for as many ASOs as we could; ideally, as we have explained to the Court, we would have secured a SBB for every large ASO that has employees dispersed among different States or regions. *See* Tr. I at 23:20 to 24:20. The Blues, in turn, resisted this demand, tenaciously seeking to preserve the existing features of the Blue system to the greatest extent possible. Months of arms-length negotiations and hard bargaining ultimately resulted in the compromise that is now before the Court; namely, the requirement that the Blues provide the right to request an SBB to so-called "Qualified National Accounts"—a selection of national self-funded accounts that meet certain dispersion criteria and that serve 33 million Members in the aggregate.

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[5] The Self-Funded Sub-Class comprises those members of the Damages Class who purchased administrative services only ("ASO") plans, as well as the employees covered by those ASO plans. The Sub-Class members are sometimes referred to herein as "ASOs".

[6] As Subscriber Plaintiffs have consistently maintained, although an SBB will be provided only to those ASOs satisfying the criteria for a Qualified National Account, the increased Blue-on-Blue competition for those accounts will nevertheless benefit the entire ASO sub-class as a whole "by generating new, innovative products and services that can be then made available to the marketplace generally and lowering the overall prices that are paid." Preliminary Approval Hr'g Tr., Nov. 16, 2020 at 27:13 to 23. In addition, as Dr. Rubinfeld has opined, "all class members also benefit from the increased flow of pricing information to insurance brokers and otherwise throughout the market that results from increased bidding competition, including from bids not presented to or even available to them." Rubinfeld Suppl. Decl., ECF No. 2812-7 at ¶ 16.

Settlement Agreement, ECF No. 2610-2 at ¶¶ 1.u, 15. *See also* Final Approval Br., ECF No. 2812-1 at 75–89.

Not long after completion of the preliminary approval proceedings, the Court advised the parties that it had "serious concerns about [the SBB relief] being classified under (b)(2) with no opt-out right and the potential burden that might have on the opt-out right." Tr. I at 24:23 to 24:25. Subscriber Plaintiffs and Defendants, accordingly, carefully studied the question whether the SBB relief qualifies not only as classwide relief, but also as "indivisible" relief within the meaning of recent caselaw interpreting Rule 23(b)(2) to require that (b)(2) class relief be "indivisible." *Wal-Mart Stores, Inc. v. Dukes*. 564 U.S. 338, 360 (2011).[7]

As the Supreme Court in *Wal-Mart* explained, "[t]he key to the (b)(2) class is 'the indivisible nature of the injunctive or declaratory remedy warranted—the notion that the conduct is such that it can be enjoined or declared unlawful only as to all of the class members or as to none of them.'" *Id.* (*quoting* Richard A. Nagareda, *Class Certification in the Age of Aggregate Proof*, 84 N.Y.U.L.REV. 98, 132 (2009). Rule 23(b)(2) thus demands that plaintiff seek "an indivisible injunction benefitting all its members at once." *Id.* at 362. The Supreme Court has since reaffirmed that certification under Rule 23(b)(2) is proper " 'only when a single injunction or declaratory judgment would provide relief to each member of the class.' " *Jennings v. Rodriguez*, 138 S.Ct. 830, 851-852 (2018) (quoting *Wal-Mart*, 564 U.S. at 362).[8] Lower courts have applied the teaching of *Wal-Mart* to deny certification where the injunctive relief sought does

[7] Maureen Carroll, "*Class Actions, Indivisibility, and Rule 23(b)(2)*," 99 B.U.L.REV 59, 63 (2019) (observing that, prior to *Wal-Mart,* "[t]hat term ("indivisible" or "indivisibility") had never before appeared in a published federal opinion as a Rule 23(b)(2) requirement").

[8] *See also id.* (observing that *Wal-Mart's* "holding may be relevant on remand because the Court of Appeals has already acknowledged that some members of the certified class may not be entitled to bond hearings as a constitutional matter").

not indivisibly benefit all class members at once, *C.G.B. v. Wolf*, 464 F.Supp.3d 174, 206 (D.D.C. 2020), where the injunction does not provide a uniform remedy, *Castañeda Juarez v. Asher,* 2020 WL 6434907, at *7 (W.D. Wash. July 6, 2020), or where the injunctive relief combines an array of remedies, some of which will benefit only certain subsets of the class. *Cholakyan v. Mercedes-Benz, USA, LLC,* 281 F.R.D. 534, (C.D. Cal. 2012). *See also Jamie S. v. Milwaukee Pub. Sch.*, 668 F.3d 481, 499 (7th Cir. 2012) (holding that Rule 23(b)(2) is not satisfied where "the relief sought would merely initiate a process through which highly individualized determinations of liability and remedy are made").

The somewhat unique features of the far-reaching injunctive relief provided under this Settlement Agreement, and in particular the features of the SBB relief provided under Paragraph 15, do not easily lend themselves to a simple, binary classification under either Rule 23(b)(2) or Rule 23(b)(3). Because Blue-on-Blue competition will benefit the entire market for ASO services, the SBB relief is in the nature of classwide relief.[9] But the mechanism used to create this classwide benefit can also be characterized as individualized and divisible;[10] the Settlement provides a right to request a SBB only to those individual Self-Funded Sub-Class members who satisfy the

[9] *See, e.g.*, American Law Institute, PRINCIPLES OF THE LAW OF AGGREGATE LITIGATION, ("ALI") § 2.04(a) ("Divisible remedies are those that entail the distribution of relief to one or more claimants individually, without determining in practical effect the application or availability of the same remedy to any other claimant."). *See id.*, Comment a ("When a claimant seeks a prohibitory injunction or a declaratory judgment with respect to a generally applicable policy or practice maintained by a defendant, those remedies—if afforded—generally stand to benefit or otherwise affect all persons subject to the disputed policy or practice, even if relief is nominally granted only as to the named claimant.").

[10] Subscriber Plaintiffs will follow the practice of courts and commentators in the post-*Wal-Mart* era, and the practice of this Court in this case, and will use the terms "divisible" and "individualized" interchangeably to describe the relief available to the members of a (b)(3) class.

definition of a "Qualified National Account."[11] As the Court noted at the final approval hearing, "some [ASOs] will benefit from second Blue bids, some will not." Tr. I at 25:21 to 25:22. The SBB relief thus does not fall neatly within either (b)(2) or (b)(3); it has characteristics of both indivisible and divisible forms of injunctive relief.

After extensive additional analysis, Subscriber Plaintiffs have come to the view that the SBB relief is more appropriately treated as (b)(3) relief for purposes of class certification. Several factors supported this decision. First, given that only certain qualifying ASOs will be entitled to directly request a second Blue bid, the SBB relief seems more readily characterized as "divisible" and thus tips the balance over to the (b)(3) side.

Second, treating the SBB relief as individualized (b)(3) relief more readily conforms to the Settlement Agreement, which provides that class members who opt out of the Damages Class do not meet the definition of an Employer, and thus cannot satisfy the definition of a Qualified National Account eligible to receive a SBB. Under the terms of the Settlement, in other words, an ASO that opts out from damages relief is opting out of the right to receive a second Blue bid as well. The Settlement Agreement thus places the SBB relief in the same category as individualized damages, and does not equate it with the indivisible relief that is provided to the members of the (b)(2) Injunctive Relief Class.

Finally, the dispositive consideration for Subscriber Plaintiffs is that characterizing the SBB relief as (b)(3) relief will afford greater protection to the rights of absent sub-class members. Rule 23(b)(3) "allows class certification in a much wider set of circumstances but with greater procedural protections." *Wal-Mart,* 564 U.S. at 362. These protections include mandatory notice

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[11] *See, e.g.,* ALI § 2.04(b) ("Indivisible remedies are those such that the distribution of relief to any claimant as a practical matter determines the application or availability of the same remedy to other claimants.").

and opt out rights—neither of which applies to members of a (b)(2) class. *Id. See also Gulino v. Board of Education of City School Dist. of City of New York*, 907 F.Supp.2d 492, 505 (S.D.N.Y. 2012) (declining to certify under Rule 23(b)(2) in case "where each class member would be entitled to a different injunction or declaratory judgment" and observing that "[i]n order to obtain individualized relief, a putative class must satisfy the requirements of Rule 23(b)(3), which includes greater procedural protections, such as notice and opportunity for members to opt out of the litigation.") (internal citations and quotation marks omitted). At the final approval hearing, the Court made clear its view that the ASO sub-class should be provided with supplemental notice and a renewed opportunity to opt out. Subscriber Plaintiffs agree. Providing these additional safeguards and protections can only benefit the members of the sub-class.

In sum, characterizing the SBB relief as (b)(3) relief is simply a better fit than (b)(2) and is the framework that best protects the interests of absent class members.[12] Subscriber Plaintiffs therefore submit that the SBB relief is properly treated as relief awarded to the Self-Funded Sub-

[12] As discussed at the Final Approval hearing, the fact that the historic and valuable SBB relief achieved in this Settlement may not fit neatly under the rubric of either (b)(2) or (b)(3) relief as those provisions of Rule 23 are applied in more conventional, run-of-the-mill class action litigation cannot mean that it may not be provided at all. *See* Tr. I at 44:8 to 44:12 (Mr. Cooper: "[I]t surely cannot be that Rule 23's class certification buckets, (b)(2) and (b)(3), are so procrustean that a type of meaningful, procompetitive injunctive relief is impermissible if it does not fit neatly, like a glove, in one bucket or the other."). Similarly, it would be an absurd result if a settlement class that could otherwise properly be certified under Rule 23 had to forego some of the relief for which it had successfully bargained—relief that would provide the members of the class with substantial economic benefits—in order to remain amenable to certification under a single provision of that Rule. Rule 23 avoids producing such a result when the relief won for the class does not all fit perfectly under either Rule 23(b)(2) or Rule 23(b)(3) by permitting hybrid certification, whereby some of the injunctive relief is provided to a class certified under Rule 23(b)(2) and the rest provided to a class certified under Rule 23(b)(3), of the sort Subscriber Plaintiffs here propose.

Class that is being certified under Rule 23(b)(3), rather than to the Injunctive Relief Class being certified under Rule 23(b)(2).[13]

That the Settlement Agreement provides both injunctive relief that is individualized and divisible, and injunctive relief that is indivisible and classwide, raises no obstacle to the certification of the classes proposed by Subscriber Plaintiffs. Where the criteria of both Rule 23(b)(2) and Rule 23(b)(3) are satisfied, the Court may certify an indivisible class under Rule 23(b)(2) and a divisible, individual class under Rule 23(b)(3). *See, e.g., Marriot v. County of Montgomery*, 227 F.R.D. 159, 175 (N.D.N.Y. 2005) (certifying a class under Rule 23(b)(2) because "final injunctive or declaratory relief would be appropriate to the class as a whole pertaining to the official Jail change-out policy" and a class under Rule 23(b)(3) because "[t]he claims of the putative class members have common questions of law and fact that predominate over such questions as to the individuals" and "[t]he circumstances of this case present a situation where a class action is a superior method for fair and efficient adjudication of the claims"). In the wake of *Wal-Mart,* courts have found certification of both a (b)(2) and a (b)(3) class to be appropriate where, as here, a class action has obtained both injunctive relief that is indivisible and classwide, as well as injunctive relief that is divisible and individualized. *See, e.g., A.R. v. Connecticut State Board of Education*, 2020 WL 2092650 (D. Conn. May 1, 2020) (certifying claims for injunctive relief that addressed systemic violations under Rule 23(b)(2), and claims for divisible injunctive relief—i.e., individualized remedial education—under Rule 23(b)(3));

[13] To be clear, in seeking to classify the SBB relief as Rule 23(b)(3) relief, Subscriber Plaintiffs are neither seeking to certify any classes for which they have not already sought certification, nor altering the membership of any of these three classes. As the Court has recognized, "the class definition, like the scope of the class" will not "change[] in any way" under this proposal to clarify how the SBB relief is classified. Tr. I at 28:6 to 28:7. The pending request to certify these classes, and the analysis of the criteria under Rule 23(a), Rule 23(b)(2), and Rule 23(b)(3), thus continue to support certification.

Easterling v. Connecticut Dept. of Correction, 278 F.R.D. 41 (D. Conn. 2011) (certifying plaintiffs' claims for classwide declaratory and injunctive relief pursuant to Rule 23(b)(2) and their claims for individualized injunctive relief—i.e., reinstatement to their positions—pursuant to Rule 23(b)(3)).[14]

A. Opt Outs from the Self-Funded Sub-Class Are Free to Pursue Their Claims for Individualized Relief So Long As That Relief Does Not Infringe Rule 23(b)(2) Indivisible \Injunctive Relief and Release Approved By The Court.

Several objectors have raised questions concerning how the release that Settlement Class members will provide pursuant to Paragraph 32 of the Settlement Agreement will affect the ability of those who opt out of the Self-Funded Sub-Class to pursue individualized claims for injunctive relief, and specifically claims for a second or for additional Blue bids. They question whether the scope of the relief and release being provided by members of the (b)(2) Injunctive Relief Class renders illusory their right to opt-out of the Self-Funded Sub-Class and to pursue additional Blue bids individually. These concerns are unfounded, and they present no obstacle to the final approval of the Settlement.

The release provided under the Settlement Agreement is, by its own terms, to "be interpreted and enforced broadly." Settlement Agreement, ECF No. 2610-2 at ¶ 32. "Released Claims" are defined to include, *inter alia*, all known and unknown claims based upon, arising from, or relating to the "factual predicates" of the Subscriber Actions and any issue raised in those

[14] *See also Chicago Teachers Union, Local No.1 v. Board of Education*, 797 F.3d 426, 443-45 (7th Cir. 2015) (certification proper where "plaintiffs siphoned that portion of the complaint that requested monetary relief and individual remedies into a request for 23(b)(3) class certification"); *In re Toll Roads Litigation*, 2018 WL 4952594, at *8 (C.D. Cal. 2018) ("Though the Court doesn't certify the class under Rule 23(b)(2), the Court isn't aware of any authority prohibiting the class from seeking forms of injunctive relief just because the class is certified under Rule 23(b)(3)."); *In re Motor Fuel Temperature Sales Practices Litigation*, 279 F.R.D. 598, 615 (D. Kan. 2012) (approving certification of (b)(3) class seeking injunctive relief and monetary damages that had originally been certified as (b)(2) class prior to *Wal-Mart*).

actions. The release also provides that "[p]ersons or entities in both the Injunctive Relief Class and the Damages Class release all Released Claims." *Id*. The important point for present purposes, however, is that the Settlement Agreement further provides that a Settlement Class member who opts out of the Damages Class provides a more limited release. Specifically, the Agreement provides, subject to certain exceptions not relevant here, that "[p]ersons or entities in the Injunctive Relief Class but not the Damages Class, release *only* claims for equitable or injunctive relief." *Id.* (emphasis added).

Read in isolation, these provisions could be interpreted to require class members who opt out of the (b)(3) Self-Funded Sub-Class to release even claims for individualized injunctive relief, including claims for a second Blue bid. This ambiguity requires clarification of two points regarding the scope of the release provided by (b)(2) class members.

First, all parties agree that members of the (b)(2) Injunctive Relief Class release *only* their claims for equitable and injunctive relief that is *indivisible*; therefore, the release provided by the members of the Injunctive Relief Class will not bar any claims for individualized relief by a class member who opts out of the Self-Funded Sub-Class. This interpretation of the (b)(2) class release is effectively mandated by *Wal-Mart*'s holding that claims for individual and divisible relief may not be resolved in a class action certified under Rule 23(b)(2). It comports, moreover, with subsequent decisions recognizing that *Wal-Mart* calls into question any (b)(2) class settlement that purports to release a range of claims that is broader than that which could have been asserted on behalf of a (b)(2) class. *See*, *e.g., West Morgan-East Lawrence Water and Sewer Authority v. 3M Company*, 737 Fed. Appx. 457, 466-467 (11th Cir. 2018) (concluding that district court abused its discretion by certifying a settlement class under Rule 23(b)(2) that purported to release

individualized damage claims of class members).[15] The Settlement Agreement itself states that, although its releases are to be interpreted and enforced broadly, they also are to be interpreted only "to the fullest extent permitted by law." Settlement Agreement, ECF No. 2610-2 at ¶ 32. Because a (b)(2) class may not lawfully release claims for individualized injunctive relief, the release being executed on behalf of the (b)(2) Injunctive Relief Class does not extend to any claims for divisible individualized injunctive relief under (b)(3).

Second, the release provided by members of the (b)(2) Injunctive Relief Class does not render the right to opt out of the (b)(3) Self-Funded Sub-Class illusory, but will permit opt outs to pursue any claims for individualized relief that they may be able to assert and prove after prevailing in a damage liability trial, so long as the relief they seek does not undermine the (b)(2) class's injunctive relief provisions. As noted above, the Release provides that it extends no further than permitted by law.

The short of it is this: After *Wal-Mart*, the law is now clear that a (b)(2) class may assert, and a (b)(2) class release may bar, only claims that challenge conduct that "can be enjoined or declared unlawful only as to all of the class members or as to none of them.'" *Wal-Mart,* 564 U.S. at 360 (internal quotations marks omitted). The (b)(2) class release here, therefore, can lawfully bar only those claims that challenge conduct that is capable of being enjoined only as to all of the class members or as to none of them. A class member who opts out of the Self-Funded Sub-Class

[15] *See also Berry v. Schulman*, 807 F.3d 600, 609 (4th Cir. 2015) (approving (b)(2) class settlement's release of indivisible injunctive relief and claims for statutory damages, since these "are not the kind of individualized claims that threaten class cohesion and are prohibited by *Dukes*"); *In re: Google Inc. Cookie Placement Consumer Privacy Litigation*, 934 F.3d 316, 329-330 (3rd Cir. 2019) (questioning, and leaving "to the District Court on remand, whether a defendant can ever obtain a class-wide release of claims for money damages in a Rule 23(b)(2) settlement, and if so, whether a release of that kind requires a heightened form of notice either under Rule 23(c)(2)(B) or due process tenets").

retains the right to pursue divisible relief including monetary relief and divisible injunctive relief on any legal or factual basis. The release provided by the members of the (b)(2) class cannot and does not bar a claim for a SBB and/or similar individualized injunctive relief.

The Objectors have voiced the concern that the line between the type of (b)(3) individualized injunctive relief that is not released by opt-outs, and the indivisible (b)(2) injunctive relief that will be covered by the release, is not clear and well-defined. The parties, the Objectors, and the Court have all devoted significant time and attention to this question in a good faith effort to provide as much guidance as is possible to members of the (b)(3) Self-Funded Sub-Class who will be faced with the decision regarding whether to exercise their opt-out rights. But let there be no mistake: any remaining uncertainty that the Objectors are confronting is not ultimately a product of the terms of the Settlement Agreement, but rather of the law itself. The Objectors will now have to follow the same path and perform the same tasks as Subscriber Plaintiffs have: they must consider "the landscape of the law" and review the caselaw interpreting *Wal-Mart*, determine whether their claims seek the sort of relief that the courts have characterized as divisible and individualized, and advise their clients accordingly on whether to exercise their right to opt out of the litigation. *See* Tr. II at 19:16 to 19:21. Neither the parties nor the Court can resolve here and now the merits of any claims for such relief that opt-out claimants may assert against individual Blue plans in the future in a materially altered Blue system. Tr. II at 19:11 to 19:16 and 30:22 to 31:3.

That said, the Settlement Agreement by no means leaves the Objectors without guidance. Read in its entirety, its terms and provisions indicate the understanding of the Parties as to what constitutes individualized relief that should not trigger the bar of the (b)(2) relief or release. In particular, by providing the SBB relief to large national ASO accounts that have a significant

presence in more than one ESA, the Settlement Agreement itself identifies certain (b)(3) Self-Funded Sub-Class members who have an individualized basis for obtaining ASO bids from more than one Blue Plan and specifies the criteria it uses to identify them. An ASO with a significant presence in more than one ESA that opts out of the Self-Funded Sub-Class, therefore, could argue based upon the terms of the Settlement Agreement itself that it has an individualized basis for asserting a claim that it is entitled to request more than one Blue bid in order to prevent economic injury to itself. Although such an ASO would be barred by the release provided by all members of the (b)(2) Injunctive Relief Class from asserting a wholesale challenge to the lawfulness of the ESAs,[16] it would not be barred from asserting a claim that, under the particular business facts and circumstances of its own case, it is nonetheless entitled under the law to seek more than one Blue bid for its business. An opt-out claimant could assert any legal claim that would potentially entitle it to individualized relief; as the Court acknowledged, the key question is "whether you can pursue the particular remedy." Tr. II at 23:25 to 24:1. To reiterate, if a (b)(3) opt-out claimant seeks divisible, individual injunctive relief after it prevails on liability, and it demonstrates that it is

[16] As the Court has itself recognized, the injunctive relief pursued by a (b)(3) opt out may not infringe on the (b)(2) indivisible injunctive relief approved by the Court. Tr. II at 18:4 to 18:6. A claim seeking an injunction prohibiting the operation of the ESAs, the local best efforts rules, or the acquisition rules would thus be barred by the (b)(2) release because those features of the Settlement Agreement could "be enjoined or declared unlawful only as to all of the class members or as to none of them." *Wal-Mart*, 564 U.S. at 360. An action seeking an injunction prohibiting the operation of the ESAs would thus be seeking indivisible relief under *Wal-Mart*. An opt-out's action seeking such an injunction would also likely run afoul of any order by this Court approving the Settlement Agreement. A claim seeking the invalidation of the ESAs would thus thwart the (b)(2) release provided by the (b)(2) class and deprive the Court's approval order of its effect. This Court would, in that situation, be empowered by the All Writs Act to issue an injunction to effectuate its judgment. *Wesch v. Folsom*, 6 F.3d 1465, 1470 (11th Cir. 1993). *See also Faught v. American Home Shield Corp.*, 660 F.3d 1289, 1293 (11th Cir. 2011) (*citing Thomas v. Blue Cross and Blue Shield Ass'n*, 594 F.3d 823, 829 (11th Cir. 2010) ("injunctions are enforced through the district court's civil contempt power.") (internal quotation marks omitted) (collecting cases); Tr. II at 24:14 to 24:18, 30:10 to 30:21, 32:10 to 32:17, 112:24 to 113:8.

necessary to request additional Blue bids in order to prevent economic harm to itself, such a request will not be barred by any release in the Settlement Agreement as long as it does not seek to infringe on the (b)(2) relief or release.

The task of adjudicating the merits of any future claim brought by an opt out seeking individualized injunctive relief must be left to a court of competent jurisdiction called upon to interpret and apply the (b)(2) release to the opt-out's specific claims for individualized relief in a live controversy. This Court need not, and indeed should not, decide in this proceeding how the (b)(2) release would operate in the context of specific claims for individualized relief that may be asserted in future proceedings. *See, e.g., In re AOL Time Warner ERISA Litig.*, 2006 WL 2789862, at *12 (S.D.N.Y. Sep. 27, 2006) (declining to rule on whether certain state court claims of objector would be released by the settlement because the "facts necessary for a resolution of this question are not before the Court, nor does the Court have jurisdiction to formally dispose of the action"). *See also Cicero v. DirecTV, Inc.*, 2010 WL 2991486, at *7-8 (C.D. Cal. July 27, 2010) (refusing to address whether particular claims fell within the release because to do so would involve "rendering an advisory opinion").[17]

B. Supplemental Notice Will Be Provided To The Self-Funded Accounts.

Courts have not hesitated to require supplemental notice under Rule 23(d)(1)(B) to provide class members with additional relevant information that may materially affect their decision to opt

[17] *See, e.g., In re Stock Exchanges Options Trading Antitrust Litig.*, 2005 WL 1635158, at *15 (S.D.N.Y. July 8, 2005) (preliminarily approving class settlement and holding that the "Court cannot provide an advisory opinion as to the scope of the release"); *In re Wells Fargo Mortgage-Backed Certificates Litigation*, 2011 WL 13240287, at *1 (N.D. Cal. Nov. 14, 2011) (declining to require additional "'clarifying' language" to proposed release contained in settlement agreement because "[i]n the face of nothing more than unidentified and purely hypothetical 'potential' claims held by the Offerings' trusts, such clarifying language would amount to an advisory opinion, which is generally disfavored").

out. *Mansfield v. Air Line Pilots Ass'n Intern.*, 2009 WL 2601296, *2-*4 (N.D. Ill. 2009) (ordering notice and a new right to opt out of a (b)(3) class when the original notice did not fully lay out potential conflicts between the interests of various class members); *Stair ex rel. Smith v. Thomas & Cook*, 254 F.R.D. 191, 204 (D.N.J. 2008) (ordering supplemental notice to inform class members of a cap on damages that would limit the class's recovery and to permit class members to opt out).

Subscriber Plaintiffs have agreed that, pursuant to a Court-approved notice plan, a supplemental notice should be provided to the Self-Funded Accounts to clarify that the SBB relief is (b)(3) relief and that opting out of the Self-Funded Sub-Class thus entails opting out not only of the right to damages but also of the right to receive a second Blue bid. This notice will also ensure that no Self-Funded Account makes the decision whether to opt out of the (b)(3) Damages Class under a misapprehension about the scope of its opt-out right. The supplemental notice will explain that the SBB relief is deemed individualized and divisible injunctive relief, and that opting out to make an individualized claim seeking such relief would not be barred by the (b)(2) class release unless the relief sought would undermine or infringe the (b)(2) relief or release. The Supplemental Notice will also explain to Self-Funded Accounts that, regardless whether they previously elected to opt out, they may exercise their right to opt-out by a date to be set by Court order.

Finally, because this supplemental notice will clarify the opt out rights of members of the Self-Funded Sub-Class, and does not materially alter the terms of the Settlement Agreement itself, an opportunity to submit additional objections to the Settlement Agreement is unnecessary. Rule 23(e) requires that a new fairness hearing be conducted only when material terms of the settlement agreement have been renegotiated, and an additional opportunity to object is not required where the changes are favorable to the members of the class. *See, e.g., Shaffer v. Cont'l Cas. Co.*, 362 F.

App'x 627, 631 (9th Cir. 2010) ("Although changes were made to the release after potential class members received the notice, the changes did not render the notice inadequate because they narrowed the scope of the release."). *See also Snyder v. Ocwen Loan Servicing, LLC*, 2019 WL 2103379, *9 (N.D. Ill. 2019) ("no new notice is required where changes to a proposed settlement are objectively favorable for class members and do not prejudice any benefit previously promised"); *Knuckles v. Elliott*, 2016 WL 3912816, at *5 (E.D. Mich. July 20, 2016); *Klee v. Nissan N. Am., Inc.*, 2015 WL 4538426, at *5 (C.D. Cal. July 7, 2015); *Keepseagle v. Vilsack*, 102 F.Supp.3d 306, 313 (D.D.C. 2015).

III. The Allocation Between The Self-Funded Sub-Class Members And The Fully Insured Class Members Was Reasonable And Rationale.

At the final approval hearing, the Bradley Objectors asked the Court to reject and override the arm's-length allocation negotiation between Settlement Class Counsel and Self-Funded Sub-Class Counsel that was approved by mediator Mr. Kenneth Feinberg, and replace that negotiated resolution with one that they contend, without proof, is better. The presentations by all parties at the final approval hearing amply demonstrated why these objections are meritless.

While the discussion below walks through the major errors in the arguments made by the Bradley objectors, one point stands out. The Bradley objectors and their proffered experts ignore the differences between the fully insured and self-funded ASO markets, and thereby ignore the fact that during the relevant time periods the fully insured business was vastly more profitable for the Defendants than was the ASO business. This is evident both from public record evidence and from documents produced in discovery. Indeed, some of these documents show that the fully insured business could be anywhere from as much as ***four to ten times more profitable*** for some

Defendants than the ASO business.[18] Other documents show that the ASO business was often not profitable at all, and could be a loss leader or only a break-even line of business.[19] This large difference in relative profitability is highly relevant to the allocation issue because higher profitability is likely to correlate with a stronger claim that the prices generating those profits contained a significant overcharge; conversely, the low levels of profitability, or zero profitability, for the ASO business means that the Self-Funded Sub-Class would face much more difficulty in showing an overcharge, and any overcharge it could show would likely be substantially smaller than the overcharge in the fully insured market. The Bradley objectors ignore this. The actuarial expert they presented at the final approval hearing admitted that he was vaguely aware of documents reporting on this large difference in profitability, but said he did not investigate them. Tr. II at 250:14 to 251:12, 252:24 to 253:16 and 255:9 to 257:3. He then gave this stunning

[18] *See* 2012 BCBS-CA Report at 4 and 9 (attached hereto as Ex. A) (showing predicted profits for FI and losses for ASO and stating "in an environment where corporate g&a is not driven by membership volume a fully insured member is worth 10 times a self funded member"); 2010 Anthem Report at 147 (attached hereto as Ex. B) ("Fully Insured business provides nearly 6 times as much Operating Gain PMPM as ASO."); 2010 BCBS-AR Report, ECF No. 2812-12 at 3 (showing that FI was more profitable than ASO by more than 4.25 to 1).

[19] "The Congressional Research Service reported that commercial ASO contracts are break-even deals on average . . . ." Bob Herman, *Self-Service Insurance: Insurers Forced to Compete Harder For Self-insured Customers*, Modern Healthcare, January 03, 2015, at 3 (attached hereto as Ex. C and cited by Bradley objector's actuarial expert, Mr. Okpewho, ECF No. 2812-19 at 10 n.2). *See also* 2016 Anthem 10-K at 30 (attached hereto as Ex. D) (describing ASO as a business with "lower margins" that had the potential to materially and adversely impact the company's profits if more business moved from FI to ASO"); 2011 BCBS-ID Report at 4 (attached hereto as Ex. E) ("many Plans have opted to set prices such that the self-funded business makes some contribution to overhead, but does not fully cover fixed costs."); BCBS-AZ Report, ECF No. 2812-10 at 2 (noting that administering networks and insurance "is a low margin business. Traditional functions such as claims and enrollment administration will generate very little profit or become loss leaders"); 2013 BCBS-FL Report at 8 (attached hereto as Ex. F) ("In order to remain in the market, Florida Blue has utilized a market based approach to setting ASO fees which does not cover all our costs.").

admission, which undermines both the relevance of his methodology and opinions, as well as the arguments made by the Bradley objectors:

> Q. "Sir, do you believe that the allocation of damages should be based on the relative amounts of overcharges that the two groups of customers paid?
>
> A. No."

Tr. II at 258:21 to 258:24.

This admission is fatal to the Bradley objectors. The point of the allocation is to reflect a reasonable estimate of the relative size of the damages that the two groups of customers could potentially have recovered. While it is very difficult to do that perfectly, and many different metrics could reasonably be considered, a methodology that completely ignores that fundamental question is obviously irrelevant.

For these and other reasons given below, the Court should reject the allocation arguments made by the Bradley objectors.

A. The legal standard for the allocation is reasonableness, not perfection.

The Bradley objectors fail to come to grips with the relevant legal standard. The question is not whether the allocation to the Self-Funded Sub-Class is perfect, or even whether the Court believes it is the best conceivable allocation and the same allocation that the Court would have ordered if the issue had been fully litigated. Rather, the inquiry is whether the allocation is "reasonable" and "rational." *In re Payment Card Interchange Fee and Merch. Disc. Antitrust Litig.*, 2019 WL 6875472, at *20 (E.D.N.Y. Dec. 16, 2019). "An allocation formula need only have a reasonable, rational basis, particularly if recommended by experienced and competent class counsel." *In re Am. Bank Note Holographics, Inc.*, 127 F. Supp. 2d 418, 429–30 (S.D.N.Y. 2001) (quotation marks omitted) "Rule 23's flexible standard allows for the unequal distribution of settlement funds so long as the distribution formula takes account of legitimate considerations and

the settlement remains 'fair, reasonable, and adequate.'" *Radcliffe v. Hernandez*, 794 Fed. App'x 605, 607 (9th Cir. 2019) (quoting Fed. R. Civ. P. 23(e)(2)). Whether the allocation plan is equitable is "squarely within the discretion of the district court." *In re PaineWebber Ltd. P'ships Litig.*, 171 F.R.D. 104, 133 (S.D.N.Y.), *aff'd*, 117 F.3d 721 (2d Cir. 1997) (*per curiam*); *id.* ("in the case of a large class action the apportionment of a settlement can never be tailored to the rights of each plaintiff with mathematical precision."). The Bradley objectors never address this legal standard, and therefore never tailor their arguments to an effort to show why the standard has not been met here. It plainly has, as shown in our prior briefs and below.

Moreover, the case law also recognizes that it is justifiable to allocate larger portion of the settlement to the class members with the "strongest meritorious claims in the case." *See also In re Ins. Brokerage Antitrust Litig.*, 282 F.R.D. 92, 116-117 (D.N.J. 2012). Here, for a number of reasons, the fully insured class members have stronger claims than the Self-Funded Sub-Class members. As shown below, the fully-insured class members have been in this case from the beginning, and their damages claims indisputably include the entire period going all the way back to January 1, 2008. By contrast, Self-Funded Sub-Class members have damages claims for a smaller period, going back only to October of 2017. That means that fully insured class members have a damages period that is 2.5x that of the Self-Funded Sub-Class members.

In addition, the fact that not a single Self-Funded Account sought to file suit during the eight years between the *Cerven* complaint and the settlement – as compared to dozens of fully insured class members stepping forward to do so – speaks volumes about the extent to which ASO sub-class members felt themselves to be suffering antitrust injury as a result of Defendants' conduct. The ASO objectors who have come forward since the settlement was announced are mostly large entities with very substantial resources; yet none saw fit to lend its resources to this

litigation, or even to join it in a nominal way, during more than eight years of trench warfare litigation.

Further, as demonstrated by the economics expert presented by the Self-Funded Sub-Class Settlement Counsel, the ASO market is more competitive than the fully-insured market because additional substitute products—including third-party administrators, the option to administer healthcare plans in-house, and the existence of large national health plan administrators like United, Cigna, and Aetna—are available to self-funded ASO customers that are often not available to fully-insured customers. Tr. II at 41:8 to 44:25. And as we have shown in our prior submissions and again at the final approval hearing, the fully-insured market was vastly more profitable for Defendants than the ASO market during the relevant time periods, and thus far more likely to yield a substantial overcharge had the antitrust claims in this case gone all the way to trial.[20]

For all these reasons, there was a substantial difference in terms of the strength and overall value of the claims held by fully-insured class members versus ASO sub-class members.

B. The mediation before Mr. Feinberg was a rational process that resulted in a reasonable allocation.

As shown above, the Subscribers showed that the inquiry for the Court is whether the allocation was rational and reasonable, not whether it was perfect. Here, the Subscribers and the separate counsel and class representative for the Self-Funded Sub-Class engaged in an arm's-length mediation over the allocation issue before the highly reputable mediator Mr. Kenneth Feinberg. At that mediation, both sides presented a settlement range to Mr. Feinberg: Settlement Class Counsel's estimates of the appropriate recovery for the Self-Funded Sub-Class ranged from

[20] *See* Final Approval Br., ECF No. 2812-1 at 108-110; Mason Expert Report, ECF No. 2812-9 at 7-8 and 15-16 (describing ASOs as less profitable than FI plans). *See also supra* notes 18 and 19.

3.4% to 6.8%, while the Self-Funded Sub-Class Settlement Counsel's estimates varied from 7.6% to 16%. The two sides ultimately agreed on a compromise allocation of 6.5%, and presented that to Mr. Feinberg. Mr. Feinberg approved the allocation compromise, and stated in his sworn declaration:

- "the negotiated number falls towards the low end of Self-Funded Sub-Class Settlement Counsel's estimate, and the high end of Settlement Class Counsel's estimate . . . one would expect an outcome in that range" (ECF No. 2016 at ¶ 14);
- "The relative size of the Self-Funded Claimants' share makes sense given the statute of limitations and premiums vs. administrative fees issues" (*id.)*;
- "The fact that the division resulted from protracted negotiations between sophisticated counsel also supports its reasonableness." *Id.*

The legal and factual arguments presented by Subscribers and Self-Funded Sub-Class counsel at the final approval hearing overwhelmingly support both the reasonableness of this outcome, and the judgment of Mr. Feinberg in approving it.

C. The Self-Funded Sub-Class was not included in any complaint before 2020, and Eleventh Circuit case law would not allow their addition to relate back to 2012.

As shown at the final approval hearing, the original *Cerven* complaint did not include any ASO customer as a class representative, did not purport to include ASO customers in the class definition, and only referenced the ASO market to show that it was different from the product market being alleged in the case. Tr. II at 149: to 150:24, 159:18 to 162:15. The *Cerven* Complaint expressly defined the product market as follows: "The relevant product market is the sale of full-service commercial health insurance products to individuals and small groups." *Cerven v. Blue Cross and Blue Shield of North Carolina,* 12-cv-17 (W.D.N.C) ECF No. 1 at ¶ 124. ("*Cerven* Complaint"). This definition clearly refers to fully insured customers only, and excludes ASOs. Indeed, the *Cerven* Complaint proceeds to allege facts showing that the ASO market is ***different*** from the fully-insured market, in a paragraph entitled "Fully-insured health insurance versus ASO

products." *Id*. at ¶ 129 (emphasis in original). There is thus no way to read the *Cerven* Complaint as bringing claims on behalf of ASO customers, or as putting Defendants on notice that they were likely going to face such claims in this class action. The same is true for each of the other complaints filed in this case prior to the 2020 amendment that was filed at the time of the settlement. Quite simply, the ASOs were never included – there was no ASO class representative; there were no claims advanced on behalf of ASOs; the product market quite clearly excluded the ASO market; and ASOs were only ever mentioned to show why they were ***not*** part of the relevant product market at issue in the case.

Under Eleventh Circuit case law, the foregoing facts make clear that the addition of ASOs to this case in 2020 – as part of the overall settlement – does not relate back to the 2012 filing of the *Cerven* Complaint. In *Cliff v. Payco General American Credits, Inc*., the Eleventh Circuit held that courts in this Circuit may not allow relation back unless, at a minimum, it is shown that: (A) the new claims arise out of the same conduct set out in the original pleading, (B) the defendant will not be prejudiced, and (C) the defendant knew or should have known that it would have to defend against the newly-asserted claims and plaintiffs. 363 F.3d 1113, 1131 (11th Cir. 2004). *See also Makro Cap. of Am., Inc. v. UBS AG*, 543 F.3d 1254, 1259 (11th Cir. 2008).

Here, the claims in *Cerven* and all subsequent complaints expressly put Defendants on notice that they were ***not*** facing claims from ASO customers, and that the relevant product market in the case ***excluded*** the ASO market. There would therefore have been no way for the ASO sub-class to achieve the relation back that the Bradley objectors insist would have been the only possible outcome.

The only response the Bradley objectors had to this point at the final approval hearing was to argue that large, fully-insured groups were also not in the *Cerven* Complaint, yet they have been

given the benefit of the fully-insured class period going back to 2008. But there is an obvious difference between how claims on behalf of large fully-insured groups relate to the claims in *Cerven* and how those of ASO customers do: the former purchased the same type of product (i.e., fully-insured health insurance) as did the other class members in the *Cerven* Complaint; the latter do not. ASO products and fully insured products are significantly different products. Fully-insured products put the insurance company at risk for unexpectedly high healthcare costs, in exchange for a premium calculated in advance; by contrast, ASO products provide "administrative services only" and leaves the employer "at risk" for any unexpectedly high healthcare costs.

Moreover, the *Cerven* and other complaints in this case defined "small groups" as including all employers who purchased fully insured policies and had up to 200 employees. *Cerven* Complaint at ¶ 130. That definition actually captures groups that go all the way up to the size where self-insurance starts to become a viable option. Thus, most fully-insured groups fell squarely within *Cerven*'s class definition, and there is a reasonable argument – and far better than that of the Bradley Objectors -- that Defendants were put on notice that they may face the same claims from other fully insured groups who fell outside the 200 employee cut-off.

D. The allocation of settlement funds was based on a reasonable, rational basis, and the Bradley objectors failed to show otherwise.

As shown at the final approval hearing, there is no merit to the Bradley objectors' demand that the Court should alter the allocation between the Self-Funded Sub-Class and the fully-insured class members.

Other than the issue of the length of the respective damages periods, the Bradley objectors make no serious effort to address the fact that the value of the claims held by fully-insured class members was substantially larger than the value of the claims held by Self-Funded Sub-Class members. Instead, they simply assert, with no support, that the antitrust violations are the same

and therefore the harm suffered must also be the same. But that is not correct. The extent of the harm depends upon the nature of the relevant product market – including the availability of other viable competitors, and the extent to which the Defendants were able to extract substantial profits from the customers in that market. Tr. II at 41:8 to 44:25. The Bradley objectors never address that. They merely assume that the profitability and alleged overcharges in the ASO and fully insured markets were the same. But they present no basis for that assumption, and the evidence in the case, and in the public domain, directly contradicts it.

As shown at the hearing, the expert retained by the Self-Funded Sub-Class (Dr. Joseph Mason) performed a far more searching and thorough analysis than the experts retained by the Bradley objectors. Dr. Mason explained at the hearing that he analyzed four different metrics that could be used to compare the defendants' ASO business to their fully insured business as a potential basis for the allocation of settlement funds: gross revenues; net revenues; operating gain differential; and revenue per member growth. Tr. II at 46:19 to 47:13. Pasted below is the chart from Dr. Mason's report showing the conclusions he reached as to the implied allocation to the ASO sub-class using each one of these different metrics:

	Implied Settlement Allocation to Self-Funded Sub-Class
Gross Revenue	1.7%
Net Revenue	< 10.7%
Operating Gain Differential	< 3.9% – 6.3%
Revenue Per Member Growth	3.4% – 3.8%

Mason Expert Report, ECF No. 2812-9 at 15.

The Bradley objectors focus all their complaints on the very first of these four metrics – gross revenue. It is that measure alone that contains what the Bradley objectors complain is an

"apples to oranges" comparison by comparing total gross revenues from ASO customers to total gross revenue from fully insured customers. Tr. II 49:9 to 52:1, and 55:5 to 57:13. As Dr. Mason explained, that criticism was unfounded because the payments ASO customers made to providers were not paid to Defendants and were never part of this case (and could not ever form the baseline for any damages claimed from Defendants), whereas the full amount of the premiums paid by fully- insured subscribers to Defendants was always part of this case (and could form the baseline for any damages analysis).Tr. II at 49-8 to 52:1, 55:5 to 57:13, and 224:3 to 224:6. Regardless, the fact is that Dr. Mason's other metrics are not subject to this criticism. In particular, by looking at "net revenue" and "operating gain differential," Dr. Mason did something none of the alleged experts for the Bradley objectors did – i.e., he looked at the ***relative profitability*** of the ASO and fully-insured business, which is highly relevant because it correlates to the extent to which Defendants could have extracted anticompetitive overcharges from those respective types of different business. Tr. II at 45:1 to 45:25 and 208:22 to 211:24. Dr. Mason took this into account as obviously relevant to the allocation issue (*see id.* and Mason Expert Report, ECF No. 2812-9 at 7-8); the Bradley objectors and their proffered experts totally ignored it. *See* Tr. II at 248:11 to 257:8.

Both public record information and the documents produced in discovery in this case show that the fully insured business is far more profitable to Defendants than the ASO business, which has often been a barely break-even or even loss-making business. For example, a 2015 document that is cited (for other reasons) by the Bradley objectors' proffered actuarial expert, Mr. Okpewho, states that "The Congressional Research Service reported that commercial ASO contracts are break-even deals on average . . . ." Modern Healthcare, January 03, 2015, at 3 (attached hereto as Ex. C and cited in ECF No. 2812-19 at 10 n.2). Likewise, the 2016 10-K filed

by Anthem (the largest of Defendants), states that the ASO business has "lower margins" which had the potential to materially and adversely impact the company's profits if more business moved from FI to ASO. 2016 Anthem 10-K at 30 (attached hereto as Ex. D) Documents produced in discovery in this case state that "many Plans have opted to set prices such that the self-funded business makes some contribution to overhead, but does not fully cover fixed costs." 2011 BCBS-ID Report at 4 (attached hereto as Ex. E). *See also* BCBS-AZ Report, ECF No. 2812-10 at 2 (noting that administering networks and insurance "is a low margin business. Traditional functions such as claims and enrollment administration will generate very little profit or become loss leaders"); 2013 BCBS-FL Report at 8 (attached hereto as Ex. F) ("In order to remain in the market, Florida Blue has utilized a market based approach to setting ASO fees which does not cover all our costs."). Other documents produced in discovery state that the fully insured business could be anywhere from ***4 to 10 times more profitable*** than the ASO business.[21] *See also* Final Approval Br., ECF No. 2812-1 at 108-110 and Mason Expert Report, ECF No. 2812-9 at 7-8 and 15-16 (describing ASOs as less profitable than FI plans).

During cross-examination, the actuarial expert proffered by the Bradley objector (Mr. Okpewho) gave several admissions establishing that his opinion and methodology cannot be relied upon in determining whether the allocation in this case was reasonable. He admitted:

[21] *See* 2012 BCBS-CA Report at 4 and 9 (attached hereto as Ex. A) (showing predicted profits for FI and losses for ASO and stating "in an environment where corporate g&a is not driven by membership volume a fully insured member is worth 10 times a self funded member"); 2010 Anthem Report at 147 (attached hereto as Ex. B) ("Fully Insured business provides nearly 6 times as much Operating Gain PMPM as ASO."); 2010 BCBS-AR Report, ECF No. 2812-12 at 3 (showing that FI was more profitable than ASO by more than 4.25 to 1). *See also* 2012 Bernstein Research Report, ECF No. 2812-11 at 11-12 (estimated that, for the industry as a whole, FI business produced four times the profit that ASO business did); Booz Allen Hamilton Report at 3-5 (attached hereto as Ex. G) (ASO business was "not profitable," whereas FI business is "profitable" and is a "Major sweet spot of underwriting").

- That he was never previously involved in an effort to allocate damages among class members. Tr. II at 249:16 to 249:23.

- That he never made "any effort to determine how much overcharge, if any, Blue Cross's self-funded customers paid." Tr. II at 249:13 to 249:15.

- That he was aware of a document stating that the fully insured business could be ten times as profitable as the ASO business. Tr. II at 250:14 to 250:24

- That this document is inconsistent with his contention that the Defendants valued ASO and fully insured lives the same. Tr. II at 251:17 to 252:2.

- That he relied upon a Modern Healthcare Magazine article, and that in one paragraph not cited in his report, it states that according to the Congressional Research Service, ASO contracts are on average "break-even". Tr. II 254:20 to 255:18.

- That he did not investigate whether Defendants made any money as part of his analysis, but that he knew Blue Cross fully insured pricing is not break even. Tr. II 255:10 to 257-8.

- That he did not believe that the allocation of damages should be based on the relative amounts of overcharges that the two groups of customers paid. Tr. II at 258.21 to 258.24.

These admissions foreclose the Bradley objectors and the Court from placing any reliance on Mr. Okpewho's opinions regarding allocation. Far from showing that the allocation arrived at through the arm's-length mediation was irrational and unreasonable, Mr. Okpewho's testimony on cross-examination shows instead that it is the objections made by the Bradley objectors which are unreasonable, unreliable, and meritless.

IV. It Is Clearer Than Ever That The "Arbitration Clause" Objection Lacks Merit.

The National Account Objectors originally contended that the Settlement should be disapproved because it would "damage" them by displacing arbitration clauses in their Blue contracts. In their reply, ECF No. 2812-19 at 30-34, they asserted that the Blues had "breached" these arbitration agreements by entering into the Settlement.

In the wake of the Final Approval hearing, it is even more apparent that this objection is without merit. In the first place, as numerous Settlement proponents pointed out at the hearing, these Objectors (like virtually every other private and public litigant in the last 50 years) had never bothered to assert the underlying antitrust claims in any forum at all, including by arbitration. And when Objectors finally did assert them, ***they filed a lawsuit, not an arbitration demand***. *See* Complaint, *Alaska Air Group, Inc., et al. v. Anthem, Inc., et al.*, 2:21-cv-01209-AMM (N.D. Ala. 9/4/21, ECF No. 1).

Second, Objectors fail to address the most relevant in-Circuit authority, *In re Checking Account Overdraft Lit.*, 2020 WL 4586398 (S.D. Fla. Aug. 10, 2020). There, Judge King found ***in the class settlement context*** that the existence of arbitration clauses in some class members' contracts was no bar to approval, because the defendants had waived their arbitration rights. *In re Checking Account* is thus closely aligned to the facts here: it is a class settlement; it overruled a class member objection based on the existence of arbitration clauses; and it did so based on defendants' waiver of those clauses, through their agreement to the settlement. By contrast, Objectors' authority addresses objections to class certification ***by defendants***; Objectors cite no case, in or out of this Circuit, where a class member objected to the loss of arbitration "rights," much less one where that objection was sustained.

Third, Objectors' position makes no sense unless they are losing the right to assert the same claim in arbitration that they would have in court: a claim against every Blue in the country for a nationwide conspiracy to suppress competition, as presented in this MDL proceeding from the outset. But Objectors effectively concede that their arbitration clauses are limited on their face to the single Blue with which they have contracted. And their only response to this point is to suggest via an unpublished, non-precedential decision, *Northrop & Johnson Yachts-Ships, Inc. v. Royal*

Van Lent Shipyard, B.V., 855 Fed. App'x 468 (11th Cir. 2021), that the non-contracting Blues could somehow be forced into arbitration. ECF No. 2380 at 22-23.

Here too, Objectors' authority comes up short. *Northrop & Johnson* holds only that non-signatories may be joined in arbitration when "the plaintiff-signatory alleges substantially interdependent and concerted misconduct by the signatories and non-signatories, *and such alleged misconduct is founded in or intimately connected with the obligations of the underlying agreement*," quoting *Lavigne v. Herbalife, Ltd.*, 967 F.3d 1110, 1118-19 (11th Cir. 2020) (emphasis added).

In this case, the "underlying agreement" is the contract between individual Objectors and individual Blues to provide insurance services. In *Lavigne*, which is controlling, the Eleventh Circuit made it clear that "it is not enough that the alleged misconduct is somehow connected to the obligations of the underlying agreements; the misconduct must be *founded in* or *inextricably bound up with* such obligations." (Emphasis in original, citations omitted.) The anti-competitive schemes alleged by Subscribers, such as the ESAs and National Best Efforts clauses, do not come close to meeting this test. Those schemes are not referenced by, let alone incorporated in, the insurance contracts between the Blues and their ASO/Objector clients. As in *Lavigne*, the Blues' contracts with objectors are "at least one step" – and really more like two or three steps – "removed from the actual transactions that generated" the class action complaints here. Thus, the arbitration clauses at issue could not possibly cover the national class claims asserted by Subscribers, and the Settlement cannot be less than "fair, reasonable and adequate" for folding those clauses into an overall settlement agreement.[22]

[22] The other reasons for overruling this objection are comprehensively set forth in the Final Approval Br., ECF No. 2812-1 at 117-20, and need not be repeated here.

V. The Hart And Cochran Objections To The Plan Of Distribution Are Meritless.

Objectors James Hart and George Cochran have objected to the Plan of Distribution, and have submitted additional materials supporting their objections, though the substance of their objections remains the same. Mr. Hart argues that self-employed individuals, who pay 100% of their premiums, should not be subject to the Default option. As outlined in the Plan of Distribution, any individual who believes that the Default option should not apply to them has the ability to elect the Alternative option and provide documentation for a different allocation. Plan of Distribution, ECF No. 2715-1 at 10-13. Thus, the basis of Mr. Hart's objection is obviated by the Plan of Distribution itself.

Mr. Cochran complains that any unclaimed employee premiums revert to the employer, rather than to the respective Net Settlement Fund. This issue was considered by Class Counsel in developing the Plan of Distribution. In determining the Default percentages, one of the factors considered by Class Counsel was the fact that FI Groups would retain 100% of the value of unclaimed FI Employee premiums, and this allowed for the Default percentages for employees to be higher than it otherwise might have been. Plan of Distribution, ECF No. 2715-1 at ¶ 19(f); Chodorow PA Decl., ECF No. 2610-9 at ¶ 38. The Chodorow Declaration notes:

> FI Groups could benefit from their status as the residual claimant on FI Group premiums. Because part of the economic burden of FI Group premiums was borne by claimants that will not submit claims or that cannot surpass the minimum distribution threshold, the Default percentage to FI Employees can be increased somewhat without necessarily harming FI Groups relative to other claimants. However, increasing the Default percentages could improve both the claims submission rate and the potential for employees to exceed the minimum distribution threshold. This would further the economically reasonable goal of providing broader-based relief to the FI Authorized Claimants.

Chodorow PA Decl., ECF No. 2610-9 at ¶ 40. This provision of the Plan of Distribution is thus reasonable and economically rational, which is all that is required.

CONCLUSION

For all the foregoing reasons, Subscriber Plaintiffs request that the Court enter an order granting final approval to the Settlement.

Date: November 12, 2021

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on November 12, 2021, the foregoing Subscribers' Post-Hearing Brief In Support Of Final Approval Of Class Settlement was filed with the Clerk of the Court and served on counsel of record via ECF.

/s/ Michael D. Hausfeld

Michael D. Hausfeld

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N.D. OF ALABAMA

EXHIBIT A

2013 pricing margin and membership guidance discussion

the team went through 2013 target margins to validate if they are achievable and to identify membership implications

	margin %		margin $	
	2012 Plan Margin	2013 Scenario	2012 Plan Margin	2013 Scenario
Md/Large U/W	**3.9%**	**5.1%**	$ 55.0	$ 74.0
Md/Large ASO	-33.8%	-36.3%	$ (6.1)	$ (6.7)
Md/Large Shared Advantag	-5.7%	-7.8%	$ (0.3)	$ (0.4)
National Par	-256.0%	-273.8%	$ (15.4)	$ (15.3)
LG Alternative Funding	2.3%	2.5%	$ 1.4	$ 1.7
Tri-west & Blue Card	39.6%	36.6%	$ 13.8	$ 12.8
Specialty Benefits	17.2%	17.2%	$ 25.4	$ 26.7
LGSB	**4.4%**	**5.3%**	**$ 74.0**	**$ 92.7**
FEP	0.1%	0.2%	$ 1.0	$ 1.7
LPS Underwritten	**3.0%**	**4.0%**	$ 35.0	$ 47.3
LPS ASO	-48.6%	-51.5%	$ (17.0)	$ (18.4)
LPS Shared Advantage	-63.2%	-66.4%	$ (15.2)	$ (16.9)
LPS Alternative Funding	1.8%	2.5%	$ 5.0	$ 7.5
CPLPS	**0.5%**	**0.8%**	**$ 23.3**	**$ 41.5**
Individual	-3.5%	-3.2%	$ (33.2)	$ (30.0)
Small Group Broker GA	**4.4%**	**5.1%**	$ 84.1	$ 102.2
Medicare HMO	**0.9%**	**4.4%**	$ 4.8	$ 24.0
Medicare PPO	**7.9%**	**4.4%**	$ 20.6	$ 11.8
Healthy Family	-26.2%	-32.5%	$ (8.9)	$ (10.9)
ISGBU	**1.8%**	**2.6%**	**$ 67.4**	**$ 97.1**
BSC Operating income	**1.7%**	**2.2%**	**$ 167.9**	**$ 234.5**
Foundation	-0.4%	-0.4%	$ (37.0)	$ (37.0)
Shield Advance	-0.7%	-0.8%	$ (73.0)	$ (80.0)
Investment income	2.0%	1.9%	$ 200.0	$ 200.0
Income taxes	-1.0%	-1.0%	$ (104.7)	$ (105.5)
BSC Net margin	**1.5%**	**2.0%**	**$ 153.2**	**$ 212.0**

Margins Achievable?	Membership Implications?
Yes	↓
Yes	=
No	↓

membership loss in IFP due primarily to narrow network

in an environment where corporate g&a is not driven by membership volume a fully insured member is worth 10 times a self funded member

contribution margin analysis (based on 2012 plan)

scenarios	hgsb			hpa		
	fully insured	asc	sg	fully insured	asc	sg
2012 plan oi pmpm	$15.23	($6.57)	($0.61)	$13.15	($9.04)	($4.41)
2012 plan corp g&a admin pmpm	$20.66	$13.92	$7.22	$18.00	$14.40	$7.42
2012 plan contribution margin pmpm	**$35.89**	**$7.34**	**$6.61**	**$31.14**	**$5.36**	**$3.00**
contribution margin ($ in millions)						
10,000 new members	$4.3	$0.9	$0.8	$3.7	$0.6	$0.4
25,000 new members	$10.8	$2.2	$2.0	$9.3	$1.6	$0.9
50,000 new members	$21.5	$4.4	$4.0	$18.7	$3.2	$1.8
75,000 new members	$32.3	$6.6	$5.9	$28.0	$4.8	$2.7
100,000 new members	$43.1	$8.8	$7.9	$37.4	$6.4	$3.6

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U.S. DISTRICT COURT
N.D. OF ALABAMA

EXHIBIT B

Anthem 2010

Phase Three

Strategic Options Assessment
Recommended Strategies

Although margins are high for the Large Group ASO business, the Fully Insured business produces a significantly higher operating gain per member for Anthem.

Region	Large Group – FI Operating Gain PMPM	Large Group - ASO Operating Gain PMPM	Large Group - FI Operating Margin PMPM	Large Group – ASO Operating Margin PMPM
East	$19.81	$4.63	6.0%	19.3%
Southeast	$15.54	$5.49	7.0%	20.9%
Midwest	$11.98	$1.71	4.8%	8.8%
West	$25.11	$0.77	10.1%	3.0%
Average Across All Regions	$18.11	$3.15		

Fully Insured business provides nearly 6 times as much Operating Gain PMPM as ASO

Sources: Anthem Regional Business Plans

EXHIBIT C

Modern Healthcare

January 03, 2015 12:00 AM

Self-service insurance: Insurers forced to compete harder for self-insured customers

BOB HERMAN

As more employers explore the advantages of self-insurance and administrative services only contracts, insurers have to find innovative ways to appeal to employers and help them reduce costs and improve care.

Last March, Aetna scored one of the biggest single contracts in its history when the Teacher Retirement System of Texas shifted the administration of its self-insured healthcare benefits program from Blue Cross and Blue Shield of Texas to Aetna.

The TRS' ActiveCare account insures 415,000 active public school teachers and their dependents and pays out more than $1.5 billion in healthcare claims every year.

BCBS of Texas had the account for 12 years, but TRS officials determined that Aetna offered the best overall value for its teachers, said Sally Imig, Aetna's top sales executive for public businesses in Texas. “Like all public entities, they have to save costs,” she said. For TRS members, the change means little. But the deal matters a lot to Aetna. It is an administrative services only, or ASO, contract resulting in hundreds of millions of dollars in new revenue.

ASO contracts are a big part of health insurers' business, representing billions of dollars in annual revenue. ASO plans are also becoming a preferred option for smaller and larger employers alike, in part because of the Patient Protection and Affordable Care Act. As more employers explore the advantages of self-insurance and ASO contracts, insurers know they have to compete to retain or grab that business. That means they have to find innovative ways—including wellness programs, accountable-care networks, hospital bill audits and direct contracting with providers—to appeal to employers and help them reduce costs and improve care.

“The standard things in administering claims aren't going to keep claims down,” said Jonathan Edelheit, Employer Healthcare & Benefits Congress president. “Self-funded employers are demanding getting better value from their plans.”

Health insurers provide ASO services to self-insured companies, which pay their employees' medical claims expenses. Under such contracts, employers pay a fee to third-party administrators such as Aetna to handle claims processing, organize provider networks and manage other health plan logistics.

It's essentially an outsourcing deal where insurers generally bear little or no financial risk, unlike in fully insured products. Instead, employers take on the financial risk of their employees' health, and they typically buy stop-loss insurance to protect themselves against catastrophic claims. Stop-loss insurance often can be purchased from the same insurer providing the ASO services. Some employers, though, hold health plans accountable for some financial risk. For example, employers may place a portion of the ASO fee at risk and judge the insurer's performance by measures such as employee satisfaction.

Employers of all sizes are moving toward self-insurance. Self-insuring and hiring a third-party administrator under an ASO contract can save employers 10% to 25% on their healthcare costs. That's because insurers build in higher profit margins for fully insured products, partly reflecting the actuarial risk they are taking for higher-than-expected healthcare costs.

Another big reason is that self-insured company plans are exempt from state insurance regulations and premium taxes under the federal Employee Retirement and Income Security Act. They also are not subject to many of the provisions of the ACA. Experts say healthcare reform has prompted more employers to become self-insured.

Cost savings and less regulation have clearly produced a shift. Traditional fully insured membership dropped more than 10% from September 2013 to September 2014, according to data from consulting firm Mark Farrah Associates.

Meanwhile, ASO membership increased more than 3% in the same time frame, totaling more than 101 million people. “Once you move to ASO, you rarely move back,” said Beth Bierbower, president of Humana's employer group division.

Most Americans with employer-provided insurance are in self-funded plans, and that's been the case since at least 2010. Roughly 60% of members at Aetna, Anthem and Cigna are in ASO plans. More than 3 in 5 U.S. companies are self-insured, and self-insurance is almost universal among large employers. About 91% of people in companies with 5,000 or more

workers were in self-insured plans in 2014, compared with 15% of people in companies with fewer than 200 workers, according to the Kaiser Family Foundation. Fifteen years ago, only 62% of workers in companies with 5,000 or more employees were in self-insured plans.

But ASO contracts aren't usually as profitable as insurers' full-risk products. The Congressional Research Service reported that commercial ASO contracts are break-even deals on average, though larger national insurers can reap 5% margins. Insurers would rather keep companies in the more lucrative fully insured plans. But they take the business they can get. And it's becoming an increasingly cutthroat one, with local governments and union health plans more willing to change third-party administrators to keep costs down.

Greg Maddrey, a director at the Chartis Group, a Chicago-based consulting firm, said he has seen small employers with as few as 10 workers moving to self-insured plans. But he and other experts say employers of that size are far too small to take on the financial risk of one or more employees experiencing high medical costs. Nevertheless, Humana offers ASO arrangements and stop-loss insurance to companies with fewer than 50 employees, Bierbower said. UnitedHealthcare and others do as well.

Corporate wellness programs have been one of the most popular health plan add-ons for insurers to attract self-funded employers. Companies pay insurers a few extra dollars per employee per month to provide the wellness programs, which typically offer workers financial incentives to exercise and monitor their health. But findings on whether employee wellness programs produce cost savings and improved health have been mixed. Some of the most recent research suggests wellness programs don't save any money at all.

Insurers also are creating and selling more accountable-care and “value-network” products as self-insured employers demand better care coordination. In these narrow-network plans, hospitals and doctors form an accountable care organization and are financially responsible for the care of a contracted employee population. The insurer acts as the claims administrator and distributes the defined budget.

Cigna Corp. has aggressively pursued this ACO strategy. This past summer, Cigna met its goal of creating 100 private ACOs, which are offered to all groups. Aetna has accountable-care deals with Houston-based Memorial Hermann Health System and other major providers in Texas, which are being offered to self-insured public schools within the TRS, Imig said.

In some cases, ACOs are partnering with smaller third-party administrators to create their own health plan. Kelsey-Seybold Clinic, a multispecialty physician group in Houston that has an ACO, partnered with benefits company Boon-Chapman in 2013 to offer its own health

plan. The plan, called KelseyCare, is offered to partially self-funded employers with 50 or more workers in the greater Houston area.

Insurers that will win the most business in the ASO space are those that offer services demonstrating unique, long-term value, Edelheit said. One such service is hospital bill auditing, which is when an insurer verifies that every procedure or code is correct. Employers can save 10% to 15% on their hospital expenses if their third-party administrator conducts these deep reviews, Edelheit said.

Some industry observers think established insurers are at risk of losing some ASO business as more employers directly contract with health systems. Boeing Co., for instance, signed deals with two major systems in Washington state last summer. Intel Corp. similarly cut out its insurance middleman in 2013 and contracted with Presbyterian Healthcare Services, an integrated delivery system in Albuquerque that has its own health plan.

But not all health systems have their own insurance infrastructure, which means insurers may still play an administrative role in direct contracting deals. And many say those direct deals will be more the exception than the rule for self-insured employers. “Not many companies can do what a Boeing is doing,” said Brian Marcotte, CEO of the National Business Group on Health, which represents large corporations, including Boeing. “And not even Boeing can do it in every market.”

Follow Bob Herman on Twitter: @MHbherman

Inline Play

EXHIBIT D

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2016
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to
Commission file number: 001-16751

ANTHEM, INC.
(Exact name of registrant as specified in its charter)

INDIANA	**35-2145715**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**
120 MONUMENT CIRCLE INDIANAPOLIS, INDIANA	**46204**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: **(317) 488-6000**
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of each exchange on which registered**
Common Stock, Par Value $0.01	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer", and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒ Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if a smaller reporting company Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are "affiliates") as of June 30, 2016 was approximately $34,510,272,302.

As of February 10, 2017, 264,378,577 shares of the Registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 18, 2017.

Anthem, Inc.

Annual Report on Form 10-K
For the Year Ended December 31, 2016

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This Annual Report on Form 10-K, including Management's Discussion and Analysis of Financial Condition and Results of Operations, contains forward-looking statements, within the meaning of the Private Securities Litigation Reform Act of 1995, that reflect our views about future events and financial performance. When used in this report, the words *"expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan,"* and similar expressions are intended to identify forward-looking statements, which are generally not historical in nature. Forward-looking statements include, but are not limited to, financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Forward-looking statements are subject to known and unknown risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various disclosures made by us, which attempt to advise interested parties of the factors that affect our business, including "Risk Factors" set forth in Part I, Item 1A hereof and our reports filed with the U.S. Securities and Exchange Commission, or SEC, from time to time. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof or to reflect the occurrence of unanticipated events.

References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries.

government funded programs. Failure to comply with these laws and regulations could result in investigations, litigation, fines, restrictions on, or exclusions from, program participation, the imposition of corporate integrity agreements or other agreements with a federal or state governmental agency that could adversely impact our business, cash flows, financial condition and results of operations.

We are regularly subject to CMS audits of our Medicare Advantage plans to validate the diagnostic data and patient claims, as well as audits of our Medicare Part D plans by the Medicare Part D Recovery Audit Contractor, or RAC. These audits could result in retrospective adjustments in payments made to our health plans. In addition to these federal programs, a number of states have implemented Medicaid RAC programs which were authorized by the ACA. State RAC programs could increase the number of audits and any subsequent recoupment by the federal and state governments, which could adversely affect our financial condition and results of operations. If we fail to report and correct errors discovered through our own auditing procedures or during a CMS or RAC audit, or otherwise fail to comply with applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations.

In addition, there are an increasing number of investigations regarding compliance with various provisions of the ACA. These investigations are being conducted by both CMS and state regulators. As a result, we could be subject to multiple investigations of the same issue. These investigations, and any possible enforcement actions, could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We may not complete the acquisition of Cigna within the time frame we anticipate or at all, which could have a negative effect on our business or our results of operations.

On July 23, 2015, we entered into an Agreement and Plan of Merger, or Merger Agreement, under which we will acquire all of the outstanding shares of Cigna. The acquisition is subject to a number of closing conditions, such as antitrust and other regulatory approvals, which may not be received or may take longer than expected. The acquisition is also subject to other risks and uncertainties. If the acquisition is not consummated within the expected time frame, or at all, it could have a negative effect on our ability to execute on our growth strategy or on our financial performance.

Failure to complete the acquisition could negatively impact our share price and future business, as well as our financial results.

If the acquisition is not completed, our ongoing business may be adversely affected and, without realizing any of the benefits of having completed the acquisition, we could be subject to a number of risks, including the following: we may be required to pay Cigna a termination fee of $1.85 billion or an expense fee of up to $600 million if the Merger Agreement is terminated under certain circumstances (as more fully described in the Merger Agreement); and we could be subject to litigation related to any failure to complete the acquisition or related to any enforcement proceeding commenced against us to perform our obligations under the Merger Agreement. If the acquisition is not completed, these risks may materialize and may adversely affect our business, cash flows and financial condition.

Cigna's pursuit of litigation to terminate the Merger Agreement and seeking damages against us, together with our own litigation against Cigna, could cause us to incur substantial costs, may present material distractions and, if decided adverse to Anthem, could negatively impact our financial position.

As described in Note 3, Business Acquisitions and Divestiture - *Pending Acquisition of Cigna Corporation*, to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, on February 14, 2017, Cigna commenced litigation for a declaratory judgment that its purported termination of the Merger Agreement was lawful and seeking damages against us. We promptly filed our own litigation against Cigna seeking to compel Cigna's specific performance of the Merger Agreement and damages against Cigna. These lawsuits could result in substantial costs to us, including litigation costs and potential settlement costs. Further, due to the potential significance of the allegations and damages claimed by Cigna, we expect that our officers will spend substantial time focused on the litigation. Our defense against Cigna's claims, the pursuit of our claims or the settlement, or failure to reach a settlement, for any claims may result in negative media attention, and may adversely affect our business, reputation, financial condition, results of operations, cash flows and market price.

We may experience difficulties in integrating Cigna's business and realizing the expected benefits of the proposed acquisition.

The success of the Cigna acquisition, if completed, will depend, in part, on our ability to realize the anticipated business opportunities and growth prospects from combining our businesses with those of Cigna. We may never realize these business opportunities and growth prospects. Integrating operations will be complex and will require significant efforts and expenditures on the part of both us and Cigna. Our management might have its attention diverted while trying to integrate operations and corporate and administrative infrastructures. We might experience increased competition that limits our ability to expand our business, and we might fail to capitalize on expected business opportunities, including retaining current customers.

The integration process could result in a disruption of each company's ongoing businesses, tax costs or inefficiencies, or inconsistencies in standards, controls, information technology systems, procedures and policies, any of which could adversely affect our ability to maintain relationships with clients, employees or other third parties or our ability to achieve the anticipated benefits of the Cigna acquisition and could harm our financial performance.

If we are unable to successfully or timely integrate the operations of Cigna's business into our business, we may be unable to realize the revenue growth, synergies and other anticipated benefits resulting from the proposed acquisition and our business and results of operations could be adversely affected. Even if we complete the Cigna acquisition, the acquired business may underperform relative to our expectations.

The health benefits industry is subject to negative publicity, which could adversely affect our business and profitability.

The health benefits industry is subject to negative publicity, which can arise from, among other things, the ongoing debate over Health Care Reform, industry consolidation, increases in premium rates and the decision of many insurers to withdraw from, or significantly curtail their participation in, public exchanges. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by adversely affecting our ability to market our products and services, requiring us to change our products and services, or increasing the regulatory burdens under which we operate.

In addition, as long as we use the Blue Cross and Blue Shield names and marks in marketing our health benefits products and services, any negative publicity concerning the BCBSA or other BCBSA licensees may adversely affect us and the sale of our health benefits products and services. Any such negative publicity could adversely affect our business, cash flows, financial condition and results of operations.

We face competition in many of our markets and customers and brokers have flexibility in moving between competitors.

As a health benefits company, we operate in a highly competitive environment and in an industry that is subject to significant changes from legislative reform, business consolidations, new strategic alliances, aggressive marketing practices by other health benefits organizations and market pressures brought about by an informed and organized customer base, particularly among large employers. For example, we began to compete for sales on public exchanges in 2014, which has required, and will continue to require, us to develop or acquire the tools, including social media tools, necessary to interact with the exchanges and with consumers using the exchanges, increase our focus on individual customers and improve our consumer-focused sales and marketing, customer interfaces and product offerings. These factors have produced and will likely continue to produce significant pressures on our profitability.

We also will have to respond to pricing and other actions taken by existing competitors and potentially disruptive new entrants. Due to the price transparency provided by public exchanges, we face competitive pressures from new and existing competitors in the market for individual health insurance. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of private insurance exchanges or encourage their employees to purchase health insurance on the public exchanges. We can provide no assurance that we will be able to compete successfully on these public exchanges or that we will be able to benefit from any opportunities presented by such exchanges. If we are not competitive on these public exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely impacted.

We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our health care products, particularly with respect to individuals, seniors and small employer group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address Health Care Reform legislation, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure that we will be able to compete successfully against current and future competitors or that competitive pressures faced by us will not materially and adversely affect our business, cash flows, financial condition and results of operations.

We face intense competition to attract and retain employees. Further, managing key executive succession and retention is critical to our success.

Our success depends on our ability to attract and retain qualified employees to meet current and future needs, integrating and engaging employees who have joined us through acquisitions and achieving productivity gains from our investment in technology. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. An inability to retain existing employees or attract additional employees could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We would be adversely affected if we fail to adequately plan for succession of our Chairman, President and Chief Executive Officer and other senior management and retention of key executives. While we have succession plans in place for members of our senior management, and continue to review and update those plans, and we have employment arrangements with certain key executives, these plans and arrangements do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract and retain suitable successors.

A change in our health care product mix may impact our profitability.

Our health care products that involve greater potential risk generally tend to be more profitable than administrative services products and those health care products where the employer groups assume the underwriting risks. Individuals and small employer groups are more likely to purchase our higher-risk health care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government-sponsored programs also involve our higher-risk health care products. In addition, our products sold on the public exchanges have been less profitable than our other insurance products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our financial condition and results of operations.

If we fail to adequately adapt to changes in our industry and develop and implement strategic growth opportunities, our ability to grow may be adversely affected.

As a result of significant changes to traditional health insurance in recent years brought about by Health Care Reform and other factors, the health insurance industry has experienced a significant shift in membership to insurance products with lower margins. Moreover, the significant modification, repeal or replacement of Health Care Reform could have far-reaching consequences for our business. In order to profitably grow our business in the future, we need to not only grow our profitable medical membership, but also continue to diversify our sources of revenue and earnings, including through the increased sale of our specialty products, such as dental, vision and other supplemental products, expansion of our non-insurance assets and establishment of new cost of care solutions, including innovations in PBM services. If we are unable to acquire or develop and successfully manage new opportunities that further our strategic objectives and differentiate our products from our competitors, our ability to profitably grow our business could be adversely affected.

As a holding company, we are dependent on dividends from our subsidiaries. These dividends are necessary to pay our outstanding indebtedness. Our regulated subsidiaries are subject to state regulations, including restrictions on the payment of dividends, maintenance of minimum levels of capital and restrictions on investment portfolios.

We are a holding company whose assets include the outstanding shares of common stock (or other ownership interest) of our subsidiaries including our intermediate holding companies and regulated insurance and HMO subsidiaries. Our subsidiaries are separate legal entities. As a holding company, we depend on dividends from our subsidiaries. Furthermore,

our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries will have a superior claim to certain of our subsidiaries' assets. Among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends. In some states, we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. Our ability to repurchase shares or pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, cash flows, financial condition and results of operations.

Most of our regulated subsidiaries are subject to RBC standards, imposed by their states of domicile. These laws are based on the RBC Model Act adopted by the NAIC and require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. As discussed in more detail below, we are a party to license agreements with the BCBSA which contain certain requirements and restrictions regarding our operations, including minimum capital and liquidity requirements, which could restrict the ability of our regulated subsidiaries to pay dividends.

Our regulated subsidiaries are subject to state laws and regulations that require diversification of their investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed maturity securities, mortgage loans, real estate and equity investments, which could generate higher returns on our investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, require the sale of those investments.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future in connection with the Cigna acquisition or otherwise. Such indebtedness could also adversely affect our ability to pursue desirable business opportunities.

Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate in permitting us to meet scheduled debt service obligations.

If the Cigna acquisition is consummated, we expect to have incurred acquisition-related indebtedness of approximately $26.5 billion and to have assumed approximately $5.1 billion of Cigna's outstanding debt. Our substantially increased indebtedness and debt-to-equity ratio on a recent historical basis will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and may increase our borrowing costs. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources may be greater than the percentages of cash flows required to service our indebtedness or the indebtedness of Cigna individually prior to the acquisition. The increased levels of indebtedness could also reduce funds available for our investments in product development as well as capital expenditures, share repurchases, shareholder dividends, other desirable business opportunities and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

In addition to the expected acquisition-related debt financing described above, we may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit agreement or other indebtedness. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement or our other indebtedness is accelerated, we may be unable to repay or finance the amounts due.

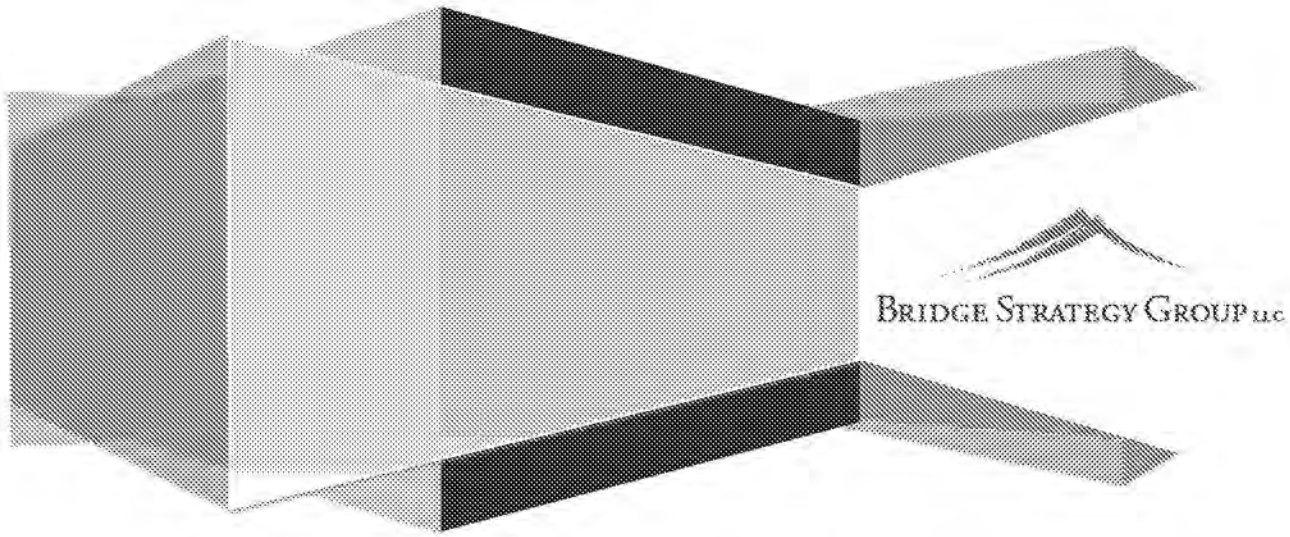
EXHIBIT E

Capturing the Self Funded Market Opportunity

Pricing and Product Approaches for BCBS Plans

Stuart Gunn, Vinod Kesavan, John Stephens

November 2011



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Capturing the Self Funded Market Opportunity

Pricing and Product Approaches for BCBS Plans

Self funded group health insurance has grown steadily over the past decade and now makes up the majority of commercial membership. We expect the segment to become more important over the next several years, due to:

- Smaller and mid-sized groups shifting from fully insured to self funded arrangements
- Low wage groups dropping group coverage in favor of employees purchasing health coverage on state-run exchanges
- Fully insured profits being squeezed by Medical Loss Ratio (MLR) requirements, tighter rate reviews, and price-focused competition on exchanges

These changes are particularly consequential to Blue Plans, many of which have historically focused on the fully insured group market and have a lower relative share of the self funded market.

Bridge Strategy Group recently conducted an analysis of the product and pricing strategies employed by health payers in the self funded market. The analysis has highlighted opportunities for Blue Plans to improve their product positioning and pricing, and ultimately the revenue generation and profitability of their self funded business.

Among the key takeaways for Blue Plans are:

- Disaggregated pricing can improve competitive positioning and increase revenue
- Self funded groups have distinct needs that require a choice of services and solutions
- Price framing is an important part of the quoting approach
- There are untapped revenues available in the self funded market
- There is a near-term need for an offering that specifically targets groups migrating from fully insured to self funded arrangements

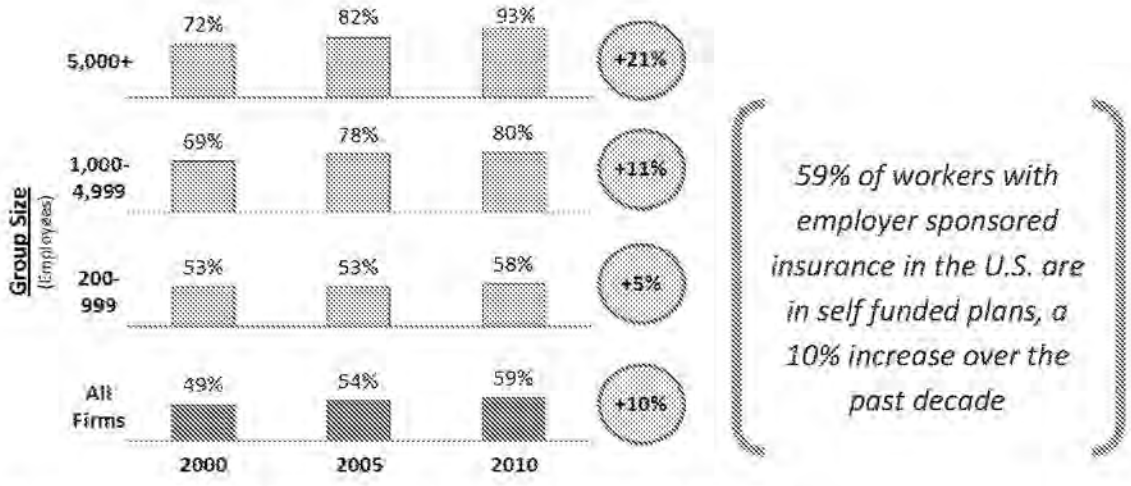
In this paper, we describe the growing importance of the self funded market. We then describe the results of our comparison of the self funded product offerings of Blue Plans and their competitors. We conclude with some thoughts to help guide Blue Plans as they tackle the self funded market going forward.

* * * * *

SELF FUNDED MARKET SIZE AND GROWTH

Employer sponsored insurance is the leading source of health insurance in the U.S., providing coverage for approximately 157 million people. In this market, more than half the members are in self funded plans. Driven by cost advantages and benefit design flexibility, self funded plans have grown in prevalence over the past decade, with the share of all workers covered by self funded plans increasing from 49% in 2000 to 59% in 2010 (see Figure 1 below).

Figure 1: Percentage of Workers in Self Funded Plans



Source: Kaiser Family Foundation & Health Research and Educational Trust (HRET) 2011 Survey of Employer Health Benefits

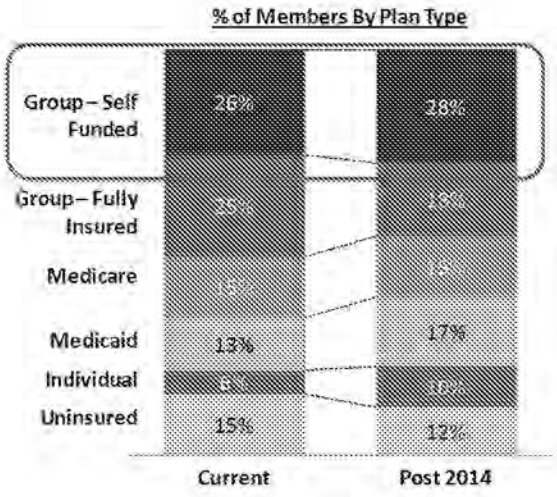
We expect the implementation of PPACA to accelerate the shift in employer sponsored insurance towards self funded arrangements (see Figure 2, next page):

- Smaller to mid-sized groups may shift from fully insured to self funded arrangements due to rate compression, reinsurance availability and premium tax increases
- Low wage groups (predominantly smaller, fully insured groups) may drop group coverage in favor of employees purchasing health coverage on state-run exchanges

As a result, self funded business is likely to become an even greater share of the group market, and may continue to grow in absolute size.[1]

[1] That said, we offer one caveat: we believe the trend toward self funding could be offset in the medium to longer term if adoption of defined contribution approach to health coverage takes off. In this model, employers provide a fixed allowance for employees to purchase health insurance on a private exchange or other mechanism.

Figure 2: Health Insurance Market Mix



We expect PPACA to increase the relative importance of the self funded group market

Source: Bridge Strategy research and assessment of public and private sector forecasts

The implementation of PPACA is also likely to erode the profitability of the fully insured group market by driving business to exchanges, where pricing flexibility is limited and product offerings are commoditized. MLR requirements and tighter rate reviews will also put pressure on payer margins. In light of these changes, health plans will need the self funded segment to be a stronger contributor to revenue and operating margin.

These market changes are particularly consequential to Blue Health Plans. While the Blues are collectively the largest provider of employer sponsored insurance, many Plans have lower penetration in the self funded market than the fully insured group market. As will be discussed later, Blue Plans have some product and pricing approaches that place them at a disadvantage to their competitors in the self funded market. And while the value of the Blue network (breadth and discounts) has historically been a differentiator, competitor networks are catching up – just as the self funded group market is increasing in importance.

Approaches to the Self Funded Market

Bridge conducted interviews with select Blue Plans and analyzed several competitors (including national commercial carriers, local and regional Third Party Administrators (TPAs)) to understand:

- Self funded product offerings
- Pricing strategies
- Opportunities to improve segment profitability

Blue Plan Approaches

While no two Plans approach the self funded market in precisely the same way, a few common themes emerged in our research.

Providing largely inclusive pricing

Most Plans we interviewed prefer to approach the self funded market with a full solution at a largely inclusive price. There is a general reluctance to price separately for individual services or provide a variety of choices to groups. This is partly rooted in the complexity of serving groups with a variety of plan options, as tracking and accounting for differing services can be difficult. Blue Plans also prefer largely inclusive pricing as it avoids the perception of 'nickel and diming' groups. So while Blues will sometimes charge separately for services (e.g. PBM integration, care management buy-ups, subrogation), typically the Plans price using a largely inclusive administrative fee.

Offering services designed for the fully insured market

Blue Plans have historically focused more heavily on serving the fully insured than the self funded market. Many Plans' self funded offerings evolved from the fully insured business where product options tend to be fairly limited to allow underwriting and operational efficiency. As a result, despite self funded group preferences for more tailored solutions, Blue Plans offer a fairly limited set of choices. Examples include providing few options for case and disease management, and limited wellness buy-ups.

Pricing to earn contribution margin

Blue Plans generally use internal activity surveys to understand resource consumption, allocate costs across segments and build an overall picture of the cost to serve the self funded market. However, Plans tend to have low confidence in the accuracy of these surveys, and are unsure about the true profitability of the self funded book of business. At the same time, when faced with highly competitive administrative fees (discussed below), many Plans have opted to set prices such that the self funded business makes some contribution to overhead, but does not fully cover fixed costs.

Offering alternative pricing models

While the majority of Blue Plan self funded business is priced on a Per Employee Per Month (PEPM) administrative fee (plus a handful of additional charges), two Plans in our research offered alternative pricing models. In the first, groups are charged a percentage of claims in lieu of an administrative fee. In the second, groups are charged a percent of network savings on claims costs in addition to a very low administrative fee. These alternative models are becoming less common, but may be worth renewed consideration as Plans compete with TPAs and national competitors across self funded market segments.

Competitor Approaches

We analyzed national commercial carriers and local and regional TPAs, and found that competitors adopt significantly different approaches to the self funded market than Blue Plans.

Providing broader choice in service offerings

As health insurance costs continue to rise, groups are looking to tailor their health plans to meet cost and ROI objectives, and as a result, desire a high degree of choice for services. Both national commercial carriers and TPAs provide a variety of solution options to address these needs. A few examples include:

Care management and wellness

- *Case and utilization management program choices*, ranging from non-network transplant negotiations to a suite of maternity programs
- *A variety of disease management program alternatives*, including disease specific buy-ups with various delivery methods and intensity (e.g., telephonic or on-site)
- *A range of wellness offerings*, from online, self-service programming to buy-ups for biometric screenings, employee assistance programs, rewards initiatives, and tailored on-site education

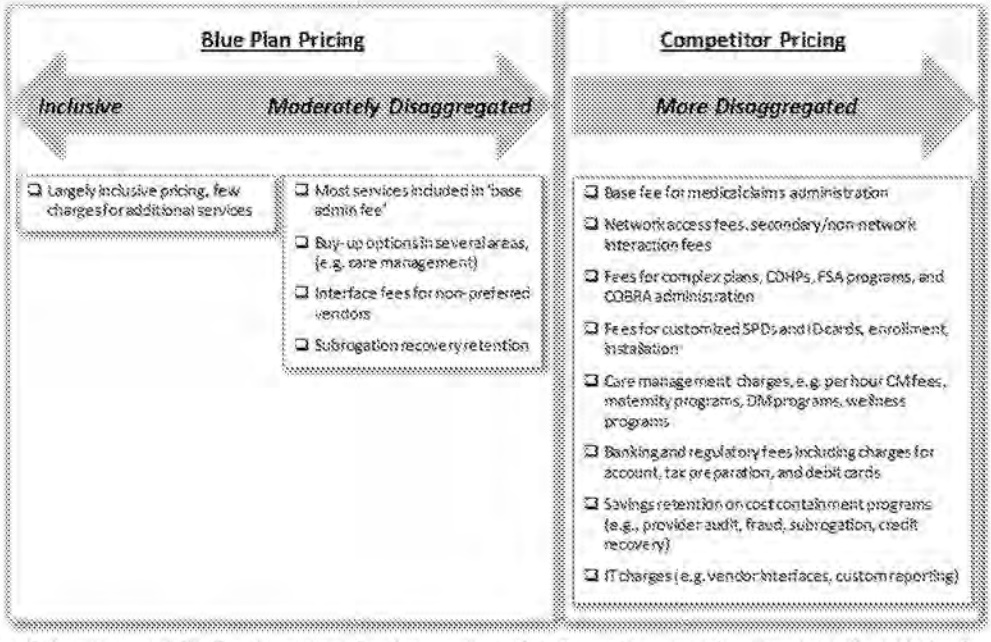
Administrative services support

- *Plan administration assistance*, including on-site installation support, expedited and customized document preparation, independent audit services, privacy education and creation of plan documentation
- *Regulatory services*, such as support for tax filings and state reporting
- *Banking services*, including custodial banking agreements, debit card programs and account reconciliation
- *Cost containment services*, including hospital audits and credit balance recoveries
- *Carve-out integration*, enabling groups to work with a multitude of partners (e.g. PBM vendors and stop loss carriers)

Disaggregating pricing

Contrary to the largely inclusive pricing philosophy at Blue Plans, competitor pricing for self funded groups is more a la carte. This has the effect of lowering the base administrative fee (as services and prices are unbundled), creating a favorable comparison to a largely inclusive price on face value. Even sophisticated groups and brokers will at times focus heavily on the base administrative fee, as comparing plans is inherently difficult, with differing service descriptions, inclusions and exclusions. Figure 3 illustrates the typical differences in pricing structure between Blue Plans and their competitors.

Figure 3: Blue Plan vs. Competitor Pricing Structure



Source: Bridge interviews with Blue Plan sales, marketing & product executives; analysis of competitive quote packages; interviews with select brokers & consultants

Capturing alternative revenue streams

Competitors have diversified their sources and modes of self funded revenue well beyond the claims administration fee. Common alternative revenue streams include:

- Retaining a percentage of savings from cost containment programs including subrogation, provider audits, and fraud recovery
- Passing through costs for special requests such as on-site program coordination, customized membership materials, and custom reporting requirements
- Retaining a share of pharmacy rebates and capturing a share of margin on prescription discounts

Providing administrative services support

Competitors also offer a number of services that support the administration of self funded plans. For groups that are resource-constrained or have little plan administration experience, access to these services can sway the choice of a plan administrator. Services include:

- Preparation of Summary Plan Descriptions (SPDs)
- Banking set-up and regular account reconciliations
- Tax form preparation (5500, 990, 1041)

Case Example: Blue Plan vs. Competitor Pricing

Following is an illustrative case analysis, highlighting the offering, pricing and revenue capture differences between a Blue Plan and a competitor for a self funded group.

Case Example

Category	Fees/Charges		Revenue	
	Competitor	Blue Plan	Competitor	Blue Plan
Medical Claims Administrative Fees	**$13.80**	**$35.07**	$ 53,323	$ 135,510
Network Access	$4.50	Included	$ 17,388	$ -
Custom Plan Administration				
- COBRA administration	$1.30	$0.50	$ 5,023	$ 1,932
- HRA	$3.00	Not available	$ 11,592	$ -
- HSA	$3.90	Included	$ 7,535	$ -
- FSA	$4.00	Included	$ 7,728	$ -
- Run-in claims processing	$10.00	Not available	Not elected	$ -
Ancillary Products				
Dental administrative fees	$1.80	$2.00	$ 6,955	$ 7,728
Vision fees	$0.70	$1.00	$ 2,705	$ 3,864
Disability	$2.00	$0.50		$ 1,932
Installation Fees				
- Plan document preparation	$1,000 one-time	Included	$ 1,000	$ -
- HSA installation (50% of contracts)	$15/participant	Included	$ 2,415	$ -
- Medical installation	$2,000 one-time	Included	$ 2,000	$ -
- CDHP installation	$2,000 one-time	Included	$ 2,000	$ -
- Printing and ID cards	$1,000 one-time	Included	$ 1,000	$ -
Medical Management				
- Utilization management	$2.10	Included	$ 8,114	$ -
- Case management	$ 125/hr	Included	$ 37,500	$ -
- Maternity program	$ 125/hr	Included	$ 6,250	$ -
- Nurse line	$0.40	Not available	$ 1,546	$ -
- Enhanced disease management	$2,000 one-time	Included	Not elected	$ -
- Wellness package	$6.80	Included	$ 13,138	$ -
Banking and Finance				
- Debit card fees	$1.00	Included	$ 3,864	$ -
- Check reconciliation	$250 per month	Included	$ 3,000	$ -
- Co-branded debit card	$500 one-time + $0.10/card	Included	$ 527	$ -
Technology				
- PBM integration (non-preferred vendor)	$2.00	Included	$ 1,932	$ -
- Custom reporting	$150 per hour	Included	$ 2,250	$ -
Tax and Regulatory			$ -	$ -
- HIPAA certificates	$0.45	Included	$ 1,739	$ -
- Reporting to states	$50 - $100/monthly	Not available	$ 900	$ -
- HCRA (tax filing)	$50 or $100/Month	Not available	$ 900	$ -
Savings Retentions				
- Provider savings	25% of savings	Free	$ 22,134	$ -
- Subrogation	25% of savings	Free	$ 2,013	$ -
Total Estimated Revenue			$ 226,470	$ 150,966

Source: Bridge Strategy analysis of competitor quote packages; disguised Blue Plan quote generated by participating plan

In this case (representative of several that we developed), the core medical claims administration fee for the competitor was 60% lower than the administrative fee quoted by the Blue Plan. However, based on the full quote, the competitor would collect 50% more revenue than the Blue Plan. 80% of this additional revenue comes from pricing differently for comparable services and 20% comes from providing additional services.

Key Takeaways for Blue Plans

1. Disaggregated pricing can improve competitive positioning and increase revenue

Competitors use disaggregated pricing (with low base administrative fees) more frequently than Blue Plans. We have found that groups and brokers – even sophisticated buyers – will often place disproportionate emphasis on the base administrative fee instead of total cost of care, putting Blue Plans at a competitive disadvantage. Blues should take steps to offer a comparable pricing structure to negate this advantage and avoid fee discounting that reduces the profitability of the self funded book.

In addition to higher win rates from offering lower administrative fees, disaggregated pricing will also help Blue Plans increase revenue for services that are often under-priced (or not priced at all). For example, by unbundling pricing, Blues may now explicitly capture a portion of the value from the Blue network and services such as subrogation and provider audit.

2. Self funded groups have distinct needs that require a choice of services and solutions

Blue Plans should build a portfolio of solution options to attract and serve self funded groups with distinct needs and a particular focus on cost of care. Providing a set of choices across care management (case and disease management, wellness) and administrative services will help to attract and retain groups looking for specific solutions, while not presenting overwhelming operational or technical challenges for plan marketing, service, or administration.

3. Price framing matters

Presentation of pricing and fees in the quote makes a material difference in how groups and brokers perceive a payer's offering. Considerations include:

- Do groups believe they are being treated fairly, or being nickel-and-dimed?
- How are pricing alternatives framed to a group, whether it is incentivizing for adopting carrier preferences (e.g., using discounts) or penalizing non-preferred choices (e.g., using interface fees)?
- How will the group view the Blue Plan's pricing vs. competitors that use a variety of optics to frame their pricing in the most positive manner?

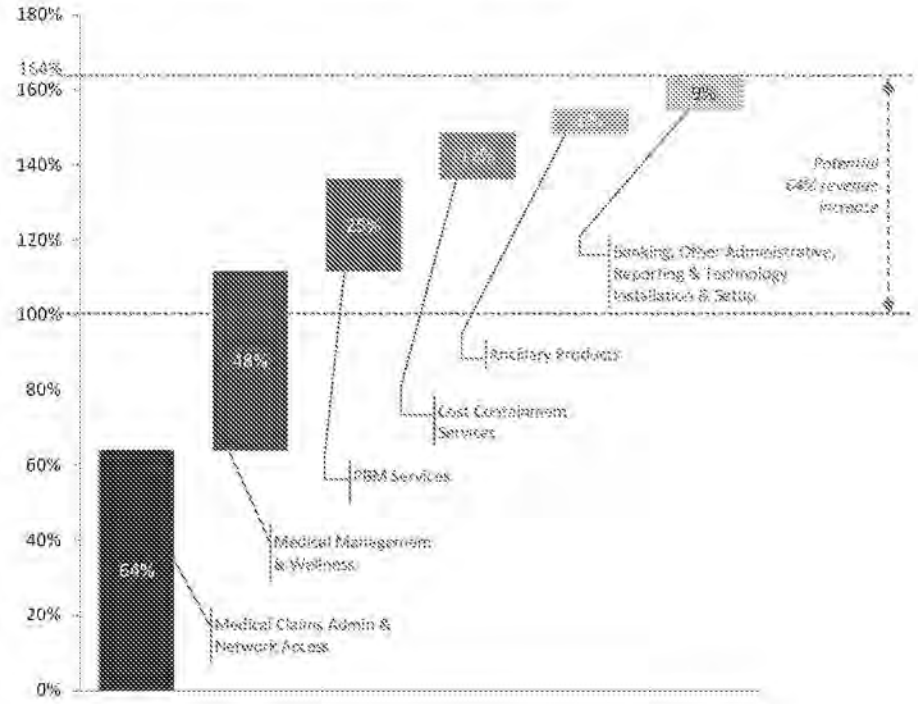
For example, a payer may choose to offer discounts to their base administrative fee tied to selecting standard benefits and preferred vendors, rather than charging 'nuisance' fees that may be more readily negotiated away. Or, payers may show PBM rebates as a highly visible credit to the administrative fee, rather than on the claims invoice where those rebates may be less visible. Blue Plans will have many opportunities (and need to make choices) to frame their pricing in ways that appeal to self funded groups and their brokers.

4. Additional revenue streams can be tapped

Blue Plans should consider a wide range of opportunities to generate revenue in the self funded segment. There are large opportunities in care management, pharmacy benefits management and cost containment services. Plans should also evaluate opportunities in providing banking support, regulatory support, and fiduciary services that allow groups to more effectively administer a self funded program.

Figure 4 illustrates the potential lift available to Blue Plans from changing product and pricing approaches and tapping into additional sources of revenue. Results will vary, of course, depending on the Plan's current approach, the specifics of the group, and the broker involved. However, our analyses suggest the potential to increase revenue by *60%* or more.

Figure 4: Illustration of Revenue Opportunities for BCBS Plans



Source: Bridge Strategy Group analysis of Blue Plan vs. competitor pricing. Revenue indexed to a 'typical' Blue Plan group's 'largely inclusive' product offering and pricing

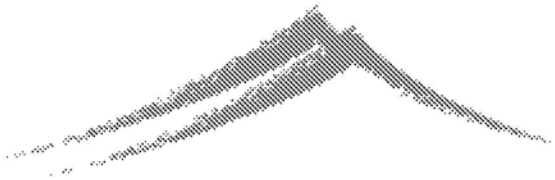
Final Note: Capturing groups migrating from fully insured to self funded arrangements

While the bulk of our research and analysis related to targeting groups that are currently self funded, we did want to highlight a meaningful segment that deserves a different approach: smaller firms converting from fully insured to self funded arrangements in reaction to PPACA.

For reasons previously noted, we believe that a meaningful portion of small and medium sized groups will transition from fully insured to self funded arrangements over the next few years. Several of our research participants have already seen an increase in self funded quoting activity for this segment. We recommend that Blue Plans develop an offering to capture their share (or more) of these new self funded groups. This offering might include:

- A packaged service offering with largely standardized benefits and a pre-defined set of buy-up options (e.g. for wellness and disease management)
- A set of relatively straightforward stop loss options with specific deductibles compatible with a group's appetite for risk
- A suite of services to tackle the administrative complexity that comes with self funding
- A base administrative fee reflective of the 'standardized' nature of the offering, and the lower (expected) costs of group installation and administration

An offering with these characteristics should be attractive to this segment that is accustomed to a standardized (fully insured) offering, and does not have the expertise or desire to become sophisticated self funded administrators. Some commercial carriers (e.g., Cigna/ Great West) have recognized this opportunity and are already using similar approaches to pursue this market aggressively.



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Our recent health insurance experience includes work on a range of strategic and operational issues, among them business strategy development (including new market entry), distribution strategy (including producer compensation design), pricing strategy, operations improvement, and service model design.

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EXHIBIT F

ASO Operating Vision, Distribution Strategy & Migration Plan 2013-2016

A Road Map towards Revenue Growth

5/8/2013

Florida Blue

In the pursuit of health

EM 2013 ASO Operating Vision and Action Plan

Situation	Position
Florida Blue has a substantial portion of its membership under an Administrative Services Only (ASO) arrangement (280 clients covering one million members). As a general statement, ASO fees continue to fall in the market place due to intense competition while demands for services continue to grow. In order to remain in the market, Florida Blue has utilized a market based approach to setting ASO fees which does not cover all our costs.	We need a different approach to the ASO market which allows for gaining additional revenue outside of the traditional health sale, and a sales incentive program with a focus on the appropriate behaviors, (e.g. additional revenue generation) to drive desired results. We must work to better understand our customer and consultatively sell these additional products including stop-loss and others to generate additional revenue, while focusing on improving our internal cost structure. We must explore other creative solutions offering low cost and high value solutions to employer markets.
Complication	**Benefit**
Our current Florida Blue ASO platform model does not allow for a base/buy-up approach based on both operational and contractual issues. This does not allow us to improve our financial position while fees are being pressed downward. Further it is likely that HCR will make ASO arrangements seem more attractive to many employers in the 100+ segment.	Maintain and grow appropriate market share. Enhance financial position. Enhance our value proposition and provide a competitive product approach to employer markets. Drive desired sales force behaviors. Offer more choice and flex bility to market. Support corporate mission, vision and values.
Implication	
This increase in volume to ASO at current fees not covering costs will drive ASO deeper into the red, impacting our competitiveness in the insured business.	

2013 Action Plans

[redacted]

[redacted]

[redacted]

EXHIBIT G

Session 2: Market Map Strategic Assessment Guided Discussion Meeting Notes

National Accounts

[redacted]

[redacted]

Profit

- ASO not profitable
- Multi-state fully insured profitable segment

[redacted]

Local Large Group

[redacted]

[redacted]

[redacted]

Profit

- ASO not profitable
- Fully insured profitable segment

[redacted]

Local Mid-size Group

[redacted]

[redacted]

Profit

- Fully insured business a high profitable area – “Major sweet spot of underwriting”
- South area very competitive – not necessarily very profitable to enter

[redacted]