Competitive Effects Analysis of Centene's Proposed Acquisition of Magellan Health

DEBORAH HAAS-WILSON, PH.D.

October 12, 2021

TABLE OF CONTENTS

I. SCOPE OF REPORT AND QUALIFICATIONS

A. Scope of Report

1. I have been retained by the Office of the California Attorney General ("OCAG") on behalf of the California Department of Managed Health Care ("DMHC") to provide an economic analysis of the competitive effects of Centene's proposed acquisition of Magellan Health.

2. I understand that California Health & Safety Code Section 1399.65(a)(4) requires that the California DMHC obtain "an independent analysis of the impact of the transaction or agreement on subscribers and enrollees, the stability of the health care delivery system, and other relevant provisions of this chapter," and that Section 1399.65(b) permits the DMHC to "disapprove the transaction or agreement if the director finds transaction or agreement would substantially lessen competition in health care plan products or create a monopoly in this state, including, but not limited to, health coverage products for a specific line of business."

3. Pursuant to this statutory scheme, this report is an independent analysis of the impact of the transaction or agreement on subscribers and enrollees and the stability of the health care delivery system. I assess whether this transaction could substantially lessen competition in health care plan products or create a monopoly in California.

4. My analysis has two parts.

5. First, I assess whether the proposed acquisition raises any horizontal concerns in California. Horizontal concerns may arise if Centene and Magellan serve as a competitive constraint on each other to keep prices low and quality high for services that

they both provide in California. Horizontal concerns may arise if, due to the merger, Centene and Magellan would no longer provide this competitive constraint on each other.

6. Second, I assess whether the proposed acquisition raises vertical concerns in California. Magellan provides a variety of services to Centene's competitors or their enrollees. Post-acquisition, Magellan has an incentive to take into account Centene's profitability when providing these services. I assess whether this change in incentives has the potential to harm the competitive process, harm enrollees, or decrease the stability of the healthcare system.

B. Qualifications

7. I am the Marilyn Carlson Nelson Professor of Economics at Smith College in Northampton, Massachusetts. I hold a B.A. in economics from the University of Michigan-Ann Arbor and a M.A. and a Ph.D. in economics from University of California at Berkeley. My research specialty is health economics and competition policies in healthcare markets.

8. Much of my professional career has focused on economic and antitrust issues in healthcare markets. I have written numerous articles on these issues that have appeared in economics journals, including the *Journal of Political Economy*, the *Journal of Economic Perspectives*, the *Journal of Law and Economics*, the *Review of Economics and Statistics*, and the *Journal of Health Economics*.

9. I am the author of *Managed Care and Monopoly Power: The Antitrust Challenge* (Harvard University Press, 2003). In this book, I discuss, among other things, the benefits of competition for consumers; the exercise of market power by insurers, physician groups, and hospitals; and the economic concepts that are essential to enforcement of antitrust laws in healthcare markets. In addition, I co-edited *Uncertain*

Times: Kenneth Arrow and the Changing Economics of Health Care (Duke University Press, 2003), and a special issue of *Health Economics* on competition and antitrust policy in healthcare markets.

10. At Smith College, I teach Introductory and Intermediate Microeconomic Theory, Health Economics, and Industrial Organization and Antitrust Policy. In these courses, I cover topics such as the organization of firms and industries, the markets for health insurance and healthcare provider services, the economics of horizontal and vertical mergers, and antitrust laws and policies.

11. In addition to my scholarly work, I have served as a consultant on antitrust issues in healthcare to the Federal Trade Commission, the Massachusetts Attorney General, the California Department of Corporations, and numerous private entities.

12. In 2005, I served as the economic expert on behalf of Federal Trade Commission staff in its retrospective challenge of the merger of Evanston and Glenbrook Hospitals, two hospitals near Chicago, with nearby Highland Park Hospital, resulting in the formation of Evanston Northwestern Healthcare Corporation. The Federal Trade Commission ultimately ruled that the merger violated Section 7 of the Clayton Act and ordered each portion of the merged entity to establish "separate and independent negotiating teams" to negotiate contracts with health insurance companies.[1] In its ruling, the Commission discussed my empirical analyses and found that they "strongly support[ed] the conclusion that the merger gave the combined entity the ability to raise prices through the exercise of

[1] *See, e.g.*, Opinion of the Commission, *In the Matter of Evanston Northwestern Healthcare Corporation*, No. 9315, Federal Trade Commission, 2008, https://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf, p. 90.

market power."[2] The ruling, issued in 2007, was the first successful challenge to a hospital merger in more than a decade.[3]

13. In 2013, I testified in Federal District Court in Idaho on behalf of plaintiffs in an antitrust lawsuit alleging competitive harm from St. Luke's Health System's acquisition of a large independent physician practice. The Court ruled that the acquisition violated Section 7 of the Clayton Act and the Idaho Competition Act, and it ordered St. Luke's to unwind the acquisition.[4] In its Findings of Fact and Conclusions of Law, the Court cited my testimony regarding effects of the acquisition on physician referrals.[5]

14. I am currently on the Editorial Board of the *American Journal of Health Economics* and the Board of Directors of the Nicholas Petris Center on Health Care Markets and Consumer Welfare at the University of California, Berkeley. I have served as a member of the Health Services Research Study Section of the Agency for Health Care Policy Research and the Executive Committee of the Health Economics Committee of the American Public Health Association.

15. I am a recipient of the Robert Wood Johnson Foundation's *Investigator Awards in Health Policy Research*.

---

2 Opinion of the Commission, *In the Matter of Evanston Northwestern Healthcare Corporation*, No. 9315, Federal Trade Commission, 2008, https://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf, pp. 4–5, 26–40.

3 Fales, Lisa Jose and Paul Feinstein, "How to Turn a Losing Streak Into Wins: The FTC and Hospital Merger Enforcement," *Antitrust Law Journal* Vol. 29, No. 1, 2014, pp. 31–38, at 31, 33.

4 Memorandum Decision and Order, *Saint Alphonsus Medical Center - Nampa, Inc. et al. v. St. Luke's Health System, Ltd., and Federal Trade Commission v. St. Luke's Health System* Vol. 1:12-CV-00560-BLW and No. 1:13-CV-00116-BLW, United States District Court in the District of Idaho, January 24, 2014, p. 4.

5 Findings of Fact and Conclusions of Law, *Saint Alphonsus Medical Center - Nampa, Inc. et al. v. St. Luke's Health System, Ltd., and Federal Trade Commission v. St. Luke's Health System*, No. 1:12-CV-00560-BLW and No. 1:13-CV-00116-BLW, United States District Court in the District of Idaho, 2014, ¶ 136.

16. A more detailed description of my background and credentials, including a list of my publications, is contained in the attached copy of my curriculum vitae (Appendix A).

II. EXECUTIVE SUMMARY

A. Definition of Terms

17. Throughout my report, I use the phrase "healthcare financing services," which include "basic health care services" regulated by the DMHC and defined in California Health & Safety Code Section 1345(f), "health insurance" regulated by the California Department of Insurance (CDI) and defined California Insurance Code Section 106(b), as well as self-insured ERISA plans offered to groups in which groups have access to a provider network and contract for administrative services.

18. I use the phrases "sellers of health care financing services" or "insurers," which include "health care service plans" regulated by the DMHC and defined in California Health & Safety Code Section1345(f) and "health benefit plans" regulated by the CDI and defined in California Insurance Code Section10700(j).

19. I use the phrase "behavioral-specific healthcare financing services" to include: "specialized health care service plan contract[s]" with covered benefits for behavioral health, as regulated by the DMHC and defined in Health and Safety Code section 1345(o); "specialized health insurance polic[ies]" with covered benefits for behavioral health, as regulated by the CDI and defined in California Insurance Code Section106(b); and behavioral health services available through self-insured ERISA plans offered to groups.

B. Overview of Potential Competition Concerns

20. Centene and Magellan both operate in California as sellers of (1) behavioral-specific healthcare financing services, (2) Pharmacy Benefit Manager (PBM) services, (3) specialty pharmacy services, and (4) Employee Assistance Programs (EAPs). In addition, Centene operates in California as a seller of the full set of healthcare financing services. Further, Magellan sells (1) behavioral-specific healthcare financing services, (2) PBM services, and (3) specialty pharmacy services to sellers of healthcare financing services that compete with Centene.

21. There are two potential ways the acquisition could lessen competition.

22. First, Centene and Magellan would no longer compete head-to-head in the above areas in which they both operate in California. If there are only a few competitors that sell (1) behavioral-specific healthcare financing services, (2) PBM services, (3) specialty pharmacy services, or (4) EAPs, then for those services being supplied by few competitors, the acquisition could lessen competition. This is often referred to as a "horizontal" competition concern.

23. Second, when Magellan sells (1) behavioral-specific healthcare financing services, (2) PBM services, or (3) specialty pharmacy services to Centene's competitors for the sale of healthcare financing services, the incentives of Magellan and Centene may be different post-acquisition. The proposed acquisition could lessen competition in the sale of healthcare financing services by decreasing the ability of Centene's competitors to compete with Centene. This is often referred to as a "vertical" competition concern. I consider two types of vertical competition concerns: *direct* vertical competition concern and *indirect* vertical competition concern.

24. The direct vertical competition concern is that post-acquisition, Magellan may have an incentive to charge higher prices to Centene's competitors for (1) behavioral-specific healthcare financing services, (2) PBM services, and (3) specialty pharmacy services. To the extent these higher prices increase Centene's competitors' costs (as might be the case, if there are few alternative sellers of these services to whom Centene's competitors may switch), Centene's competitors become less attractive when competing with Centene for potential enrollees. As an extreme case, Magellan may refuse to sell its services to Centene's competitors.

25. The indirect vertical competition concerns are that post-acquisition: (1) Centene would gain access to competitively sensitive information about its competitors in healthcare financing services, and (2) Magellan and some of its customers of behavioral-specific healthcare financing services (i.e., those customers who are also Centene's competitors in the sale of healthcare financing services) would no longer agree to contract for Magellan's behavioral-specific healthcare financing services. In this case, continuity of care could be disrupted for those customers' enrollees, specifically those enrollees who currently access behavioral care providers through Magellan's network.

C. Summary of Opinions

26. Based on my training and experience in health and antitrust economics and my review and analysis of the available evidence, my primary opinions are as follows.[6]

27. With respect to horizontal competition concerns:

---

[6] This evidence includes data, documents, and arguments that I received from Centene and Magellan, interviews of several health plans and other parties operating in California, and a variety of publicly available sources. Due to limitations in available data, I was unable to perform some analyses using as granular data as would have been ideal on the geographic location of customers or on the differences in the products that they purchased. My conclusions are subject to change in light of any additional evidence that I may review.

- For behavioral-specific healthcare financing services, based on available data and evidence, the proposed acquisition is not likely to substantially lessen competition. The state-level shares of Centene and Magellan in California are 8.8 percent and 7.9 percent, based on 2020 data, respectively. These shares likely overstate the extent to which Centene and Magellan have competed head-to-head for business, as most of Centene's enrollment is managed Medicare and managed Medi-Cal, and almost all of Magellan's enrollment is non-public commercial. A caveat of a state-level analysis of competitive effects for behavioral-specific healthcare financing services is that it may mask greater overlap in smaller geographic areas in California, and access to a local network of behavioral care providers is important for these services. While data at a sub-state level are more limited, these data indicate that the proposed acquisition is not likely to substantially lessen competition.
- For EAPs, based on available data and evidence, the proposed acquisition is likely to substantially lessen competition in sales to at least some groups, including employers in California. There are only a small number of sellers of EAPs with state-wide provider networks in California. Documentary evidence suggests that Centene and Magellan are among this small number of sellers of EAPs with state-wide provider networks that meet the needs of some employers. Given the data provided by Centene and Magellan, I am also unable to rule out the possibility that the acquisition would substantially lessen competition among sellers of EAPs for those employers that do not require a state-wide provider network. Redacted

  Using the data they did provide, I am not able to credibly assess whether Centene's and Magellan's overlap is or is not larger in some areas of California than others. Given the small number of sellers of EAPs with state-wide provider networks in California, I recommend that either Centene or Magellan be required to divest its EAP business in California, including its contracts with providers for EAPs and its contracts with its customers for EAPs. If it is Magellan that divests its EAP business, then those groups that currently contract with Magellan for EAP services should be given the option to switch to Centene on the same or better terms, as their contract with Magellan, for a short

period following the acquisition. If it is Centene that divests its EAP business, then those groups that currently contract with Centene for EAP services should be given the option to switch to Magellan on the same or better terms, as their contract with Centene, for a short period following the acquisition. I note that some large state employers currently contract with Magellan for their EAPs, and that Magellan's state-wide share of EAPs is more than twice Centene's state-wide share of EAPs. To minimize the disruption to enrollees associated with a divestiture, it is sensible for Magellan to divest its EAP business, rather than Centene.

- For PBM services, based on available data and evidence, the proposed acquisition is not likely to substantially lessen competition. Centene's and Magellan's national shares are small, and they do not appear to be imposing a significant competitive constraint on each other.
- For specialty pharmacy services, based on available data and evidence, the proposed acquisition is not likely to substantially lessen competition. Centene's and Magellan's national shares are small, and they do not appear to be imposing a significant competitive constraint on each other.

28. With respect to direct vertical competition concerns:

- For behavioral-specific healthcare financing services, based on available data and evidence, the proposed acquisition is not likely to substantially lessen competition at the state-wide level, but I cannot rule out a lessening of competition in certain parts of California. Several interviewees expressed concern that without access to the providers in Magellan's network, they would be unable to provide adequate coverage for their enrollees. These concerns are in the broader context of there being too few behavioral care providers, especially in rural areas. There is a risk that the acquisition could result in less access to these behavioral care providers in certain areas. To mitigate this concern, I recommend that post-acquisition the Centene-Magellan combined entity be prohibited from making any contractual arrangements with behavioral care providers that restrict behavioral care providers' ability to contract with direct purchasers of healthcare services, such as employers, and sellers of healthcare financing services.

- For EAPs, based on available data and evidence, the proposed acquisition is not likely to substantially lessen competition because Magellan does not sell EAPs to sellers of healthcare financing services that compete with Centene in California.
- For PBM services, based on available data and evidence, the proposed acquisition is not likely to substantially lessen competition. Magellan is a small player in the sale of PBM services and thus, lacks competitive significance as a seller of these services to Centene's competitors. In addition, Centene accounts for a small share of healthcare financing services in California.
- For specialty pharmacy services, based on available data and evidence, the proposed acquisition is not likely to substantially lessen competition. Magellan is a small player in the sale of specialty pharmacy services and thus, lacks competitive significance as a potential seller of these services to Centene's competitors. In addition, Centene accounts for a small share of healthcare financing services in California.

29. With respect to indirect vertical competition concerns:

- Competitively Sensitive Information: Post-acquisition, Centene could gain access to competitively sensitive information about its competitors in healthcare financing services. Centene's access to this information on those competitors that purchase these services from Magellan could harm the competitive process, harm enrollees, and decrease the stability of the healthcare system. To mitigate these concerns, I recommend that measures similar to the ones outlined in the Conflict Avoidance Plan proposed by the Department of Health Care Services (DHCS) with respect Magellan's Medi-Cal business be implemented for *all* of Magellan's business; in particular, Magellan should not be able to integrate or share its employees, processes, information technology systems, or data with Centene; Centene should also not share its employees with Magellan; and a third-party monitor should ensure compliance.
- Continuity of Care: The acquisition could prompt changes in whether Magellan and some of Magellan's customers contract for behavioral-specific healthcare financing

services. Post-acquisition, Magellan or some of Magellan's customers, specifically those customers who are Centene's competitors in the sale of healthcare financing services, could no longer agree to contract for Magellan's behavioral-specific healthcare financing services. In this case, continuity of care could be disrupted for enrollees, specifically those enrollees who pre-acquisition accessed behavioral care providers through Magellan's network as a result of a contract between Magellan and their seller of healthcare financing services. During interviews, sellers of healthcare financing services conveyed that building their own networks of behavioral care providers could take more than a year. In other words, these enrollees could lose access to their behavioral care provider absent a contract between Magellan and their seller of healthcare financing services. To mitigate this potential concern, I recommend that for any enrollees of health plans that currently provide access to the services of behavioral care providers through the Magellan network, the post-acquisition Centene-Magellan entity be required to continue to provide access to these services for a period of two years at prices that increase by no more than the prior year's inflation rate.

III. OVERVIEW OF THE PARTIES AND THE PROPOSED ACQUISITION

A. Magellan Health, Inc.

30. Magellan Health, Inc. ("Magellan") is a healthcare company that sells multiple services, including behavioral-specific healthcare financing services (risk-bearing for behavioral health services, access to its network of behavioral care providers, and management of behavioral health benefits), EAPs, PBM services, and specialty pharmacy services.[7] Magellan's customers include health insurers, employers, state and local governments, and federal agencies. Magellan does not currently sell the full set of healthcare financing

[7] Magellan Health, Inc., Form 10-K for the Fiscal Year Ended December 31, 2020, pp. 2–3.

services, which include, for example, access to a network of not only behavioral care providers, but also medical and surgical care providers.[8]

31. Often sellers of the full set of healthcare financing services purchase behavioral-specific healthcare financing services (risk-bearing, utilization management, and access to a provider network for behavioral healthcare) from companies, such as Magellan. Another way to frame this is that the behavioral-specific healthcare financing services that Magellan sells can be inputs into the full set of healthcare financing services sold by health insurers. Similarly, PBM services, and specialty pharmacy services sold by Magellan can be inputs into the full set of healthcare financing services sold by health insurers.

B. Centene Corporation

32. Centene Corporation ("Centene") is a healthcare company that sells the full set of healthcare financing services (for medical, surgical, and behavioral health), PBM services, EAPs, and specialty pharmacy services. Unlike some insurers that purchase behavioral-specific healthcare financing services, Centene self-supplies behavioral-specific healthcare financing services. Centene also sells behavioral-specific healthcare financing services to employers and local governments.

33. Centene has acquired a number of other healthcare companies in recent years. Centene has acquired several sellers of healthcare financing services including HealthNet in 2016,

[8] Magellan divested Magellan Complete Care—which offers Medicaid and Medicare enrollees the full set of healthcare financing services—to Molina in January 2021. "Molina Healthcare Announces the Closing of its Acquisition of Magellan Complete Care," Molina Healthcare, January 4, 2021, https://investors.molinahealthcare.com/news-releases/news-release-details/molina-healthcare-announces-closing-its-acquisition-magellan; Magellan Complete Care, accessed October 10, 2021, https://www.magellancompletecare.com/.

Fidelis in 2017, and WellCare in 2019.[9] When Centene acquired HealthNet, Centene also acquired HealthNet's subsidiary Managed Health Network, which is a seller of behavioral-specific healthcare financing and EAPs.[10] Centene has also acquired multiple sellers of specialty pharmacy services, including Acaria in 2013 and PANTHERx in 2020.[11]

C. The Proposed Acquisition

34. On January 4, 2021, Centene and Magellan announced that they entered an agreement under which Centene would acquire Magellan for $2.2 billion. According to Centene, the agreement with Magellan would establish "a leading behavioral health platform"; "add to Centene's leadership in government sponsored healthcare, bringing 5.5 million new enrollees on government-sponsored plans"; and add two million PBM enrollees.[12,13,14]

---

9 "Centene Completes Acquisition of Health Net," Cision PR Newswire, March 24, 2016, https://www.prnewswire.com/news-releases/centene-completes-acquisition-of-health-net-300241037.html; "Centene Corporation to Enter New York Through Transaction with Fidelis Care," Centene Corporation, September 12, 2017, https://investors.centene.com/news-events/press-releases/detail/206/centene-corporation-to-enter-new-york-through-transaction; "Centene Completes Acquisition of WellCare," Centene Corporation, January 28, 2020, https://www.centene.com/news/centene-completes-acquisition-of-wellcare.html.

10 Health Net, Inc., Form 10-K for the Fiscal Year Ended December 31, 2015, p. 9.

11 "Centene Corporation Completes Acquisition of Specialty Pharmacy Leader AcariaHealth," Centene Corporation, April 2, 2013, https://investors.centene.com/news-events/press-releases/detail/454/centene-corporation-completes-acquisition-of-specialty; "Centene Completes Acquisition of PANTHERx Rare Pharmacy (PANTHERx)," Centene Corporation, December 30, 2020, https://investors.centene.com/news-events/press-releases/detail/8/centene-completes-acquisition-of-pantherx-rare-pharmacy.

12 "Centene Signs Definitive Agreement to Acquire Magellan Health," Centene Corporation, January 4, 2021, https://investors.centene.com/news-releases/news-release-details/centene-signs-definitive-agreement-acquire-magellan-health.

13 The descriptions in this section are representations of Centene, and I do not take any position on their accuracy or lack thereof.

14 These statements reflect Magellan's enrollment nationally, not for California.

35. According to Centene, "Magellan will operate as a standalone business unit, independent from Centene's health plans with no changes to protection or exchange of client information."[15] In particular:[16]

- the agreement includes administrative firewalls between Magellan and Centene;
- operational systems and client data will remain independent, so Centene's health plans will not have access to Magellan's clients' data; and
- Magellan's transactional systems will remain independent from Centene's.

IV. OVERVIEW OF THE SERVICES PROVIDED BY THE PARTIES

36. In this section, I describe five services—healthcare financing services for medical and surgical care, behavioral-specific healthcare financing services, EAPs, PBM services, and specialty pharmacy services—in which Centene and/or Magellan operate (*see* Exhibit 1). I evaluate how the proposed acquisition might affect competition in the provision of each of these services and negotiations between the sellers of healthcare financing services and sellers of behavioral-specific healthcare financing services, EAPs, PBM services, and specialty pharmacy services. I focus on behavioral-specific healthcare financing services, EAPs, PBM services, and specialty pharmacy services for two reasons. First, Centene and Magellan both provide each of these services. Second, each of these services is a complement to healthcare financing services for medical and surgical care, and Centene sells healthcare financing services for medical, surgical, and behavioral care. The proposed acquisition might give Magellan an incentive to charge higher prices to

[15] Redacted

[16] Redacted

Centene's healthcare financing services competitors and a reduced incentive to contract with these competitors at all.

Exhibit 1 - Summary of Services Offered by Centene and Magellan[17]

Service	Centene	Magellan
Healthcare Financing for Medical and Surgical Services	✓	
Behavioral-Specific Healthcare Financing Services	✓	✓
EAPs	✓	✓
PBM Services	✓	✓
Specialty Pharmacy Services	✓	✓

Note: Magellan also provides services in areas of specialty healthcare such as diagnostic imaging and musculoskeletal management.[18]

37. In my analysis, I consider whether these services have close substitutes, and thus whether the availability of close substitutes may provide competitive constraint on the post-acquisition Centene-Magellan entity. I also consider the geographic area over which firms tend to compete in the provision of these services.[19]

---

17 Magellan Health, Inc., Form 10-K for the Fiscal Year Ended December 31, 2020, pp. 2–3; "California Health Insurers, Enrollment, 2021 — Data (ZIP)," California Health Care Almanac, California Health Care Foundation, July 30, 2021, available at https://www.chcf.org/publication/2021-edition-california-health-insurance-enrollment/#related-links-and-downloads ("Almanac");Redacted

Fein, Adam J., "DCI's Top 15 Specialty Pharmacies of 2020: PBMs Expand Amid the Shakeout—While Walgreens' Outlook Dims," Drug Channels Institute, May 4, 2021, https://www.drugchannels.net/2021/05/dcis-top-15-specialty-pharmacies-of.html; Fein, Adam J., "The Top Pharmacy Benefit Managers of 2020: Vertical Integration Drives Consolidation," Drug Channels Institute, April 6, 2021, https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html.

18 Magellan Health, Inc., Form 10-K for the Fiscal Year Ended December 31, 2020, p. 2.

19 Antitrust analysis may also include market definition, which is a tool to identify lines of commerce or geographic areas in which competitive concerns might arise. *See, e.g.*, "Horizontal Merger Guidelines," U.S. Department of Justice and the Federal Trade Commission, August 19, 2010, https://www.justice.gov/atr/horizontal-merger-guidelines-08192010, p. 7. While I consider whether services have close substitutes and the geographic area over which firms compete, I do not undertake a formal market definition analysis. I understand that a market definition analysis is not required for this regulatory proceeding.

A. Healthcare Financing Services

38. The insurer is the seller of multiple services to employers and other groups that purchase healthcare financing services on behalf of their employees or members (*i.e.*, the final users of the insurer's healthcare financing services or the enrollees). I use the term "insurer" (or "seller of healthcare financing services") to include what I understand to be "health care service plans" regulated by the DMHC, "health benefit plans" regulated by the CDI, as well as self-insured ERISA plans offered to groups, such as large employers, in which groups have access to the insurer's network and contract for administrative services. These services include: (1) access to a network of healthcare providers in the subscribers' geographic area(s); (2) administrative services, such as claims processing, facilitation of and/or payments to healthcare providers, medical management, and other administrative services; and in some cases (3) risk-bearing services, *i.e.*, traditional insurance that provides financial protection against health-related costs.

39. These services need not be performed by one entity for a given subscriber. For example, an insurer may sell all of these healthcare financing services to some groups, but only a subset of services to other groups. For example, an insurer may sell all of these services, except risk-bearing, to some employers.

40. Insurers can be commercial entities (*e.g.*, Centene), government programs (*e.g.*, Medicare, Medicaid), or other types of third-party payers (*e.g.*, workers' compensation). Commercial insurers create networks of healthcare providers by contracting with healthcare providers over the terms of inclusion in the insurers' networks, including the prices paid for the services to be rendered. Commercial insurers also pay healthcare providers for the services they provide to their enrollees (claim reimbursements).

41. Individuals become subscribers of specific health insurance plans typically either by signing up for ("taking up") an insurance plan offered by their employers or, since 2013, purchasing an insurance plan on one of the Health Insurance Marketplaces ("HIMs") established by the Affordable Care Act.[20] California's Health Insurance Marketplace is called Covered California.

42. Some employers that provide health insurance for their employees are "fully insured," meaning these employers purchase the service of risk-bearing. These employers pay the insurer to bear the risk of their employees' expenditures on healthcare services. Fully insured employers and their employees pay premiums to insurers, who provide risk-bearing and other services, such as access to healthcare provider networks in employees' geographic area(s) and administrative services, such as payment of claims.

43. Within commercial healthcare financing services, there are several subsegments, such as individual, small group, and large group.

44. California healthcare regulation classifies employers with 1–100 employees as "small group" employers and classifies employers with 101 or more employees as "large group"

---

[20] The HIMs, open as of October 1, 2013, are regulated online marketplaces for the purchase of health insurance for individual policies and small-group policies, with the aim of increasing health insurance coverage of previously uninsured individuals, and helping people to shop for and enroll in affordable health insurance ("Health Insurance Marketplace," *HealthCare.gov*, https://www.healthcare.gov/glossary/health-insurance-marketplace-glossary/; "Introducing the Health Insurance Marketplace," *HealthCare.gov*, June 21, 2013, https://www.healthcare.gov/blog/introducing-the-health-insurance-marketplace/. In addition to the federally facilitated marketplace, HealthCare.gov, there are also state-based marketplaces in 16 states ("The Health Insurance Marketplace," *IRS.gov*, https://www.irs.gov/affordable-care-act/individuals-and-families/the-health-insurance-marketplace). The HIMs were also designed to lower barriers to entry to sell healthcare financing services by steering a pool of subsidy-eligible patients to HIMs and helping them to achieve minimum viable scale to operate (Dafny, Leemore, Jonathan Gruber, and Christopher Ody, "More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces," *American Journal of Health Economics* Vol. 1, No. 1, 2015, pp. 53–81). In the first two years of operation, 85 percent of enrollees received federal health insurance subsidies (Lissenden, Brett, "Three's a Crowd? The Effect of Insurer Participation on Premiums and Cost-Sharing Parameters in the Initial Years of the ACA Marketplaces," *American Journal of Health Economics* Vol. 3, No. 4, 2017, pp. 477–506, at 477).

employers.[21] "National accounts" are a subset of the largest employers that operate in multiple states.[22] Industry practices commonly distinguish between small group, large group, and national accounts as distinct lines of business.

45. Other employers that provide health insurance for their employees are "self-insured," meaning these employers bear the risk of their employees' expenditures on healthcare goods and services. While these self-insured employers bear the insurance risk, they generally contract with sellers of healthcare financing services for "administrative services only" (ASO) plans. With the exception of risk-bearing, ASO plans tend to provide the same services as fully insured plans. Under ASO plans, employers pay insurers' fees, which include the prices for other healthcare financing services, such as administrative services and access for their covered employees and their dependents to insurers' provider network(s), at contracted prices in their geographic area(s). In addition, the employer reimburses the seller of the ASO plan for the healthcare costs (payments to healthcare providers) of its covered employees and their dependents.

46. Medicare is a federal health insurance program that covers primarily individuals age 65 year and older.[23] Traditional Medicare (sometimes called Fee-for-Service Medicare) and Medicare Advantage (a managed Medicare program) account for about a fifth of personal

---

21 California Health & Safety Code Sections 1357.500, 1367.010.

22 Complaint, United States of America et al. v. Anthem, Inc. and Cigna Corp., No. 1:16-CV-01493, United States District Court for the District of Columbia, July 21, 2016, ¶ 16.

23 Medicare also covers some people with disabilities and all people with End-Stage Renal Disease ("What's Medicare?," Medicare.gov, accessed September 2, 2021, https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html).

healthcare expenditures.[24,25] Traditional Medicare is administered by the federal government. Medicare Advantage plans are administered by commercial insurers, to which the federal government makes capitated payments (per enrollee).[26]

47. Medicaid is a joint federal and state program that provides health insurance to some low-income populations.[27] California's Medicaid healthcare program is called Medi-Cal.[28]

48. In California, Centene is a seller of the full set of commercial healthcare financing services, including managed Medi-Cal and managed Medicare plans. Magellan sells a subset of commercial healthcare financing services.

B. Behavioral-Specific Healthcare Financing Services

49. Even prior to the passage of the Affordable Care Act, over 90 percent of group plans included behavioral-specific healthcare financing services.[29] Since the passage of the Affordable Care Act, individual and small group plans sold on the HIMs and possibly other plans in California as well are required to include behavioral-specific healthcare financing services and provide parity protections.[30] This means that the coverage limits

---

24 Baker, Laurence C. et al., "Medicare Advantage Plans Pay Hospitals Less Than Traditional Medicare Pays," *Health Affairs* Vol. 35, No. 8, 2016, pp. 1444–1451, p. 1444.

25 "National Health Expenditure Accounts Methodology Paper, 2017," Centers for Medicare & Medicaid Services, 2017, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/dsm-17.pdf, p. 4.

26 "Medicare Advantage," The Henry J. Kaiser Family Foundation, May 11, 2016, http://www.kff.org/medicare/fact-sheet/medicare-advantage/.

27 "National Health Expenditure Accounts Methodology Paper, 2017," Centers for Medicare & Medicaid Services, 2017, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/dsm-17.pdf, p. 19.

28 "myMedi-Cal: How to Get the Health Care You Need," California Department of Health Care Services, accessed July 13, 2021, https://www.dhcs.ca.gov/Documents/myMediCal.pdf.

29 Frank, Richard G., Kirsten Beronio, and Sherry A. Glied, "Behavioral health parity and the Affordable Care Act.," *Journal of Social Work in Disability & Rehabilitation* Vol. 13, No. 1–2, 2014, pp. 31–43.

30 *See, e.g.*, Cal. Health & Safety Code, § 1374.72, 1374.721; Cal. Insurance Code § 10144.5, 10144.52; Insurance Code § 10144.4; DMHC, Health & Safety Code § 1367.005; DOI, Insurance Code 10112.27; DMHC, Health & Safety Code 1357.508 (references 42 U.S.C. 18022 (b)(1)(E)); Welfare & Institutions

applied to behavioral health and substance abuse services cannot be more restrictive than limits applied to medical and surgical services. Behavioral health and substance abuse services include inpatient care, counseling, psychotherapy sessions, and drugs.[31,32]

50. Sellers of healthcare financing services can self-supply some or all of the behavioral-specific healthcare financing services or purchase some or all of these services. Sellers of healthcare financing services can self-supply risk-bearing services, administrative services, and access to a network of behavioral care providers. Sellers of healthcare financing services that purchase certain behavioral-specific healthcare financing services contract with sellers of behavioral-specific healthcare financing services to manage these specialized services.[33]

51. Purchasing behavioral healthcare services from a company that specializes in behavioral-specific healthcare financing services can reduce costs.[34] Companies that specialize in behavioral-specific healthcare financing services are sometimes referred to as managed behavioral health organizations (MBHO). The potential benefits of purchasing behavioral-specific healthcare financing services from sellers of these services, rather than self-supply, can include:

Code, § 14189; Welfare & Institutions Code, § 14197.1; Welfare & Institutions Code, § 14184.402; Insurance Code 10144.51.

31 "Behavioral Health Treatments and Services," Substance Abuse and Mental Health Services Administration, last modified April 21, 2020, https://www.samhsa.gov/find-help/treatment.

32 "What Does the Affordable Care Act Mean for Behavioral Health,?" Substance Abuse and Mental Health Services Administration, accessed September 8, 2021, https://www.samhsa.gov/sites/default/files/samhsa_infographic2_final_banner_rev_r111314b.pdf.

33 *See, e.g.*, Garfield, Rachel L., "Mental Health Financing in the United States: A Primer," The Henry J. Kaiser Family Foundation, April 2011, p. 7.

34 Frank, Richard G., and Thomas G. McGuire, "Economics and Mental Health," in *Handbook of Health Economics*, Anthony J. Culyer and Joseph S. Newhouse, eds., 1st Edition, Vol. 1B, Handbooks in Economics, 2000, pp. 905–907; Frank, Richard G., Thomas G. McGuire, and Joseph P. Newhouse, "Risk Contracts in Managed Mental Health Care," *Health Affairs* Vol. 14, No. 3, 1995, pp. 51–64, at 52–54.

a. Economies of specialization: Sellers of behavioral-specific healthcare financing services offer sellers of healthcare financing services the opportunity to hire organizations that focus only on behavioral healthcare services, which can result in more efficient contracting, monitoring, and treatment management.[35]

b. Economies of scale: Sellers of behavioral-specific healthcare financing services spread the fixed cost of developing a network of behavioral care providers and care management protocols across multiple sellers of healthcare financing services. The advantages of economies of scale are particularly important for smaller to mid-size sellers of healthcare financing services for whom these fixed costs would be prohibitive.[36]

52. On the other hand, purchasing may increase costs or lower the quality of healthcare financing services:

a. Incentive alignment: Absent regulation, sellers of behavioral-specific healthcare financing services may have an incentive to impose lower limits for spending on behavioral healthcare services than is optimal from the perspective of the sellers of healthcare financing services for medical and surgical care. If sellers of behavioral-specific healthcare financing services are providing risk-bearing services, they likely profit from limiting spending on behavioral health services. Sellers of healthcare financing services for medical and surgical care might prefer a higher level of

---

35 Frank, Richard G. and Rachel L. Garfield, "Managed Behavioral Health Care Carve-Outs: Past Performance and Future Prospects," *Annual Review of Public Health* Vol. 28, 2007, pp. 303–320, at 306.

36 Frank, Richard G. and Rachel L. Garfield, "Managed Behavioral Health Care Carve-Outs: Past Performance and Future Prospects," *Annual Review of Public Health* Vol. 28, 2007, pp. 303–320, at 307.

spending on behavioral healthcare services, as it could potentially increase the quality of care for enrollees and potentially reduce spending on medical and surgical care.[37]

b. Coordination of care: It can be more difficult to coordinate care when patients have one seller of healthcare financing services for medical and surgical care and a different seller of behavioral-specific healthcare financing services. Patients' behavioral care providers and medical/surgical care providers will likely contract with different provider networks, which can increase fragmentation and therefore lead to lower quality of care or higher spending.[38]

C. Employee Assistance Programs

53. EAPs, offered by private and public employers to their employees (and often to their immediate family members), provide a variety of confidential services aimed at addressing issues that can be detrimental to employees' wellbeing and productivity. EAPs cover a broad range of services for psychological issues, stress and grief management, substance abuse, nutritional, financial, legal, and work-life balance concerns.[39]

54. According to the International Employee Assistance Professional Association:[40]

> In general, an EAP is a set of professional services specifically designed to improve and/or maintain the productivity and healthy functioning of the

---

37 Frank, Richard G. and Rachel L. Garfield, "Managed Behavioral Health Care Carve-Outs: Past Performance and Future Prospects," *Annual Review of Public Health* Vol. 28, 2007, pp. 303–320, at 314.

38 Frank, Richard G. and Rachel L. Garfield, "Managed Behavioral Health Care Carve-Outs: Past Performance and Future Prospects," *Annual Review of Public Health* Vol. 28, 2007, pp. 303–320, at 313.

39 "What is an Employee Assistance Program (EAP)?," U.S. Office of Personnel Management, accessed August 24, 2021, https://www.opm.gov/FAQs/QA.aspx?fid=4313c618-a96e-4c8e-b078-1f76912a10d9&pid=2c2b1e5b-6ff1-4940-b478-34039a1e1174&result=1; "Policy, Data, Oversight: Work-Life," U.S. Office of Personnel Management, accessed August 24, 2021, https://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/.

40 "Definitions of an Employee Assistance Program (EAP) and EAP Core Technology," International Employee Assistance Professional Association, accessed September 6, 2021, https://www.eapassn.org/About/About-Employee-Assistance/EAP-Definitions-and-Core-Technology.

> workplace and to address a work organization's particular business needs through the application of specialized knowledge and expertise about human behavior and mental health.
>
> More specifically, an EAP is a workplace program designed to assist: (1) work organizations in addressing productivity issues, and (2) "employee clients" in identifying and resolving personal concerns, including health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance.

55. According to the U.S. Office of Personnel Management:[41]

> An Employee Assistance Program (EAP) is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems. EAPs address a broad and complex body of issues affecting mental and emotional well-being, such as alcohol and other substance abuse, stress, grief, family problems, and psychological disorders. EAP counselors also work in a consultative role with managers and supervisors to address employee and organizational challenges and needs. Many EAPs are active in helping organizations prevent and cope with workplace violence, trauma, and other emergency response situations.

56. Some services covered by EAPs can be provided regardless of where the employee and provider are located, whereas in-person services covered by EAPs can only be provided when the employee and provider are located near each other. Providers offer different modalities, including in-person, over the phone, or over video sessions.[42] The telehealth modality (defined as over the phone or over video sessions) became more popular in 2020 because of the COVID-19 pandemic.[43] These different modalities to access EAPs

---

41 "What is an Employee Assistance Program (EAP)?," U.S. Office of Personnel Management, accessed August 24, 2021, https://www.opm.gov/FAQs/QA.aspx?fid=4313c618-a96e-4c8e-b078-1f76912a10d9&pid=2c2b1e5b-6ff1-4940-b478-34039a1e1174&result=1.

42 "Employee Assistance Program," American Psychiatric Association Foundation: Center for Workplace Mental Health, American Psychiatric Association accessed August 25, 2021, https://www.workplacementalhealth.org/mental-health-topics/employee-assistance-programs.

43 "Telehealth utilization has stabilized at levels 38X higher than before the pandemic" (Bestsennyy, Oleg, et al., "Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?," McKinsey & Company, July 9, 2021, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality).

mean that for some services, telehealth can happen no matter the geographic proximity of patients and providers, but for patients who prefer in-person interactions, geographic proximity still matters.

57. In California, EAPs can be subject to one of two levels of regulation and reporting requirements based on the services provided. EAPs with benefits that include more than three treatments for health, mental health, or substance abuse within a six-month period are regulated as managed care plans by the California DMHC. EAPs with benefits that include three or fewer of these treatments within a six-month period are exempt from most DMHC regulation and reporting requirements. Exempt EAPs must still comply with certain requirements related to truthful advertising and representations, maintaining a system for addressing enrollee or provider complaints, and retaining records.[44] All EAPs can provide an unlimited number of services to treat nutritional, financial, and legal concerns. Further, all EAPs can include services for identifying mental health issues and substance abuse disorders and referral services to healthcare providers who are covered by enrollees' healthcare plans' behavioral healthcare benefits.[45]

58. The services offered by EAPs differ from the services covered by behavioral-specific healthcare financing services in several important ways. First, EAPs tend to offer a wider range of services, including services to treat financial and legal concerns. Second, the services offered by EAPs are typically free for employees, whereas the services of behavioral care providers included in health plans typically have cost-sharing

---

44 "EAP Exemption Criteria," California Department of Managed Health Care, last modified May 2018, https://www.dmhc.ca.gov/Portals/0/Docs/OPL/EAP%20Exemption%20Criteria.pdf.

45 "Employee Assistance Program," California Department of Managed Health Care, accessed September 2, 2021, https://www.dmhc.ca.gov/LicensingReporting/EmployeeAssistanceProgram.aspx.

arrangements.[46] Third, EAPs typically cover fewer than 10 sessions and are designed to address short-term needs, whereas the services covered by behavioral-specific healthcare financing services can address both short-term and long-term needs. Often employees using the services of EAPs who need longer-term assistance will transition from EAP services to the services covered by their behavioral-specific healthcare financing services.[47,48]

59. EAPs also differ from firms selling online therapy, such as Talkspace and Ginger,[49] which may offer services that are substitutes for some—but not all—services offered by EAPs.[50]

60. Users of Talkspace purchase unlimited messaging with licensed counselors and, depending on the subscription plan, also live video sessions.[51] Users of Ginger purchase text-based behavioral health coaching, video therapy, and personalized skill-building

---

46 Sharar, David A., "General Mental Health Practitioners as EAP Network Affiliates: Does EAP Short-Term Counseling Overlap with General Practice Psychotherapy?," *Brief Treatment and Crisis Intervention* Vol. 8, No. 4, 2008, pp. 358–369, at 358.

47 When employers' EAPs and behavioral-specific healthcare financing services have overlapping provider networks, employees may be able to continue with the same behavioral health provider at prices that depend on the deductible and coinsurance rates of their plans. Otherwise, EAPs can provide support finding referrals for employees. *See* Zanfardino, Kelly, "How an Employee Assistance Program Benefits Employees," Insperity, accessed September 2, 2021, https://www.insperity.com/blog/employee-assistance-programs/.

48 Merrick, Elizabeth S. et al., "Integrated Employee Assistance Program/Managed Behavioral Health Care Benefits: Relationship with Access and Client Characteristics," *Administration and Policy in Mental Health and Mental Health Services Research* Vol. 36, No. 6, 2009, pp. 416–423.

49 Other providers include smaller platforms such as BetterHelp (https://www.betterhelp.com) and Lyra Health (https://www.lyrahealth.com).

50 These firms focus on providing online services for psychotherapy and psychiatry (including, for example, assistance with anxiety and depression management, or couple and family therapy), though they do not offer services related to substance abuse treatments.

51 "How Does Talkspace Work", Talkspace, accessed September 13, 2021, ,https://www.talkspace.com/online-therapy/unlimited-messaging-therapy/; "How Much Does Talkspace Cost", Talkspace, March 26, 2020, https://help.talkspace.com/hc/en-us/articles/360041531131-How-much-does-Talkspace-cost-.

activities.[52] Both Talkspace and Ginger offer online referral services that match individuals to counselors and other healthcare providers.[53]

61. I do not have data on the number of users of Ginger, Talkspace, and other firms that sell online therapy and do not consider them further in this report. Given the differences between the EAP services sold by companies, such as Magellan and Centene, and the services of Ginger, Talkspace, and other firms that sell online therapy, it is unlikely many employers would consider them to be substitutes.

62. Employers can provide their employees with access to EAPs by contracting with a company that sells only EAPs or a company that sells both EAPs and behavioral-specific healthcare financing services.[54] Some large employers may self-supply EAPs, while others may provide them through employee unions.[55]

63. Many employees have access to EAPs. As of March 2020, in the Western Census Region, which includes California and 12 other states,[56] about 55 percent of employees

---

52 "You Deserve Incredible Mental Healthcare", Ginger, accessed September 13, 2021, https://www.ginger.com/experience.

53 "The Benefits of Being a Talkspace Therapist", Talkspace, accessed September 13, 2021, https://www.talkspace.com/blog/talkspace-online-therapist-provider-jobs-perks-benefits/ ; "Practice Policies and Informed Consent", Ginger, accessed September 13, 2021, https://www.ginger.com/practice-policies-and-procedures-important-patient-information.

54 Elizabeth L. Merrick et al., "Patterns of Service Use in Two Types of Managed Behavioral Health Care Plans," *Psychiatric Services* Vol. 61, No. 1, 2010, pp. 86–89, at 86.

55 "Managing Employee Assistance Programs," Society of Human Resource Management, accessed August 24, 2021, https://www.shrm.org/resourcesandtools/tools-and-samples/toolkits/pages/managingemployeeassistanceprograms.aspx.

56 The Western Census Region is defined as Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming ("Census Regions and Divisions of the United States," U.S. Census Bureau, accessed September 14, 2021, https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf).

had access to EAPs.[57] About 50 percent of private sector employees had access to EAPs compared to over 84 percent of state and local employees.[58]

64. Given the small number of sellers of EAPs with state-wide providers networks in California, I recommend that either Centene or Magellan be required to divest its EAP business in California, including its contracts with providers for EAPs and its contracts with customers of EAPs. If it is Magellan that divests its EAP business, then those groups that currently contract with Magellan for EAP services should be given the option to switch to Centene on the same or better terms, as their contract with Magellan, for a short period following the acquisition. If it is Centene that divests its EAP business, then those groups that currently contract with Centene for EAP services should be given the option to switch to Magellan on the same or better terms, as their contract with Centene, for a short period following the acquisition. I note that some large state employers currently contract with Magellan for their EAPs, and that Magellan's state-wide share of EAPs is more than twice Centene's state-wide share of EAPs. To minimize the disruption associated with a divestiture, it is sensible for Magellan to divest its EAP business, rather than Centene.

D. Services of Pharmacy Benefit Managers

65. Since the passage of the Affordable Care Act, individual and small group plans that are offered on the exchanges are required to include prescription drug benefits; most large

---

57 "National Compensation Survey: Employee Benefits in the United States," U.S. Department of Labor and U.S. Bureau of Labor Statistics, March 2020, https://www.bls.gov/ncs/ebs/benefits/2020/employee-benefits-in-the-united-states-march-2020.pdf, p. 148.

58 "National Compensation Survey: Employee Benefits in the United States," U.S. Department of Labor and U.S. Bureau of Labor Statistics, March 2020, https://www.bls.gov/ncs/ebs/benefits/2020/employee-benefits-in-the-united-states-march-2020.pdf, pp. 332, 516.

group plans include them too.[59] In 2019, approximately 10 percent of U.S. healthcare spending was on retail prescription drugs.[60]

66. Sellers of healthcare financing services have the option to self-supply prescription drug benefits or purchase prescription drug benefits by contracting with a PBM.[61,62] Sellers of healthcare financing services that are financially integrated with PBMs tend to self-supply. Other sellers of healthcare financing services tend to contract with PBMs to manage prescription drug benefits on their behalf.[63] PBMs provide a variety of services, including processing pharmacy claims, creating drug formularies,[64] creating pharmacy networks, and conducting drug utilization reviews.[65]

---

59 Braverman, Beth, "What are the ACA Essential Health Benefits?" HealthCareInsider, last modified January 21, 2021, https://healthcareinsider.com/what-are-the-aca-essential-health-benefits-210386. However, health insurance plans are not required to cover all drugs. For example, some health plans may only cover generic versions of drugs, and not branded ones. *See* Neighmond, Patti, "When Insurance Won't Cover Drugs, Americans Make 'Tough Choices' About Their Health," National Public Radio, January 27, 2020, https://www.npr.org/sections/health-shots/2020/01/27/799019013/when-insurance-wont-cover-drugs-americans-make-tough-choices-about-their-health.

60 "National Health Expenditures 2019 Highlights," Centers for Medicare & Medicaid Services, 2019 , https://www.cms.gov/files/document/highlights.pdf, p. 1.

61 PBM services can also be sold directly to employers who then purchase other healthcare financing services separately.

62 PBM services may be sold in other specialized products, such as Medicare Part D plans.

63 "Pharmacy Benefit Managers and Their Role in Drug Spending," The Commonwealth Fund, April 22, 2019, https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending.

64 A formulary is a list of drugs that are covered under a prescription drug plan. Typically, formularies are divided into separate tiers for generic drugs, preferred branded drugs, and non-preferred branded drugs. The tiers are generally based on the co-payments enrollees are required to pay for the drugs, and the level of pre-authorization required for plan enrollees to obtain the drugs. *See* Torrey, Trisha, "What is a Health Insurer's Drug Formulary and Tier Pricing?," Verywell Health, February 26, 2020, https://www.verywellhealth.com/drug-formulary-tiers-pricing-health-insurance-plans-2615042.

65 Drug utilization reviews are programs that are intended to assess a drug's effectiveness and potential dangers, ensure the drug is administered correctly, and confirm that patients are taking the proper steps for treatment and are using the drug appropriately. *See* "What is a Pharmacy Benefit Manager (PBM) and how Does a PBM Impact the Pharmacy Benefits Ecosystem?," Truveris, January 17, 2021, https://truveris.com/what-is-a-pharmacy-benefit-manager-pbm-and-how-does-a-pbm-impact-the-pharmacy-benefits-ecosystem/.

67. PBMs negotiate with both drug manufacturers and pharmacies to obtain lower prescription drug prices.[66] PBMs steer patient volume using formularies and pharmacy networks that might contain only a subset of prescription drugs and pharmacies.

68. Many PBMs are integrated with sellers of healthcare financing services (*see* Exhibit 2).[67]

69. Purchasing prescription drug services from a PBM can reduce costs. As with purchasing other services, such as behavioral-specific healthcare financing services, the benefits PBMs can offer to sellers of healthcare financing services include economies of specialization, economies of scale, and economies in price negotiations. The benefits of self-supply (including ownership of a PBM) are incentive alignment and coordination of care.

Exhibit 2 - Vertically Integrated Sellers of PBM and Healthcare Financing Services[68]

Seller of Healthcare Financing Services	Associated PBM
Aetna	CVS Caremark
Cigna	Express Scripts
UnitedHealth	OptumRx
Humana	Humana Pharmacy Solutions
BlueCross BlueShield	Prime Therapeutics
Anthem	IngenioRx
Centene	Envolve Pharmacy Solutions

66 "Pharmacy Benefit Managers and Their Role in Drug Spending," The Commonwealth Fund, April 22, 2019, https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending.

67 These PBMs include CVS Caremark, Express Scripts, OptumRx, Humana Pharmacy Solutions, and Prime Therapeutics, which are five of the six largest PBMs in the United States (*See* Section V.C).

68 Fein, Adam J., "Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020? (rerun)," Drug Channels Institute, May 4, 2020, https://www.drugchannels.net/2020/05/insurers-pbms-specialty-pharmacies.html; Centene Corporation, Form 10-K for the Fiscal Year Ended December 31, 2020, p. 11.

70. PBMs tend to offer their services nationally.[69] PBMs can construct formularies and negotiate drug prices with drug manufacturers at the national level. Many of the pharmacy chains that PBMs negotiate with are also national in their footprint.[70,71]

E. Specialty Pharmacy Services

71. Specialty pharmacies provide drugs to people with relatively complex health problems that require expensive and challenging drug regimes, such as hemophilia, multiple sclerosis, HIV/AIDS, growth hormone deficiency, infertility, and hepatitis C.[72] Often the drugs to treat these health conditions require special handling; they may need special storage, may get injected/infused through IVs, and/or may need to be administered in physicians' offices or hospitals.[73] Specialty pharmacies tend to be responsible for handling these drugs and instructing patients on how to use them properly.[74]

72. Specialty pharmacies have fewer locations than traditional pharmacies but can typically serve patients who are not located near their physical locations. Specialty pharmacies

---

69 Garis, Robert I. et al., "Examining the Value of Pharmacy Benefit Management Companies," *American Journal of Health-System Pharmacy* Vol. 61, No. 1, 2004, pp. 81–85, at 83.

70 Garis, Robert I. et al., "Examining the Value of Pharmacy Benefit Management Companies," *American Journal of Health-System Pharmacy* Vol. 61, No. 1, 2004, pp. 81–85, at 83.

71 In 2012, the Federal Trade Commission did not provide any analysis of potential geographic differentiation in its statement on the merger between Medco Health Solutions and Express Scripts, Inc., two of the three largest PBMs in the US at that time (Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts, Inc., No. 111-0210, Federal Trade Commission, April 2, 2012, https://www.ftc.gov/sites/default/files/documents/closing_letters/proposed-acquisition-medco-health-solutions-inc.express-scripts-inc./120402expressmedcostatement.pdf).

72 "Specialty Pharmaceuticals," Academy of Managed Care Pharmacy, July 18, 2019, https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/specialty-pharmaceuticals.

73 "Specialty Pharmaceuticals," Academy of Managed Care Pharmacy, July 18, 2019, https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/specialty-pharmaceuticals.

74 "Specialty Pharmaceuticals," Academy of Managed Care Pharmacy, July 18, 2019, https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/specialty-pharmaceuticals.

typically ship medications using specialized packing and insulation methods to ensure drugs maintain proper temperature.[75] The largest specialty pharmacies in the U.S. deliver nationwide.[76]

73. Many specialty pharmacies are jointly owned with a seller of healthcare financing services (*see* Exhibit 3).

Exhibit 3 - Vertically Integrated Sellers of Specialty Pharmacy and Healthcare Financing Services[77]

Seller of Healthcare Financing Services	Associated Specialty Pharmacy
Aetna	CVS Specialty
Cigna	Accredo
UnitedHealth	BriovaRx
Humana	Humana Pharmacy
BlueCross BlueShield	AllianceRx
Centene	AcariaHealth and PANTHERx

[75] *See, e.g.*, "Six Thoughts: Temperature-Controlled Shipping," Optum, accessed September 12, 2021, https://www.optum.com/business/resources/library/cool-thoughts-shipping-sensitive-medications.html; Peppers, Susan, "Delivering Your Meds on Time and at Temperature," Express Scripts, June 10, 2020, https://www.express-scripts.com/corporate/articles/delivering-your-meds-time-and-temperature.

[76] *See, e.g.*, "Medication Pick Up and Delivery," CVS Specialty, accessed September 12, 2021, https://www.cvsspecialty.com/manage-prescriptions/medication-pickup-delivery.html; "Your Health Matters," Express Scripts, accessed September 12, 2021, https://militaryrx.express-scripts.com/news/get-specialty-medications-home-through-express-scriptsr-pharmacy#:~:text=4342.,1900; "Home Delivery," AllianceRx, accessed September 12, 2021, https://www.alliancerxwp.com/home-delivery.

[77] Fein, Adam J., "Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020? (rerun)," Drug Channels Institute, May 4, 2020, https://www.drugchannels.net/2020/05/insurers-pbms-specialty-pharmacies.html; Fein, Adam J., "DCI's Top 15 Specialty Pharmacies of 2020: PBMs Expand Amid the Shakeout—While Walgreens' Outlook Dims," Drug Channels Institute, May 4, 2021, https://www.drugchannels.net/2021/05/dcis-top-15-specialty-pharmacies-of.html; "Centene Completes Acquisition of PANTHERx Rare Pharmacy (PANTHERx)," Centene Corporation, December 30, 2020, https://investors.centene.com/news-events/press-releases/detail/8/centene-completes-acquisition-of-pantherx-rare-pharmacy.

V. ANALYSIS OF HORIZONTAL CONCERNS

74. Centene and Magellan both sell behavioral-specific healthcare financing services, PBM services, specialty pharmacy services, and EAP services.[78] A potential concern is that currently Centene and Magellan may serve as a competitive constraint on each other to keep prices low, keep quality high, and innovate in California, and that the proposed acquisition would eliminate this potential competitive constraint. Centene and Magellan constrain each other when they are the top two choices to a customer. For the first three of these overlapping services—behavioral-specific healthcare financing services, PBM services, and specialty pharmacy services—the customers tend to be government agencies and sellers of the full set of healthcare financing services that contract for these services. For EAPs, the customers tend to be employers.

75. For each of these overlapping services, one indicator of the extent to which Centene and Magellan serve as competitive constraints on each other is each company's share of the service. More specifically, if Centene and Magellan have higher shares, that is an indication that they are more likely to be among a customer's top two choices. Another indicator of the extent to which Centene and Magellan serve as competitive constraints on each other—and the likely horizontal competitive effects of the proposed acquisition—is the competitive significance of other sellers of these services. If customers have good alternatives to Centene and Magellan, the horizontal competitive effects of the proposed acquisition will likely be smaller. Measures to assess the competitive significance of other sellers of these services include the shares of the other

[78] *See* Exhibit 1.

sellers, the number of other sellers, the change in Herfindahl-Hirschman Index ("HHI") from the proposed acquisition, and the post-acquisition HHI.[79]

A. Full Set of Healthcare Financing Services

76. The full set of healthcare financing services is not an area of horizontal competitive concern. Centene provides the full set of healthcare financing services in California, and Magellan does not. I report Centene's share of the full set of healthcare financing services in California in this section for two reasons. First, Centene self-supplies behavioral-specific healthcare financing services to its enrollees who purchase the full set of healthcare financing services.[80,81] Accordingly, Centene's share of the full set of healthcare financing services is relevant to Centene's competitive significance in behavioral-specific healthcare financing services. Second, Magellan sells behavioral-specific healthcare financing services to some of Centene's competitors who sell the full set of healthcare financing services. Centene's share of the full set of healthcare financing services is therefore also relevant to potential vertical concerns, as I discuss in Section VI.

77. Exhibit 4 shows, by segment, Centene's share measured as its percent of enrollees in California with the full set of healthcare financing services, based on 2020 data.

---

79 *See, e.g.*, "Horizontal Merger Guidelines," U.S. Department of Justice and the Federal Trade Commission, August 19, 2010, https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf, pp. 18–19.

80 Redacted

81 The list of PBMs registered by the DMHC indicates that Centene self-supplies PBM services; Envolve Pharmacy Solutions is Centene's PBM and California Health and Wellness Plan is a Centene subsidiary. *See* "Registered Pharmacy Benefit Management (PBM)," California Department of Managed Health Care, May 12, 2021, https://www.dmhc.ca.gov/Portals/0/Docs/OPL/Registered%20Pharmacy%20Benefit%20Management%20(PBM)%20-%205_12_2021.pdf?ver=2021-05-12-111748-260; Centene Corporation, Form 10-K for the Fiscal Year Ended December 31, 2020, Exhibit 21.

Centene's overall share of enrollees in non-public commercial, managed Medicare, and managed Medi-Cal is 8.4 percent, based on 2020 data. For non-public commercial healthcare financing services, Centene's share of enrollees in California is 4.7 percent. Looking at subsegments of enrollment in non-public commercial, Centene's share is 12.3 percent of enrollees in individual plans, 4.6 percent of enrollees in small group plans, and 2.0 percent of enrollees in large group plans.[82] Centene's share of enrollees in managed Medicare is 5.4 percent, and its share in managed Medi-Cal is 18.4 percent, based on 2020 data.

Exhibit 4 - Centene's Shares for Healthcare Financing Services by Segment California, 2020[83]

Segment	Share
Total	**8.4%**
Non-Public Commercial	4.7%
Individual	12.3%
Small	4.6%
Large	2.0%
Fully Insured	3.1%
ASO	0.0%
Managed Medicare	5.4%
Managed Medi-Cal	18.4%

Notes:
[1] I calculate Centene's shares as the percentages of total California enrollees within each segment for which Centene provides healthcare financing services.
[2] Shares include enrollees from WellCare, which Centene acquired on January 23, 2020.[84]
[3] Centene's managed Medi-Cal share includes approximately 400,000 enrollees reported under "From Other Plans (FOP)" in the data from Almanac. In addition, Centene's managed Medi-Cal share includes

82 The large segment is a combination of the fully insured large subsegment and the ASO subsegment. I treat fully insured large and ASO as one segment because large employers who are able to self-insure could substitute between these subsegments in response to price changes in one of them. Centene accounts for 3.1 percent of fully insured large group enrollees. Centene does not have ASO large group enrollment.

83 Almanac. The Almanac data include enrollment reported by DMHC and CDI.

84 "Centene Completes Acquisition of WellCare," Centene Corporation, January 28, 2020, https://www.centene.com/news/centene-completes-acquisition-of-wellcare.html.

enrollees of CalViva Health and Molina, two other sellers of healthcare financing services that have contracted with Centene to provide healthcare financing services to managed Medi-Cal plans.[85]

B. Behavioral-Specific Healthcare Financing Services

78. I calculate Centene's and Magellan's shares of behavioral-specific healthcare financing services in California. That said, geographic markets for certain behavioral-specific healthcare financing services, specifically access to a local network of behavioral care providers, are smaller than California. I discuss below an additional analysis of Centene's and Magellan's shares at the core based statistical area ("CBSA") level to address this point.

79. Exhibit 5 shows Centene's and Magellan's shares of behavioral-specific healthcare financing services in California, based on 2020 data.[86] I compute Centene's and Magellan's shares in non-public commercial, managed Medicare, and managed Medi-Cal. The numerators for these shares are the numbers of enrollees in Centene's or Magellan's behavioral-specific healthcare financing services in California in 2020. Centene self-supplies behavioral-specific healthcare financing services for its enrollees, so Centene's own enrollees are included in its numerators. The denominators for these shares are the total number of enrollees in non-public commercial, managed Medicare, and managed Medi-Cal healthcare financing services, respectively, in California in 2020.

---

85 *See* Health Net Community Solutions, Inc. Annual HMO/Health Plan Financial Statement, California Department of Managed Health Care, 2020, available at https://wpso.dmhc.ca.gov/fe/search/, at sheet "4 - Write-Ins." Note this is an underlying source to the data from Almanac. Health Net Community Solutions, Inc. is a subsidiary of Centene. *See* Almanac.

86 The data that I received from Magellan did not include enrollment information for its contract with Kaiser. Magellan terminated its contract with Kaiser in April 2020. It is my understanding that Kaiser paid Magellan Redacted per year for access to its network. This amount is equal to approximately Redacted percent of Magellan's revenue related to the sale of behavioral-specific healthcare financing services in California in 2020. This additional information on its contract with Kaiser does not change my conclusions, but I reserve the right to change my opinion pending additional information.

Exhibit 5 - Estimated Centene and Magellan Shares for Behavioral-Specific Healthcare Financing Services
California, 2020[87]

	Estimated Shares			
Organization	Non-Public Commercial	Managed Medicare	Managed Medi-Cal	Total
Centene	3.8%	7.2%	18.3%	8.8%
Magellan	13.4%	0.04%	0.01%	7.9%
Total	**17.2%**	**7.2%**	**18.4%**	**16.7%**

Note: I calculate estimated shares as the percentages of total California enrollees within each segment for which Centene or Magellan provide behavioral-specific healthcare financing services. *See* Appendix Exhibit C.1, Exhibit C.2, Exhibit C.3, and Exhibit C.4 for further details.

80. Centene's and Magellan's estimated state-level shares in behavioral-specific healthcare financing services for non-public commercial are 3.8 percent and 13.4 percent, respectively; for managed Medicare are 7.2 percent and 0.04 percent, respectively; and for managed Medi-Cal are 18.3 percent and 0.01 percent, respectively based on 2020 data. Based on these shares, Centene's acquisition of Magellan would increase the HHI by 102 points for non-public commercial, 1 point for managed Medicare, and 0 points for managed Medi-Cal.

81. Aggregating across these three segments, Centene's share is 8.8 percent, and Magellan's share is 7.9 percent based on 2020 data. Based on these shares, post-acquisition the HHI would increase by 140 points.[88]

[87] *See* Appendix Exhibit C.1, Exhibit C.2, Exhibit C.3, and Exhibit C.4 for the sources. The data include enrollment reported by DMHC and CDI.

[88] I report separately by segment and overall because it is uncertain whether Centene's and Magellan's competitive significance in each segment is best reflected by its segment-specific share or its overall share. The differences in shares across segments might reflect differences in the competitive significance of these parties by segment or might be at least partially a result of chance due to the discrete nature of winning contracts.

82. These state-level share estimates should be used with caution in an evaluation of the horizontal competitive impact of the proposed acquisition because the geographic market for certain behavioral-specific healthcare financing services, specifically access to a local network of behavioral care providers, is smaller than California. These state-level share estimates may be masking greater overlap in smaller geographic areas of California.

83. I performed a sensitivity analysis to examine whether Centene and Magellan's overlap is larger in some CBSAs than in others. [89,90] Centene and Magellan have higher shares for behavioral-specific healthcare financing services, including non-public commercial, managed Medicare, and managed Medi-Cal in some small CBSAs, measured by total population. Their combined shares for public and non-public commercial behavioral-specific healthcare financing services are above 30 percent in El Centro (52 percent), Chico (35 percent), Fresno (41 percent), and Madera (34 percent). In the largest CBSAs, the combined shares of Centene and Magellan are 18 percent in Los Angeles-Long Beach-Anaheim, 9 percent in Riverside-San Bernadino, and 8 percent in San Francisco-Oakland-Hayward.

84. The data I was able to review did not include the number of enrollees in behavioral-specific healthcare financing services for Centene's and Magellan's competitors. Available data from DMHC on "psychological plans," however, indicate that, in addition to Centene and Magellan, there are multiple options with which sellers of the full set of

89 Sensitivity analyses are used to determine the robustness of my assessment based on state-level data.

90 In particular, Appendix Exhibit C.6 presents Centene's and Magellan's behavioral-specific healthcare financing services shares by CBSA. I also present the population in each CBSA based on data from the U.S. Census Bureau and Centene's and Magellan's enrollment as a share of the population. Because the whole population is not enrolled in a non-public commercial, managed Medicare, or managed Medi-Cal plan, the shares are not comparable to the shares reported in the main report. However, the variability in the shares is informative about whether Centene's and Magellan's overlap is larger in some parts of California than others.

healthcare financing services can contract for behavioral-specific healthcare financing services in California. At least three national firms operate in California, including Beacon Health Options of California ("Anthem"),[91] Evernorth Behavioral Health of California, Inc., formerly known as Cigna Behavioral Health of California ("Cigna/Express Scripts"), and U.S. Behavioral Health Plan ("United/Optum").[92,93] In addition, there are regional firms selling behavioral-specific healthcare financing services in California such as Holman Professional Counseling.[94,95] That said, the data I was able to review did not include enrollment for Centene's and Magellan's national and regional competitors at a sub-state level to fully assess their network breadth and depth in California.

---

91 Anthem acquired Beacon Health Options in March 2020 ("Anthem, Inc. Completes Acquisition of Beacon Health Options," Beacon Health Options, March 2, 2020, https://www.beaconhealthoptions.com/anthem-inc-completes-acquisition-of-beacon-health-options/).

92 Redacted

93 U.S. Behavioral Health Plan, California is a subsidiary of United/Optum (UnitedHealth Group, Form 10-K for the Fiscal Year Ended December 31, 2020, Exhibit 21.1).

94 Redacted

95 Each of these companies holds the requisite Knox-Keene license to provide behavioral-specific healthcare financing services on a prepaid basis and has a behavioral-specific healthcare financing services provider network for at least a portion of the state.

85. While healthcare financing services, such as risk-bearing and administrative services, can be done nationally, access to a network of behavioral care providers is very local.

86. Several interviewees expressed concern that without access to the providers in Magellan's network, they would be unable to provide adequate coverage for their enrollees. Given the variability in Centene and Magellan's share across geographies, these concerns could be more substantial in some parts of California than others. These concerns are in the broader context of having too few behavioral care providers in the United States,[96] and in California specifically,[97] especially in rural areas.

87. The DHCS, the DMHC, and the Department of Insurance assess whether sellers of healthcare financing services provide access to an adequate behavioral care provider

---

[96] *See, e.g.*, Butryn, Tracy et al., "The Shortage of Psychiatrists and Other Mental Health Providers: Causes, Current State, and Potential Solutions," *International Journal of Academic Medicine* Vol. 3, No. 1, 2017, pp. 5–9; Johnson, Kaprea F. and Dana L. Brookover, "Counselors' Role in Decreasing Suicide in Mental Health Professional Shortage Areas in the United States," *Journal of Mental Health Counseling* Vol. 42, No. 2, 2020, pp. 170–186; Keeler, Heidi et al., "Virtual Mentorship Network to Address the Rural Shortage of Mental Health Providers," *American Journal of Preventive Medicine* Vol. 54, No. 6, June 2018, pp. S290–S295; Ku, Benson S. et al., "Associations Between Mental Health Shortage Areas and County-Level Suicide Rates Among Adults Aged 25 and Older in the USA, 2010 to 2018," *General Hospital Psychiatry* Vol. 70, May–June 2021, pp. 40–50.

[97] *See, e.g.*, "2020–2025 Mental Health Services Act Workforce Education and Training Five-Year Plan," Office of Statewide Health Planning and Development and California Behavioral Health Planning Council, February 2019; "California Mental Health and Substance Use System Needs Assessment," Technical Assistance Collaborative and Human Services Research Institute, submitted to the California Department of Health Care Services, February 2012; "California Mental Health and Substance Use System Needs Assessment and Service Plan—Volume 2: Service Plan," Technical Assistance Collaborative and Human Services Research Institute, submitted to the California Department of Health Care Services and California Bridge to Reform Waiver, September 30, 2013; "Meeting the Demand for Health," California Future Health Workforce Commission, February 2019; "Mental Health Providers," County Health Rankings & Roadmaps, 2021, https://www.countyhealthrankings.org/app/california/2021/measure/factors/62/data; Howle, Elaine M., "Lanterman-Petris-Short Act: California Has Not Ensured That Individuals With Serious Mental Illnesses Receive Adequate Ongoing Care," No. 2019-119, Auditor of the State of California, July 28, 2020, https://www.bsa.ca.gov/reports/2019-119/index.html; Letter from Jonathan E. Sherin to Janice Hahn et al., "RE: Report Response to Addressing the Shortage of Mental Health Hospital Beds (Item 8, Agenda of January 22, 2019)," Department of Mental Health, October 29, 2019, http://file.lacounty.gov/SDSInter/bos/supdocs/142264.pdf.

network for their enrollees or subscribers.[98] This includes assessing the ratio of specialist physicians to enrollees, including psychiatrists, geographic access to behavioral care facilities and providers, and timely access to appointments with behavioral care providers.

88. For example, the DHCS conducts a "Timely Access" survey of "all Medi-Cal managed care health plans (MCPs) to benchmark the plan's performance with respect to provider availability and wait time standards for urgent and non-urgent pediatric and adult appointments among network provider types." The 2019 DHCS survey found that many plans (or sellers of behavioral-specific healthcare financing services) do not provide comparable access to behavioral care providers, especially in more rural areas.[99,100,101] For example, CalViva in Madera only scheduled an urgent mental health appointment within 96 hours, 50 percent of the time.[102] In a 2019 survey of California residents by the Kaiser Family Foundation, 52 percent of respondents indicated that their community did

---

98 See, e.g., Medicaid Managed Care Final Rule: Network Adequacy Standards, Department of Health Care Services, 2018, https://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAStandards3-26-18.pdf; Cal. Health & Safety Code, § 1366.1, 1367, 1367.03; Cal. Code of Regulations, tit. 28, §§ 1300.51.H, 1300.67.2, subd. (d), 1300.67.2.1, 1300.67.2.2, subd. (c); Cal. Insurance Code, § 10133.5 ; Cal. Code of Regulations, tit. 10, §§ 2240.1, subd. (b), 2240.5, subd. (b), 2240.7

99 "Medi-Cal Managed Care 2019 Annual Timely Access Report," State of California—Health and Human Services Agency and Department of Health Care Services, 2019, https://www.dhcs.ca.gov/Documents/MCQMD/Timely-Access-Report.pdf.

100 DMHC also produces its own report on timely access requirements. "Time Access Report: Measurement Year 2019," DMHC, 2019, https://www.dmhc.ca.gov/Portals/0/Docs/OPM/2019TAR.pdf. The State of California Office of the Patient Advocate also performs an annual assessment of HMO/PPO health plans in California on access to ongoing substance use treatment, medication for depression, and follow-up behavioral health care. "Behavioral and Mental Health Care Summary: 2020-21 Edition," State of California Office of the Patient Advocate, https://reportcard.opa.ca.gov/rc/hmo_ppo_combinedTopic.aspx?Category=HMO_PPOHEDIS&Topic=MentalHealthCare.

101 Many of DMHC's timely access requirements were codified and signed into state law on October 8, 2021. Health Care Coverage: Timely Access to Care, Cal. Senate. B. 221 (2021-2022).

102 "Medi-Cal Managed Care 2019 Annual Timely Access Report," State of California—Health and Human Services Agency and Department of Health Care Services, 2019, https://www.dhcs.ca.gov/Documents/MCQMD/Timely-Access-Report.pdf, p. 35.

not have enough behavioral care providers to serve the needs of local residents.[103] Maintaining access to available behavioral care providers is especially critical given the forecasted decrease in behavioral care providers over the next 10 years due to retirement of existing providers. A 2018 report projected that the number of psychiatrists in California was projected to decrease by 34 percent between 2016 and 2028.[104,105]

C. Employee Assistant Programs

89. I calculate Centene's and Magellan's shares of EAPs at the state-level. That said, geographic markets for some services of EAPs are smaller than the state, especially in a state as large as California. Specifically, some of the services included in EAPs involve in-person access to a network of local providers. Centene and Magellan stated that they did not have information about their membership at a sub-state level in their ordinary course of business, and the data that they did provide did not allow me to credibly calculate shares at a sub-state level, a point I return to below.

90. I calculate Centene's and Magellan's shares for EAPs using data on EAP enrollment provided by Centene and Magellan and an estimate of total EAP enrollment in California

---

103 Hamel, Liz et al., "The Health Care Priorities and Experiences of California Residents," The Henry J. Kaiser Family Foundation and California Health Care Foundation, January 2019, https://www.chcf.org/wp-content/uploads/2019/02/HealthCarePrioritiesExperiencesCaliforniaResidents.pdf, p. 7.

104 Coffman, Janet et al., "California's Current and Future Behavioral Health Workforce," Healthforce Center at UCSF, February 12, 2018, https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf, p. 1.

105 The projection of too few providers is a concern despite efforts by California to increase the number of behavioral care providers. *See* "New University of California Program Will Double Pipeline of Specialized Mental Health Providers in Response to Growing Crisis," California Health Care Foundation, January 29, 2020, https://www.chcf.org/press-release/new-university-california-program-double-pipeline-specialized-mental-health-providers/.

based on data from the U.S. Bureau of Labor Statistics.[106,107] Centene's share in California is 6.7 percent and Magellan's share in California is 14.0 percent. Based on these state-level shares, post-acquisition, the HHI would increase by 188 points.

Exhibit 6 - Centene and Magellan Shares for EAPs
California, 2020[108]

Organization	Share
Centene	6.7%
Magellan	14.0%
Total	**20.7%**

Note: I calculate estimated shares as the percentages of total California EAP enrollees for which Centene or Magellan provide EAPs. *See* Appendix Exhibit C.5 for calculation details.

91. These state-level share estimates may be masking areas of greater overlap in smaller geographic areas of California. Accordingly, these state-level share estimates should be used with caution in an evaluation of the horizontal competitive impact of the proposed acquisition because the geographic market for EAPs, specifically access to a local network of behavioral care providers, is smaller than California. Employers tend to purchase EAP services from sellers that sell access to a network of behavioral care providers located where their employees reside.[109] Many sellers of EAP services in California do not sell access to a state-wide network of behavioral care providers.

92. I requested data to perform a sensitivity analysis to examine whether Centene and Magellan's overlap is larger in some areas of California than others. As described above,

106 Appendix Exhibit C.5 describes the calculations underlying this approach in detail.

107 I include both EAPs that are exempt from regulation by the DMHC and not exempt. There are 44 exempt EAP plans registered with the DMHC that were exempt from reporting their EAP enrollment to the DMHC. These include ComPsych Behavioral Health Corporation, ACI Specialty Benefits, Inc., and Aetna Behavioral Health, LLC.[Redacted]

108 *See* Appendix Exhibit C.5.

109 "Employee Assistance Programs (EAPs)", Substance Abuse and Mental Health Services Administration, last modified September 16, 2021, https://www.samhsa.gov/workplace/toolkit/provide-support.

Centene and Magellan stated that they did not have these data, which would have allowed me to perform such an analysis.[110] As a result, I am unable to rule out the possibility that the acquisition would substantially lessen competition among sellers of EAP services.

93. Documentary evidence suggests that Centene and Magellan are among a small number of sellers of EAP services that compete for state-wide accounts.[111] The State of California provides EAP services to over 230,000 state employees and their eligible dependents.[112] Until 2014, the State of California purchased EAP services from Centene.[113] In 2014, the State of California put out a request for proposal (RFP) for EAP services.[114] Only four sellers of EAP services responded to the RFP, and only two sellers met the State of California's requirements on provider network, costs, and ability to meet the terms of the contract. Magellan won the contract, and the only other bid that the State of California received that met its requirements was Centene. Centene and Magellan were the second and first choice of the State of California.[115] Further, self-supplying EAP services is not

---

110 In particular, Appendix Exhibit C.7 presents Centene's and Magellan's EAP shares by CBSA. I calculate the shares using as the denominator the employed population in each CBSA, and as the numerator Centene's or Magellan's EAP enrollment in each CBSA based on zip code level data provided by Centene and Magellan. Based on these data, Centene and Magellan have EAP shares substantially in excess of 100 percent in some CBSAs. It is difficult to interpret these shares for multiple reasons, including problems with the data provided by Centene and Magellan. Centene reported the location of some of its EAP enrollment based on the location of the employer, rather than the location of the employee (*i.e.*, the enrollee). Magellan did not report the location of its enrollees. Magellan allocated EAP enrollment to locations based on providers' utilization in each zip code. Therefore, CBSAs with more EAP providers can have higher shares, even if these CBSAs do not have more enrollment. Further, the total employed population in each CBSA (the denominator I use in calculating the shares) is not enrolled in an EAP, and thus the shares by CBSA are not comparable to the state-level shares reported in the main report.

111 Redacted

112 Redacted

113 The California Department of Human Resources is the California government agency responsible for managing these benefits for employees of the State of CaliforniaRedacted

114 Redacted

115 Further reinforcing this point, Centene, Magellan, and Humana are the only three sellers of non-exempt EAP services that serve all 58 counties in California. The next three sellers of non-exempt EAP services that serve the largest share of counties are Aetna (57 of 58), Holman Professional Counseling (48 of 58),

an option for The State of California because of confidentiality concerns.[116] Therefore, Centene's acquisition of Magellan is likely to substantially lessen competition among sellers of EAP services to employers like the State of California.

94. A substantially lessening of competition among sellers of EAP services to large employers with a state-wide footprint—even absent a lessening of competition between sellers of EAPs selling to other employers—is itself a source of concern.

95. Given the small number of sellers of EAPs with state-wide providers networks in California, I recommend that either Centene or Magellan be required to divest its EAP business in California, including its contracts with providers for EAPs and its contracts with customers of EAPs. If it is Magellan that divests its EAP business, then those groups that currently contract with Magellan for EAP services should be given the option to switch to Centene on the same or better terms, as their contract with Magellan, for a short period following the acquisition. If it is Centene that divests its EAP business, then those groups that currently contract with Centene for EAP services should be given the option to switch to Magellan on the same or better terms, as their contract with Centene, for a short period following the acquisition. I note that some large state employers currently contract with Magellan for their EAPs, and that Magellan's state-wide share of EAPs is more than twice Centene's state-wide share of EAPs. To minimize the disruption associated with a divestiture, it is sensible for Magellan to divest its EAP business, rather than Centene.

---

and Beacon Health Options (43 of 58). Data was unavailable for one seller of non-exempt EAP services—Health Advocate West. *See* "Health Plan Dashboard," California Department of Managed Health Care, accessed September 28, 2021, https://www.dmhc.ca.gov/healthplandashboard.aspx.

116 Redacted

D. Services of Pharmacy Benefit Managers

96. Centene and Magellan both offer PBM services in California. Centene contracts with sellers of commercial healthcare financing services in California through its subsidiary, Envolve Pharmacy Solutions.[117] Magellan contracts with sellers of commercial healthcare financing services in California through its subsidiary, Magellan Rx Management.[118]

97. I calculate shares using national data on total prescription claims. PBMs and drug manufacturers negotiate drug prices nationally, and PBMs and sellers of healthcare financing services negotiate prices nationally.[119] Accordingly, national-level shares are an appropriate geographic area to assess the competitive significance of Centene and Magellan in PBM services. Based on the data I was able to review, these shares are reported for combined healthcare financing service segment (non-public commercial, Medicare, Medicaid) and not reported separately by segment.

98. Neither Centene nor Magellan are among the largest six PBMs.

---

117 Centene Corporation, Form 10-K for the Fiscal Year Ended December 31, 2020, p. 11; "Registered Pharmacy Benefit Management (PBM)," California Department of Managed Health Care, May 12, 2021, https://www.dmhc.ca.gov/Portals/0/Docs/OPL/Registered%20Pharmacy%20Benefit%20Management%20(PBM)%20-%205_12_2021.pdf?ver=2021-05-12-111748-260.

118 "Registered Pharmacy Benefit Management (PBM)," California Department of Managed Health Care, May 12, 2021, https://www.dmhc.ca.gov/Portals/0/Docs/OPL/Registered%20Pharmacy%20Benefit%20Management%20(PBM)%20-%205_12_2021.pdf?ver=2021-05-12-111748-260.

119 Garis, Robert I. et al., "Examining the Value of Pharmacy Benefit Management Companies," *American Journal of Health-System Pharmacy* Vol. 61, No. 1, 2004, pp. 81–85, at 83.

99. Exhibit 7 shows shares for the six largest PBMs, as well as the shares for Centene and Magellan, based on 2020 data. Together the six largest PBMs account for approximately 96 percent of total national prescription claims, based on 2020 data.[120]

[120] Fein, Adam J., "The Top Pharmacy Benefit Managers of 2020: Vertical Integration Drives Consolidation," Drug Channels Institute, April 6, 2021, https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html.

Exhibit 7 - PBM Shares
National, 2020[121]

Organization	Share
CVS/Aetna	32%
Cigna/Express Scripts	24%
United/Optum	21%
Humana	8%
MedImpact	6%
Prime Therapeutics	4%
All Other PBMs, including Centene and Magellan	4%

Notes:
[1] Shares are calculated as percentages of total national prescription claims received by each organization. Total prescription claims include claims at a PBM's network pharmacies plus prescriptions filled by a PBM's mail and specialty pharmacies, as well as discount card claims.
[2] CVS Health's share excludes double-counted network claims for mail choice claims filled at CVS retail pharmacies.
[3] Cigna's share includes claims from Cigna that fully transitioned to Express Scripts by the end of 2020 after Cigna acquired Express Scripts in 2018.[122] This share also includes claims from Ascent Health Services, which includes claims from Kroger Prescription Plans and partial-year claims from Prime Therapeutics (*see* note [4]).
[4] Prime Therapeutics' share excludes 2020 claims for which Ascent Health Services negotiated rebates and contracted the pharmacy network.
[5] All Other PBMs' share includes some cash pay prescriptions that use a discount card processed by one of the six largest PBMs.

100. Magellan won the contract to be the exclusive PBM for California's Medi-Cal program, starting in 2022.[123] Each of the six largest national PBMs is currently selling its PBM

121 Fein, Adam J., "The Top Pharmacy Benefit Managers of 2020: Vertical Integration Drives Consolidation," Drug Channels Institute, April 6, 2021, https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html.

122 "Cigna Closes $54 Billion Purchase of Express Scripts," CNBC, December 20, 2018, https://www.cnbc.com/2018/12/20/cigna-closes-54-billion-purchase-of-express-scripts.html.

123 "Medi-Cal Rx: Transitioning Medi-Cal Pharmacy Services from Managed Care to Fee-For-Service Frequently Asked Questions," California Department of Health Care Services, last modified June 30, 2020, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MRX-FAQ-V3-6-30-20.pdf, pp. 3–4; "Medi-Cal Rx Transition," California Department of Health Care Services, last modified September 3, 2021, https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx.

services for managed Medicaid in other states.[124,125] If California were to reopen the bidding process for its Medi-Cal PBM program, it is possible that at least some of the six national PBMs would be competitive in the state's Medi-Cal procurement process in the future. Based on Centene's and Magellan's small shares in PBM services and additional evidence described above, the proposed acquisition is not likely to substantially lessen competition among PBMs.

E. Specialty Pharmacy Services

101. Centene and Magellan both offer specialty pharmacy services in California.[126] Typically, specialty pharmacies ship to customers anywhere in the U.S.[127] Accordingly, I calculate

---

124 CVS Health Corporation, Form 10-K for the Fiscal Year Ended December 31, 2020, p. 2; "Powering Your Success in Regulated Markets," Express Scripts, accessed September 12, 2021, https://www.express-scripts.com/corporate/Regulated-Markets#medicaid; UnitedHealth Group Incorporated, Form 10-K for the Fiscal Year Ended December 31, 2020, p. 3; "Humana Health Horizons in Florida," Humana, accessed September 12, 2021, https://www.humana.com/medicaid/florida-medicaid; "Who We Serve," MedImpact, accessed September 12, 2021, https://www.medimpact.com/clients/who-we-serve; "Medicaid: Services + Solutions," Prime Therapeutics, accessed September 12, 2021, https://www.primetherapeutics.com/en/services-solutions/Medicaid.html.

125 As of 2016, 35 states used PBMs to administer some services for their Medicaid prescription drug benefits. Dranove, David, Christopher Ody, and Amanda Starc, "A Dose of Managed Care: Controlling Drug Spending in Medicaid," *American Economic Journal: Applied Economics* Vol. 13, No. 1, January 2021, pp. 170–197.

126 Redacted

127 Furthermore, if geographic proximity was necessary, then Magellan would not be imposing competitive constraints because Magellan does not have any physical location in California. Many other specialty pharmacies do have physical locations in California. If I were to assume that only specialty pharmacies with physical locations in California and Magellan competed in California, and that shares were proportionate to national shares then Centene's shares would be [4.7] percent, Magellan's shares would be below [1.6] percent, and post-acquisition HHI would increase by less than [15] points. Fein, Adam J., "The Top Pharmacy Benefit Managers of 2020: Vertical Integration Drives Consolidation," Drug Channels Institute, April 6, 2021, https://www.drugchannels.net/2021/04/the-top-pharmacy-benefit-managers-pbms.html; "Medi-Cal Contracted Specialty Pharmacy Locations for Blood Factors," California Department of Health Care Services, last modified September 1, 2021, https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/BloodFactors.aspx; "Contact," Kroger Specialty Pharmacy, accessed September 12, 2021, https://www.krogerspecialtypharmacy.com/contact; "Pharmacy Locations," AmerisourceBergen US Bioservices, accessed September 12, 2021,

shares using national data on total prescription revenue from specialty drugs. Based on the data I was able to review, these shares are reported for combined healthcare financing service segment (non-public commercial, Medicare, Medicaid) and not reported separately by segment.

102. Exhibit 8 shows the share of total prescription revenue from specialty drugs for the ten largest specialty pharmacies, based on 2020 data. The four largest account for 75 percent of the total revenue for specialty drugs, based on 2020 data. Centene is the fifth-largest seller of specialty pharmacy services, with a share of only three percent. Magellan is not among the ten largest sellers of specialty pharmacies, with a share of less than one percent. These national shares suggest that the proposed acquisition is not likely to substantially lessen competition among specialty pharmacies.

https://www.usbioservices.com/locations; "Locations," AHF Pharmacy, accessed September 12, 2021, https://locations.ahfpharmacy.org/; "Locations," Ambers Specialty Pharmacy, accessed September 12, 2021, https://www.amberpharmacy.com/locations/.

Exhibit 8 - Specialty Pharmacy Shares
National, 2020[128]

Organization	Share
CVS/Aetna	27%
Cigna/Express Scripts	21%
United/Optum	14%
Walgreens Boots Alliance	13%
Centene	3%
Humana	2%
Kroger	2%
McKesson	1%
CarePathRx	1%
AmerisourceBergen	1%
Magellan	≤1%
All Other Specialty Pharmacies	15%
Total	**100%**

Notes:
[1] Shares are calculated as percentages of total national prescription revenue from specialty drugs earned by each organization. Prescription revenue from specialty drugs includes revenues from retail, specialty, and mail pharmacies. It excludes revenues from network pharmacies of PBM-owned specialty pharmacies and infusion services covered by medical benefit.
[2] CVS Health's share includes revenues from CVS Caremark Specialty Pharmacy, CVS retail pharmacies, and revenues from various acquisitions completed in 2019. This share also includes specialty revenues from Anthem and Coventry, which switched from Express Scripts to CVS in 2019.
[3] Cigna/Express Scripts' share includes revenues from Accredo and Freedom Fertility. This share excludes revenues from Anthem and Coventry which switched from Express Scripts to CVS in 2019. Cigna acquired Express Scripts in 2018.[129]
[4] UnitedHealth's specialty pharmacy subsidiary, Optum Specialty Pharmacy, previously operated under the name BriovaRx.
[5] Walgreens Boots Alliance's share includes revenues from various acquisitions completed in 2019. This share includes revenues from AllianceRx, which is jointly owned by Walgreens Boots Alliance and Prime Therapeutics. Prime Therapeutics is owned by BlueCross BlueShield.[130]
[6] Centene' share includes revenues from AcariaHealth, Exactus Pharmacy Solutions, Foundation Care, and PANTHERx Rare Pharmacy.
[7] McKesson's share includes revenues from Specialty Pharmacy Solutions, Biologics by McKesson, and the Patient Assistance Pharmacy which previously operated under the name Care Advantage.
[8] CarePathRx's share includes revenues from BioPlus Specialty Pharmacy, ExactCare Pharmacy, and the management services organization of Chartwell Pennsylvania.

VI. ANALYSIS OF VERTICAL CONCERNS

103. Centene offers its enrollees the full set of healthcare financing services. Magellan sells behavioral-specific healthcare financing services, PBM services, and specialty pharmacy services to Centene's competitors in markets for the sale of healthcare financing services.

Accordingly, Centene's proposed acquisition of Magellan could create vertical competition concerns. First, the proposed acquisition could affect Magellan's willingness to contract with other sellers of healthcare financing services (Centene's competitors) or affect the prices that Magellan negotiates with Centene's competitors in the markets for the sale of healthcare financing services. I refer to this concern as a "direct" vertical concern. Second, post-acquisition Centene could potentially obtain competitively sensitive information about its competitors through Magellan. Finally, the proposed acquisition could disrupt the continuity of care for the enrollees of Centene's competitors, such as Blue Shield if, post-acquisition, Magellan no longer contracts with Blue Shield, for example. I refer to the last two concerns as "indirect" vertical concerns. In this section, I examine these potential vertical concerns.

A. Direct Vertical Concerns

104. Centene's proposed acquisition of Magellan could affect Magellan's willingness to contract with Centene's competitors in markets for the sale of healthcare financing services or the prices that Magellan negotiates with Centene's competitors.

105. This direct vertical concern is a possible result of the potential post-acquisition change in Magellan's incentives. Pre-acquisition Magellan has the incentive to maximize its profits and does not consider the effect of its strategic decisions on the profits of Centene. Post-acquisition Centene and Magellan are likely to maximize their combined profits.

---

128 Fein, Adam J., "DCI's Top 15 Specialty Pharmacies of 2020: PBMs Expand Amid the Shakeout—While Walgreens' Outlook Dims," Drug Channels Institute, May 4, 2021, https://www.drugchannels.net/2021/05/dcis-top-15-specialty-pharmacies-of.html.

129 "Cigna Closes $54 Billion Purchase of Express Scripts," CNBC, December 20, 2018, https://www.cnbc.com/2018/12/20/cigna-closes-54-billion-purchase-of-express-scripts.html.

130 "Walgreens and Prime Therapeutics Complete Formation of *AllianceRx Walgreens Prime*, a Combined Central Specialty Pharmacy and Mail Services Company," Prime Therapeutics, April 3, 2017, https://www.primetherapeutics.com/en/news/pressreleases/2017/alliancerx-walgreens-prime-release.html.

106. This possible change in Magellan's incentives could affect Magellan's post-acquisition decisions with respect to Centene's competitors. Post-acquisition Magellan likely would take Centene's profitability into account. If, by contracting with Centene's competitors, Magellan strengthens them, then it is possible that post-acquisition Magellan's incentives to contract with Centene's competitors at pre-acquisition prices or to contract at all would decrease post-acquisition. This is because post-acquisition Magellan faces a new "cost" of contracting with Centene's competitors: that doing so decreases Centene's profitability. In this case, Magellan may have an incentive to charge higher prices to Centene's competitors and may have a reduced incentive to contract with Centene's competitors at all.

107. I assess the extent to which the proposed acquisition is likely to change Magellan's incentives using the methodology of a vertical gross upward pricing pressure index ("vGUPPI"). In the section, I describe the vGUPPI methodology and report vGUPPI estimates based on the data available at the state-level. Data to estimate the vGUPPIs are not available at a geographic area smaller than the state. These state-level estimates provide an indication of the direct vertical concern associated with Centene's proposed acquisition of Magellan.

1. vGUPPI Methodology

108. The vGUPPI quantifies the profit that Centene would lose if Magellan were to contract with Centene's competitors.[131] The larger the profit that Centene would lose if Magellan

[131] The vGUPPI framework was developed in two different articles: Rogerson (2020) and Salop and Moresi (2013). I perform my analysis using the vGUPPI framework developed in Rogerson (2020). The Rogerson vGUPPI framework was used in public analyses of the effects of the News Corp./DirecTV merger, the Comcast/NBCU merger, and the AT&T/Time Warner merger. The Rogerson vGUPPI framework is appropriate for analyzing the effect of a merger or acquisition between a "downstream" firm and an "upstream" input supplier that negotiates over the price at which it sells its inputs to the competitors of the

contracts with Centene's competitors, the larger the vGUPPI. Because Magellan takes into account Centene's profits post-acquisition, strategic decisions that lower Centene's profits are "costly" to Magellan post-acquisition. The vGUPPI provides a way of quantifying how much more costly it is to contract with Centene's competitors. Using this framework, I report the "gross price effect," which is an estimate of how much more Centene's competitors would be expected to pay Magellan post-acquisition for its services.

109. There are two main factors that affect the vGUPPI and, therefore, my conclusions:[132]

a. **Magellan's competitive significance as a potential seller of behavioral-specific healthcare financing services, PBM services, and specialty pharmacy services to Centene's competitors.** Magellan's competitive significance as a supplier to Centene's competitors affects the likelihood that the employers/enrollees of Centene's competitors would switch to an alternative seller of healthcare financing services. If the decision of a seller of healthcare financing services not to contract with Magellan has a small effect on employers'/enrollees' choice of that seller of healthcare financing services, then—all else equal—the vGUPPI would be lower. If Centene's competitors have good substitutes to contracting with Magellan for these services, then—all else equal—the vGUPPI would be lower.

---

downstream firms. A seller of healthcare financing services that merges with a seller of behavioral-specific healthcare financing services, a seller of PBM services, of a seller of specialty pharmacy services could be framed in such an institutional framework. *See* Rogerson, William P., "Modelling and Predicting the Competitive Effects of Vertical Mergers: The Bargaining Leverage Over Rivals Effect," *Canadian Journal of Economics* Vol. 53, No. 2, 2020, pp. 407–436. Another vGUPPI analysis, developed by Salop and Moresi, applies to settings in which the upstream firm sets prices unilaterally. *See* Moresi, Serge, and Steven C. Salop, "vGUPPI: Scoring Unilateral Pricing Incentives in Vertical Mergers." *Antitrust Law Journal* Vol. 79, No. 1, 2013, pp. 185–214.

132 *See* Appendix B for details.

b. **Centene's share of healthcare financing services.** Centene's share of healthcare financing services in an indicator of the likelihood that those employers/enrollees who switch to another seller of healthcare financing services—if their seller of healthcare financing services no longer contracts with Magellan for behavioral-specific healthcare financing services, PBM services, or specialty pharmacy services—switch specifically to Centene. If the likelihood those employers/enrollees switch to Centene is low, then—all else equal—the vGUPPI would be lower.

110. Two practically necessary—but not sufficient—conditions for the proposed acquisition to potentially raise direct vertical concerns are:

a. There are sellers of healthcare financing service that compete with Centene and that contract with Magellan for behavioral-specific healthcare financing services, PBM services, or specialty pharmacy services; and

b. These sellers of healthcare financing services that compete with Centene have employers/enrollees who could switch to Centene.[133,134]

2. Behavioral-Specific Healthcare Financing Services

111. Magellan sells behavioral specific healthcare financing services to sellers of healthcare financing services that decide to contract with Magellan for behavioral-specific financing services. Some of these sellers of healthcare financing services compete with Centene—

---

133 In Appendix Exhibit C.8, I evaluate whether these two conditions are met for each of Magellan's customers in each segment.

134 There could be theoretical competitive concern even absent these conditions, but such concerns would be of little practical significance. The concern would be that Magellan is the second choice of sellers of healthcare financing services, that as the second choice, Magellan would be constraining the first choice, and that the proposed acquisition would reduce the amount of competitive constraint that Magellan imposes on the first choice. I restrict my analysis to vertical concerns for Magellan's actual customers because I lack data with which to calculate vGUPPIs for other customers and do not know which other customers Magellan is a second choice for.

meaning they sell to some segment (non-public commercial, managed Medicare, managed Medicaid) that Centene also sells to—in at least some parts of California.

112. The sellers of healthcare financing services that both compete with Centene in at least some parts of California and contract with Magellan for behavioral-specific healthcare financing services in California include California Physicians' Services, doing business as Blue Shield of California ("BSC"), and Western Health Advantage ("WHA").[135] In interviews with payers and other groups that contract with Magellan, Redacted noted the importance of Magellan's network to the provision of behavioral health services.[136] Centene, BSC, and WHA all sell non-public commercial healthcare financing services to individuals, small groups, and large groups in California. The sellers of public healthcare financing services that both compete with Centene in at least some parts of California and contract with Magellan for behavioral-specific healthcare financing services in California include Positive Healthcare ("PHC") for managed Medicare, and PHC and Health Plan of San Mateo for managed Medi-Cal. I calculate vGUPPIs for both BSC and WHA, separately for individuals, small groups, and large groups; for PHC for managed Medicare and managed Medi-Cal; and for Health Plan of San Mateo for managed Medi-Cal and report the results in Exhibit 9. I also calculate an enrollment-weighted average across the vGUPPIs for BSC, across the vGUPPIs for WHA, and across the vGUPPIs for PHC.

135 As I already mentioned, until 2020 Kaiser was a customer of Magellan.

136 Redacted

Exhibit 9 - Gross Price Effect for Magellan for Behavioral-Specific Healthcare Financing Services[137]

Segment	First-Order Approximation Gross Price Effect
Blue Shield of California	0.9%
Individual	2.5%
Small	0.8%
Large (Fully Insured + ASO)	0.3%
Western Health Advantage	0.3%
Individual	0.9%
Small	0.3%
Large (Fully Insured + ASO)	0.1%
Positive Healthcare	1.7%
Managed Medicare	0.7%
Managed Medi-Cal	2.5%
Health Plan of San Mateo	2.6%
Managed Medi-Cal	2.6%
Weighted Average	**0.9%**

Note: See Appendix B and Appendix Exhibit B.1 and B.2 for calculation details.

113. On average, across the four sellers of healthcare financing services that contract with Magellan for behavioral-specific healthcare financing services in California, the vGUPPIs are small. The enrollment-weighted average across Magellan's behavioral-specific healthcare financing services customers is 0.9 percent. Acquisitions are typically evaluated in part based on how large efficiencies from the acquisition would need to be to outweigh any competitive harm. Based on the enrollment-weighted average vGUPPI, efficiencies would not need to be very large to outweigh competitive harm. Specifically, if the proposed acquisition led to efficiencies in the form of marginal cost savings for Magellan's behavioral-specific healthcare financing services of at least 0.9

[137] *See* Appendix Exhibit B.2 for the sources.

percent, then those efficiencies would outweigh competitive harm on average. That said, the average masks variability across Magellan's customers and across the segments in which these customers operate. For example, across Magellan's customers, the average vGUPPI for Positive Healthcare is 1.7 percent and only 0.3 percent for Western Health Advantage.[138] Across the segments for Blue Shield of California, the vGUPPI for the individual segment is 2.5 percent and only 0.3 percent for the large group segment. The vGUPPIs are larger for managed Medi-Cal, 2.5 percent for Positive Healthcare and 2.6 percent for Health Plan of San Mateo. This makes sense, as Centene in California has a smaller presence in private commercial and a larger presence in managed Medi-Cal.

114. Two important factors that lead to the small average vGUPPIs across Magellan's customers for behavioral-specific healthcare financing services are (1) the availability of good alternatives to Magellan for those sellers of healthcare financing services that decide to contract for behavioral-specific healthcare financing services, rather than self-supplying behavioral-specific healthcare financing services and (2) Centene's small presence in markets for the sale of healthcare financing services in California. Again, for some specific customers in some specific segments, such as Blue Shield of California for the individual segment and Positive Healthcare for Managed Medi-Cal, the small average vGUPPI masks variability that results from Centene being a more important presence in some segments.

115. The vGUPPIs calculated using geographic areas smaller than California could be larger or smaller. In Appendix B, I report the results of two sensitivity analyses. These

[138] If Magellan and sellers of healthcare financing services contract on an "all-or-nothing" basis across segments, then vGUPPIs by segments would not be reflective of actual gross price effects. Only the average vGUPPIs by seller of healthcare financing services would be reflective of actual gross price effects.

sensitivity analyses do not indicate a significantly higher level of direct vertical concern across geographies on average.

116. The first sensitivity analysis addresses the potential biases associated with including Kaiser as a potential second choice for enrollees switching away from Centene. The second sensitivity analysis partially addresses the potential biases associated with using data at the state-level, rather than smaller geographies, such as CBSAs. Specifically, I use data from California's health insurance exchange–Covered California's marketplace—to investigate the possible issue of underestimating the vGUPPIs due to the limitations of only having state-level data available.

117. The first sensitivity analysis addresses the potential of underestimating the vGUPPIs as a consequence of including Kaiser as a potential second choice for those enrollees who switch away from Centene's competitors. More specifically, by including Kaiser, the analysis may underestimate the share of enrollees of BSC, WHA, PHC, or Health Plan of San Mateo whose second choice is Centene. Because Kaiser is differentiated from other sellers of healthcare financing service, it may be a less likely second choice than would be expected otherwise based on its overall share. As the sensitivity analysis reported in Appendix Exhibit B.3 shows, excluding Kaiser from the potential set of second choices does not change the estimates of the gross price effect for Magellan for behavioral-specific healthcare financing services.

118. The second sensitivity analysis partially addresses issues associated with the lack of data by geographies smaller than the state. There is likely variation in the shares of sellers of healthcare financing services across different parts of California. Thus, my analysis based on state-level shares using available data may underestimate the share of enrollees

of BSC, WHA, PHC, or Health Plan San Mateo whose second choice is Centene in some parts of the state and overestimate it in other parts. In addition, my analysis cannot account for variation in Magellan's share of behavioral-specific healthcare financing services across different parts of California. Not being able to account for variations in Centene's and Magellan's shares across California (due to data limitations) could bias my vGUPPI estimates downwards if, in certain geographic areas of California, both Centene and Magellan have larger shares.

119. In those geographic areas of California in which Magellan has a larger share of the enrollees of behavioral-specific healthcare financing services, it might be that there are fewer good alternatives to Magellan's network of behavioral care providers. If there are fewer good alternatives to Magellan's network of behavioral care providers in certain California geographies, then in those areas, enrollees may be more likely to switch away from Centene's competitors if Magellan decides not to contract with these competitors to provide behavioral-specific healthcare financing services. If Centene has a larger share of enrollees in these same parts of California, then more of the enrollees leaving Centene's competitors would switch to Centene. If enrollees are more likely to switch to Centene, this would give Magellan a stronger incentive post-acquisition not to contract with Centene's competitors.

120. I use data from California's health insurance exchange— Covered California's marketplace—to investigate the possible issue of underestimating the vGUPPIs due to the limitations of only having state-level data available.[139] As a practical matter, over 96

[139] *See* Appendix Exhibit B.3. Covered California's marketplace data provides a breakdown of enrollees by rating area. The Market Rules and Rate Review Final Rule (45 CFR Part 147) provide that each state will have a number of geographic rating areas that all issuers in the state must uniformly use as part of their rate

percent of the enrollees in Magellan's behavioral-specific healthcare financing services in California are enrollees in plans with BSC. Therefore, the geographic areas of California in which Magellan has a larger share of behavioral-specific healthcare financing services will be the same geographic areas of California in which BSC has a higher share of medical and surgical-specific healthcare financing services.

121. The vGUPPI estimates reported in Exhibit 9 suggest the direct vertical concerns are largest for BSC in the individual market. Accordingly, I calculate the likelihood that BSC enrollees on Covered California's marketplace would switch to Centene if they switched from BSC. I calculate this twice, once treating the state as the geographic area and once treating the rating area as the geographic area. The results are reported in Appendix Exhibit B.4. I find that the likelihood that BSC enrollees on Covered California's marketplace would switch to Centene if they switched from BSC is not higher when the methodology uses the rating area rather than the state as the geographic area.

122. This analysis using data from Covered California's marketplace suggests the geographic correlation between Magellan's shares in behavioral-specific healthcare financing services and Centene's shares in medical and surgical-specific healthcare financing services are not leading to underestimates of the vGUPPIs.[140]

---

setting ("Market Rating Reforms," Centers for Medicare & Medicaid Services, last modified May 5, 2020, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra). California is comprised of 19 standardized geographic rating areas, and each area can have different pricing and health insurance options.

[140] The diversion ratios are higher in some rating areas than others. That said, if Magellan and sellers of healthcare financing services contract on an "all-or-nothing" basis across geographies, then vGUPPIs by geography would not be reflective of actual gross price effects. Only the average vGUPPIs by seller of healthcare financing services would be reflective of actual gross price effects. Similarly, diversion ratios by rating area would also not be reflective of the overall diversion ratio.

123. This analysis is specific to Covered California's marketplace and thus, I cannot rule out the possibility that the vGUPPIs are underestimated for other segments, such as small group, large group, and managed Medi-Cal.

124. I discussed above in Section V.B the concern expressed by several interviewees about their ability to provide adequate coverage for their enrollees if they were to lose access to the providers in Magellan's network, the current challenges that the DMHC and Kaiser Family Foundation have documented with providing access to behavioral health services, especially in rural areas, and the projected decrease in behavioral care providers in California over the next decade.

125. Based on the vGUPPI analysis, as well as the concerns expressed by interviewees, there is a risk that the acquisition could result in less access to behavioral care providers in certain areas. To mitigate this concern, I recommend that post-acquisition the Centene-Magellan entity be prohibited from making any contractual arrangements with behavioral care providers that restrict behavioral care providers' ability to contract with employers and sellers of healthcare financing services.

3. Employee Assistance Programs

126. There is no direct vertical concern for EAPs because Magellan does not sell EAPs to sellers of healthcare financing services that compete with Centene. Magellan's EAPs are typically sold to employers, rather than sellers of healthcare financing services. As a result, Magellan's contracting decisions would not be expected to affect Centene's profit.

4. Pharmacy Benefit Manager Services

127. There is potential for direct vertical concern for PBM services because Magellan does sell PBM services to sellers of healthcare financing services, some of whom compete with Centene.

128. That said, Magellan did not provide information about its enrollment for PBM services.[141] Accordingly, I cannot analyze the likelihood of direct vertical concern for PBM services based on estimates of vGUPPIs.

129. What is known, however, is that Magellan is a small player in the provision of PBM services (less than 4 percent nationally).[142] It is also known that Centene accounts for a small share of healthcare financing services in California. Centene's share of non-public commercial enrollment in California is 4.7 percent, its share in managed Medicare is 5.4 percent, and its share in managed Medi-Cal segment is 18.4 percent based on 2020 data. These two factors suggest the likelihood of a significant direct vertical concern for PBM services in California is negligible.

130. Magellan's ability to competitively weaken Centene's competitors by not contracting with them is limited by the fact that Magellan is a small player in the provision of PBM services and, thus, lacks competitive significance as a potential PBM service option for Centene's competitors. Many major, national PBMs supply (or can supply) to sellers of healthcare financing services in California.[143]

131. Centene's low share of healthcare financing services means that even if Magellan could competitively weaken Centene's competitors, few enrollees would switch to Centene.

---

141 I have a list of customers from Magellan, but the list does not have enrollment and the customers appear to be employers, rather than sellers of the full set healthcare financing services. Magellan may have an incentive to negotiate higher prices with employers for PBM services to get them to purchase the full set of healthcare financing services from Centene, but I lack the data to quantify such a concern. Further, I do not have information on whether Magellan provides PBM services for non-public commercial and/or managed Medicare enrollees.

142 *See* Exhibit 7.

143 "Registered Pharmacy Benefit Management (PBM)," California Department of Managed Health Care, May 12, 2021, https://www.dmhc.ca.gov/Portals/0/Docs/OPL/Registered%20Pharmacy%20Benefit%20Management%20(PBM)%20-%205_12_2021.pdf?ver=2021-05-12-111748-260.

132. Currently in California, Magellan has the contract for PBM services for Medi-Cal. Magellan, however, contracts with the state and not with sellers of managed Medi-Cal plans. Accordingly, there is not a direct vertical concern for PBM services and managed Medi-Cal.

5. Specialty Pharmacy Services

133. There is potential for direct vertical concern for specialty pharmacy services because Magellan does sell specialty pharmacy services to sellers of healthcare financing services, some of whom compete with Centene.

134. That said, Magellan did not provide information about its enrollment for specialty pharmacy services.[144] Accordingly, I cannot analyze the likelihood of direct vertical concerns for specialty pharmacy services based on estimates of vGUPPIs.

135. What is known, however, is that Magellan is a small player in the provision of specialty pharmacy services (less than one percent nationally). It is also known that Centene accounts for a small share of healthcare financing services in California. These two factors suggest the likelihood of a significant direct vertical concern for PBM services in California is negligible.

136. Magellan's ability to competitively weaken Centene's competitors by not contracting with them is limited by the fact that Magellan is a small player in the provision of specialty pharmacy services and, thus, lacks competitive significance as a potential option for specialty pharmacy services for Centene's competitors. Many major, national

144 Magellan did not provide information about its customers for specialty pharmacy services, or in other words which sellers of healthcare financing services contract with Magellan for their specialty pharmacy services. Further, Magellan did not provide information on whether it supplies specialty pharmacy services for non-public commercial, managed Medicare, or managed Med-Cal enrollees.

specialty pharmacies supply (or can supply) to sellers of healthcare financing services in California.

137. As I noted when evaluating direct vertical concerns for PBM services, Centene's low state-wide share of healthcare financing services means that even if Magellan could competitively weaken Centene's competitors, few enrollees would switch to Centene.

B. Indirect Vertical Concerns: Access to Competitively Sensitive Information

138. A vertical merger may reduce competition by allowing a merging firm to gain access to competitively sensitive information about its competitors. In some circumstances, the merging firm's potential access to competitively sensitive information could harm competition and adversely affect the stability of the health care delivery system.[145]

139. Post-acquisition Centene could gain access to potentially competitively sensitive information about those competitors in healthcare financing services that contract with Magellan for these services. Some of Centene's competitors in healthcare financing services contract with Magellan for behavioral-specific healthcare financing services, PBM services, and/or specialty pharmacy services. The competitively sensitive information could include information about use of prescription drugs or behavioral healthcare services by competitors' enrollees, which could enable Centene to better predict the healthcare spending of the enrollees of Centene's competitors in healthcare financing services. Potentially this information could enable Centene to adjust its strategy when bidding to sell healthcare financing services to the groups currently purchasing their healthcare financing services from its competitors. With this

[145] *See, e.g.*, Salop, Steven C., "A Suggested Revision of the 2020 Vertical Merger Guidelines," Georgetown University Law Center, July 7, 2021.

competitively sensitive information, Centene could potentially lower its bids to sell healthcare financing services to individuals and groups with lower predicted healthcare spending and increase its bids to sell healthcare financing services to groups with higher predicted healthcare spending.

140. Centene's access to this information could potentially harm competition for the sale of healthcare financing services. If relative to its competitors Centene can better predict the healthcare spending of certain groups, other sellers of healthcare financing services may have less incentive to compete with Centene to sell healthcare financing services to these groups. In this case, with fewer sellers of healthcare financing services competing for the business of certain groups, the prices paid by these groups for healthcare financing services may increase. Furthermore, Centene having this information has the potential to undermine the risk-reducing benefits of insurance by increasing differentials in prices paid for healthcare financing services by higher risk and lower risk groups. These changes overall have the potential to adversely affect the stability of the health care delivery system.

141. To the extent there are independent sellers of behavioral-specific healthcare financing services, PBM services, and specialty pharmacy services (not owned by a competitor in healthcare financing services) or sellers of these services with effective firewalls, Centene's competitors would have the option to contract with these independent or firewall-protected alternatives.[146] In this case with alternative independent or firewall-protected sellers, there is less potential for competitive harm, as a result of Centene's

[146] I do not have an opinion on whether there are sellers of behavioral-specific healthcare financing services, PBM services, and specialty pharmacy services with effective firewalls.

acquisition of Magellan and thus, Centene's access to competitively sensitive information.[147] With respect to PBM services, sellers of managed Medi-Cal do not have the option of choosing an alternative seller of PBM services. Accordingly, the potential for competitive harm is greater. Currently, in California for managed Medi-Cal, Magellan has the contract for PBM services. Sellers of managed Medi-Cal plans cannot use an alternative independent or firewall-protected seller of PBM services.

142. I understand that the DHCS has outlined a Conflict Avoidance Plan with respect Magellan's Medi-Cal business to "identify and avoid, neutralize, or mitigate organization and personal conflicts of interest."[148] This plan states, among other provisions, that Magellan "will be kept operationally separate from Centene's health plan business line and there will be no integration or sharing of Magellan's employees, processes, information technology systems, or data with that Centene business line."[149] The plan also includes a "Third-Party Monitor" responsible for monitoring "potential unauthorized access to [Magellan] systems used to support the Contract."[150]

143. To address the specific concerns raised by Centene's proposed acquisition of Magellan related to Centene's potential to gain access to competitively sensitive information, I recommend that measures similar to the ones outlined in the Conflict Avoidance Plan proposed by the DHCS with respect Magellan's Medi-Cal business be implemented for

---

147 Commercial and managed Medicare sellers of healthcare financing services can choose among alterative sellers of behavioral-specific healthcare financing services, sellers of services of pharmacy benefit managers, and sellers of specialty pharmacy services.

148 "Medi-Cal Rx Program Conflict Avoidance Report and Plan," Magellan Medicaid Administration, July 27, 2021, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MMA-DHCS-CAP-3.pdf, p. 1.

149 "Medi-Cal Rx Program Conflict Avoidance Report and Plan," Magellan Medicaid Administration, July 27, 2021, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MMA-DHCS-CAP-3.pdf, p. 1.

150 "Medi-Cal Rx Program Conflict Avoidance Report and Plan," Magellan Medicaid Administration, July 27, 2021, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MMA-DHCS-CAP-3.pdf, p. 2.

all of Magellan's business; in particular, Magellan should not be able to integrate or share its employees, processes, information technology systems, or data with Centene, and Centene should also not share its employees with Magellan; and a third-party monitor should ensure compliance.[151]

C. Indirect Vertical Concerns: Care Continuity Concerns

144. For multiple reasons, continuity of care is an especially important aspect of the provision of behavioral healthcare services. While there are many definitions of continuity of care, they generally concern the smooth progress of the patient through the healthcare system and over time in ways that are consistent with patients' health needs and preferences.[152] I understand that California law ensures that "subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care."[153] Continuity of the relationship with behavioral care providers is particularly important for patients, as breaks in the patient-provider relationship can lead to patient anxiety and setbacks in the treatment of behavioral health and substance abuse disorders.[154]

---

151 I understand that Centene has stated that it will maintain firewalls to ensure that clients' competitively sensitive information is not inappropriately used or shared. I also understand that these statements do not include the same level of detail or include all of the provisions outlined in the Conflict Avoidance Plan proposed by the DHCS.

152 "Continuity of Care Vital for Patients with Serious Mental Illness," Healio, November 6, 2019, https://www.healio.com/news/psychiatry/20191106/continuity-of-care-vital-for-patients-with-serious-mental-illness.

153 *See* California Health & Safety Code Section 1342(g). *See also*, "Continuity of Care," California Department of Managed Health Care, accessed September 29, 2021, https://www.dmhc.ca.gov/healthcareincalifornia/yourhealthcarerights/continuityofcare.aspx; California Health & Safety Code Sections 1373.95 and 1373.96.

154 Biringer, Eva et al., "Continuity of Care as Experienced by Mental Health Services Users - A Qualitative Study," *BMC Health Services Research* Vol. 17, No. 763, 2017; "Continuity of Care Vital for Patients with Serious Mental Illness," Healio, November 6, 2019, https://www.healio.com/news/psychiatry/20191106/continuity-of-care-vital-for-patients-with-serious-mental-illness.

145. Continuity of care with respect to behavioral healthcare services is also important as it can affect healthcare spending on medical and surgical care, as well.[155] The use of behavioral healthcare services has potentially large spillovers to other healthcare spending and to non-healthcare outcomes, such as workplace absenteeism.[156,157] Furthermore, disruptions in access to healthcare providers has been shown to increase healthcare spending.[158]

146. A factor that can disrupt continuity of care is a change in access to specific providers of behavioral care and substance abuse treatments. For enrollees in plans of the sellers of healthcare financing services that self-supply behavioral-specific healthcare financing services, a change in access could happen as a result of specific providers no longer participating in the network. For enrollees in the plans of those sellers of healthcare financing services that contract for behavioral-specific healthcare financing services or supplement their own network with a rental network(s) of providers of behavioral healthcare services, a change in access could happen for additional reasons, such as the sellers of behavioral-specific healthcare financing services no longer being willing to

---

155 "Continuity of Care Vital for Patients with Serious Mental Illness," Healio, November 6, 2019, https://www.healio.com/news/psychiatry/20191106/continuity-of-care-vital-for-patients-with-serious-mental-illness; Mainous 3rd, A. G., and James M. Gill, "The Importance of Continuity of Care in the Likelihood of Future Hospitalization: Is Site of Care Equivalent to a Primary Clinician?," *American Journal of Public Health* Vol. 88, No. 10, 1998, pp. 1539–1541.

156 "Importantly, we find that only 11 percent of the overall burden of illness was attributable to the direct medical costs of treating MDD itself, while the costs of treating comorbid medical conditions made up 24 percent. Another 4 percent was due to suicide-related costs, while fully 61 percent of the total burden in 2018 resulted from a combination of elevated workplace absenteeism and presenteeism (that is, reduced productivity as a result of working while sick)" (Greenberg, Paul E., "Major Depressive Disorders Have an Enormous Economic Impact," Scientific American, May 5, 2021, https://www.scientificamerican.com/article/major-depressive-disorders-have-an-enormous-economic-impact/).

157 *See also* "Association of Mental Health Disorders With Health Care Spending in the Medicare Population," *JAMA Network Open* Vol. 3 No. 3, March 2020.

158 Sabety, Adrienne H., Anupam B. Jena, and Michael L. Barnett, "Changes in Health Care Use and Outcomes After Turnover in Primary Care," *JAMA Internal Medicine* Vol. 181, No. 2, 2021, pp. 186–194.

contract with certain sellers of healthcare financing services or no longer being willing to rent their network to certain sellers of healthcare financing services.

147. Post-acquisition, it is possible that the Centene-Magellan entity would decide to no longer contract to provide behavioral-specific healthcare financing services, including access to Magellan's network of behavioral care providers, to other sellers of health financing services. The loss of access to Magellan's network of behavioral care providers could result in the loss of continuity of care for those enrollees who do not have access to their providers through other options, such as a replacement network of behavioral care providers.

148. Post-acquisition, it is also possible that some of the sellers of healthcare financing services that currently contract with Magellan for behavioral-specific healthcare financing services would no longer want to contract with the Centene-Magellan entity.

149. For whichever of these two possible reasons that could result in enrollees losing access to the behavioral care providers in Magellan's network, ensuring that there would be continuity of care for all enrollees could mitigate potential harm to enrollees.

150. During interviews, sellers of healthcare financing services conveyed that building a network of behavioral care providers would be costly and take a long time. Redacted estimates that it would take one to two years to build its own network of behavioral care providers. Kaiser estimated—after Magellan terminated its contract with Kaiser—that it will take 12 to 15 months to replace the behavioral care providers that it lost as a result of the Magellan termination. In parts of California, Kaiser has its own network of behavioral care providers, and thus Kaiser did not have to replace as many providers as a seller of healthcare financing services that relied exclusively on Magellan

would have to replace. To mitigate this potential concern, I recommend that those enrollees who currently have access to the services of behavioral care providers through the Magellan network, continue to have access for two years. More specifically, I recommend the post-acquisition Centene-Magellan entity be required to continue to sell to its current customers access to the Magellan network of behavior care providers for a period of two years at prices that increase by no more than the prior year's inflation rate.

VII. CONCERNS AND PROPOSED CONDITIONS

151. Based on a number of factors, the proposed acquisition is likely to substantially lessen competition among sellers of EAP services to those employers with employees dispersed across the state. Centene and Magellan are among a small number of sellers of EAP services with state-wide provider networks that meet the needs of some employers. The acquisition would substantially lessen competition among sellers of EAP services for those employers. Furthermore, data by Centene and Magellan could not be used to credibly assess whether Centene and Magellan's overlap is or is not larger in some areas of California than others. As a result, I am unable to rule out the possibility that the acquisition would substantially lessen competition among sellers of EAP services in some areas within California. Given the small number of sellers of EAPs with state-wide providers networks in California, I recommend that either Centene or Magellan be required to divest its EAP business in California, including its contracts with providers for EAPs and its contracts with customers of EAPs. If it is Magellan that divests its EAP business, then those groups that currently contract with Magellan for EAP services should be given the option to switch to Centene on the same or better terms, as their contract with Magellan, for a short period following the acquisition. If it is Centene that

divests its EAP business, then those groups that currently contract with Centene for EAP services should be given the option to switch to Magellan on the same or better terms, as their contract with Centene, for a short period following the acquisition. I note that some large state employers currently contract with Magellan for their EAPs, and that Magellan's state-wide share of EAPs is more than twice Centene's state-wide share of EAPs. To minimize the disruption associated with a divestiture, it is sensible for Magellan to divest its EAP business, rather than Centene.

152. I am concerned that there is a risk that the acquisition could result in less access to behavioral care providers in certain areas. To mitigate this concern, I recommend that post-acquisition the Centene-Magellan entity be prohibited from making any contractual arrangements with behavioral care providers that restrict behavioral care providers' ability to contract with employers and sellers of healthcare financing services.

153. I am concerned that as a result of the acquisition, Centene could gain access to competitively sensitive information about its competitors in healthcare financing services. Centene's access to this information on those competitors that contract with Magellan for these services could harm the competitive process, harm enrollees, and decrease the stability of the healthcare system. To mitigate these concerns, I recommend that measures similar to the ones outlined in Magellan's proposed Conflict Avoidance Plan be implemented for *all* of Magellan's business; in particular, Magellan should not be able to integrate or share its employees, processes, information technology systems, or data with Centene, and Centene should also not share its employees with Magellan; and a third-party monitor should ensure compliance.

154. I am concerned that the proposed acquisition could disrupt continuity of care for behavioral healthcare services for Magellan's customers. As a result of the acquisition, Magellan and some of its customers might no longer contract for services. As a result, enrollees might lose access to the behavioral care providers in Magellan's network. To mitigate this potential concern, I recommend that for any enrollees of health plans that currently provide access to the services of behavioral care providers to their enrollees through the Magellan network, the post-acquisition Centene-Magellan entity be required to continue to provide access to these services for a period of two years at rates that increase by no more than the prior year's inflation rate.

Deborah Haas-Wilson, Ph.D.
October 12, 2021

APPENDIX A: CURRICULUM VITAE

Deborah Ann Haas-Wilson

Marilyn Carlson Nelson Professor of Economics
Smith College

RESEARCH and TEACHING FIELDS:

Health Economics and Policy
Industrial Organization and Antitrust Policy
Microeconomics

EDUCATION:

University of California, Berkeley, California
Ph.D. in Economics, December 1983

University of Michigan, Ann Arbor, Michigan
B.A. in Economics with High Honors, May 1979

PROFESSIONAL EXPERIENCE:

Teaching:

Marilyn Carlson Nelson Professor of Economics
Smith College
Northampton, Massachusetts
1984-present

Visiting Professor of Public Policy
Harvard Kennedy School
Harvard University
Cambridge, Massachusetts
2014-2016

Other:

Visiting Scholar
University of California—Berkeley
January-June 2019

American Journal of Health Economics
Associate Editor
2013-present

Petris Center on Health Care Markets and Consumer Welfare—University of California, Berkeley
Member of the Advisory Committee
1999-present

Saint Alphonsus Medical System et al. v. St. Luke's Health System
Economic Consultant and Expert Witness in the successful antitrust challenge to a health system's acquisition of the largest practice of primary care physicians in Idaho
Case No. 1:12-cv-00560
2012-2013

Economic Consultant for the U.S. Federal Trade Commission
In the matter of Scott&White and King's Daughters Hospital
2009

Economic Consultant for the City of Oconomowoc, Wisconsin
In the matter of Aurora Health Care v. City of Oconomowoc
2006

Member of the Finance Committee
Town of Longmeadow, Massachusetts
2005-2009

American Society of Health Economists
Member of the Advisory Board
2004-2006

Economic Consultant and Expert Witness for the U.S. Federal Trade Commission
In the matter of Evanston Northwestern Health Corp. and ENH Medical Group, Inc.
Docket No. 9315
2003-2005

Economic Consultant for the Office of the Attorney General
Commonwealth of Massachusetts
Economic services to evaluate Baystate Health Systems' potentially anticompetitive practices
2000-2001

Economic Consultant and Expert Witness
In the matter of St. Luke's Hospital v. California Pacific Medical Center and Sutter Health Care System
San Francisco, California
1999-2000

Economic Consultant
California Department of Corporations Hearings on the Proposed Merger of Foundation Health Corporation and Health Systems International
Los Angeles, California
1997

Expert Testimony before the California Senate Committee on Insurance
Antitrust Issues Related to HMO Mergers
March 1997

Expert Testimony before the Connecticut Legislature concerning H.B. 5594: An Act Concerning Marriage and Family Therapist Vendorship
March 1992

Director, Public Policy Program
Smith College
1988-1990 and 1997-2001

Member of the Health Services Research Study Section
Agency for Health Care Policy and Research
U.S. Department of Health and Human Services
1990-1994

Member of the Executive Committee
Health Economics Group
The American Public Health Association
1994-1996

Visiting Committee
Economics Department, Amherst College
1997

Referee:
The American Economic Review, Journal of Health Economics, Journal of Law and Economics, Review of Economics and Statistics, Science, Journal of Human Resources, American Journal of Health Economics, Health Affairs, Health Services Research, Journal of Policy Analysis and Management, Policy Studies Journal, Resource and Energy Economics, Inquiry, Social Science Quarterly, Journal of Business and Economic Statistics, Journal of Industrial Economics, Review of Industrial Organization, Milbank Quarterly, The Journal of Health Politics, Policy, and Law, Population Research and Review, Journal of Economic Education

Guest Editor of *Health Economics* (with M. Gaynor) "Competition and Antitrust Policy in Health Care Markets" 7 (1998).

Guest Editor of the *Journal of Health Politics, Policy and Law* (with W. Sage and P. Hammer) "Kenneth Arrow and the Economics of Health Care," 26:5 (2001).

Guest Editor of the *International Journal of the Economics of Business* (with M. Vita) "Hospital Mergers and Antitrust Policy," (2011).

Postdoctoral Fellow, Florence Heller Graduate School for Advanced Studies in Social Welfare
Brandeis University, Waltham, Massachusetts
1987-1988

Research Assistant, Congressional Budget Office
Washington, D.C.
1977-1978

PUBLICATIONS:

BOOKS:

Managed Care and Monopoly Power: The Antitrust Challenge, Cambridge, MA: Harvard University Press (2003).

Uncertain Times: Kenneth Arrow and the Changing Economics of Health Care (co-editor with P. Hammer, M. Peterson, and W. Sage), Durham, NC: Duke University Press (2003).

CONTRIBUTIONS TO BOOKS:

"Comments on Markov and Other Models of Mental Health Treatment," in Richard Scheffler and Thomas McGuire, eds., *Advances in Health Economics and Health Services Research*, Vol. 8, JAI Press 1987.

"The Blessing and the Curse of Managed Care: Vertical Relations in Health Care Markets," (with M. Gaynor) in Michael A. Morrisey, ed., *Managed Care and Changing Health Care Markets*, Washington, D.C.: The AEI Press (1998).

"Selma J. Mushkin (1913-1979)" in Mary Ann Diman, Robert Dimand, and Evelyn Forget, eds., *A Biographical Dictionary of Women Economists*, Northampton, MA: Edward Elgar Publishing (2000).

"Revisiting a Merger: *FTC v. Evanston Northwestern Healthcare*," in John E. Kwoka Jr. and Lawrence J. White, eds., *The Antitrust Revolution: Economics, Competition, and Policy*, New York: Oxford University Press (2014).

"Hospital-Physician Integration: *The St. Luke's Case*," (with T. Chipty) in John E. Kwoka Jr. and Lawrence J. White, eds., *The Antitrust Revolution: Economics, Competition, and Policy*, New York: Oxford University Press (2018).

ARTICLES:

"The Effect of Commercial Practice Restrictions: The Case of Optometry," *Journal of Law and Economics*, Vol. 29 (April 1986).

"Tying Requirements in Markets with Many Sellers: The Contact Lens Industry," *The Review of Economics and Statistics*, Vol. 69 (February 1987).

"Demand for Mental Health Services: An Episode of Treatment Approach" (with R. Scheffler and A. Cheadle), *Southern Economic Journal*, Vol. 55 (July 1989).

"Employment Choices and Earnings of Social Workers: Comparing Private Practice and Salaried Employment," *Inquiry*, Vol. 26 (Summer 1989).

"Strategic Regulatory Entry Deterrence: An Empirical Test in the Ophthalmic Market," *Journal of Health Economics* 8:3 (December 1989).

"Quality and Provider Choice: A Multinomial Logit-Least Squares Model with Selectivity" (with E. Savoca), *Health Services Research* 24:6 (February 1990).

"Consumer Information and Providers' Reputations: An Empirical Test in the Market for Outpatient Psychotherapy," *Journal of Health Economics* 9 (1990).

"Centrally Planned Economy Vulnerability to Antidumping Protection" (with S. Brown), *Comparative Economic Studies*, 32:4 (Winter 1990).

"Quality Signals and Patient Referrals in the Market for Social Workers' Services," *Administration and Policy in Mental Health* 18:1 (September 1990).

"The Impact of Vendorship Legislation and Inter-Professional Competition in the Market for Social Workers' Services," *International Journal of Law and Psychiatry* 14:4 (October 1991).

"The Regulation of Health Care Professionals Other Than Physicians," *Regulation* 15:4 (Fall 1992).

"The Economic Impact of State Restrictions on Abortions: Parental Consent and Notification Laws and Medicaid Funding Restrictions," *Journal of Policy Analysis and Management* 12:3 (Summer 1993).

"The Relationships Between the Dimensions of Health Care Quality and Price: The Case of Eye Care," *Medical Care* 32:2 (February 1994).

"The Impact of State Abortion Restrictions on Minors' Demand for Abortions," *The Journal of Human Resources* 31:1 (Winter 1996).

"Women's Reproductive Choices: The Impact of Medicaid Funding Restrictions," *Family Planning Perspectives* 29:5 (September/October 1997).

"Introduction to the Special Issue on Competition and Antitrust Policy in Health Care Markets" (with M. Gaynor) *Health Economics* 7 (1998).

"Physician Networks and Their Implications for Competition in Health Care Markets," (with M. Gaynor) *Health Economics* 7 (1998).

"Increasing Consolidation in Health Care Markets: What are the Antitrust Policy Implications?" (with M. Gaynor) *Health Services Research* 33:5 (December 1998, Part II).

"Change, Consolidation, and Competition in Health Care Markets," (with M. Gaynor) *Journal of Economic Perspectives* 13:1 (Winter 1999).

"Regulation and the Optimal Size and Type of Abortion Provider," (with K. Lindberg) *Applied Economics* 31 (1999).

"Are Invisible Hands Good Hands? Moral Hazard, Competition, and the 2nd Best in Health Care Markets," (with M. Gaynor and W. Vogt) *Journal of Political Economy* 108:5 (October 2000).

"Kenneth Arrow and the Changing Economics of Health Care: Why Arrow? Why Now?" (with P. Hammer and W. Sage) *Journal of Health Politics, Policy and Law* 26:5 (October 2001).

"Arrow and the Information Market Failure in Health Care: The Changing Content and Sources of Health Care Information," *Journal of Health Politics, Policy and Law* 26:5 (October 2001).

"Competition and the Mental Health Care System," (with A. Cuellar) *American Journal of Psychiatry* 166:3 (March 2009).

"Hospital Mergers and Competitive Effects: Two Retrospective Analyses," (with C. Garmon) *International Journal of the Economics of Business* (February 2011). [Winner of the American Bar Association's Prize for Best Published Paper on Merger Retrospectives, 2012]

"Mergers between Competing Hospitals: Lessons from Retrospective Analyses," (with M. Vita) *International Journal of the Economics of Business* (February 2011).

"Use of Multiple Control Groups and Data Sources as Validation in Retrospective Studies of Hospital Mergers," (with C. Garmon) *International Journal of the Economics of Business* (February 2011).

OTHER:

"Healthy Competition: What's Holding Back Health Care and How to Free It," *New England Journal of Medicine* 354 (April 27, 2006).

"Two Hospital Mergers on Chicago's North Shore: A Retrospective Study" (with C. Garmon) Federal Trade Commission, Bureau of Economics Working Papers (January 2009).

"Tolerance of Cheating Violates the Principles of Education," Essay in *NCAA Champion Magazine* (Spring 2010).

RESEARCH GRANT AWARDS:

"Antitrust Policy and the Transformation of the Health Care Delivery System," Principal Investigator (M. Gaynor, Co-Investigator) Investigator Award in Health Policy Research, Robert Wood Johnson Foundation, September 1995-August 1999

EXPERT TESTIMONY IN THE LAST FOUR YEARS:

In Re: Blue Cross Blue Shield Antitrust Litigation, No. 2:13-CV-20000-RDP, United States District Court for the Northern District of Alabama Southern Division (Expert Report and Deposition, 2019; Declaration and Expert Report, 2020; Deposition, 2021)

APPENDIX B: VGUPPI ANALYSIS FOR MANAGED BEHAVIORAL HEALTHCARE SERVICES

1. In this appendix, I provide additional information on the vGUPPI analysis for behavioral-specific healthcare financing services.

A. vGUPPI Inputs and Data

2. In this section, I describe the inputs into a vGUPPI and the sources that I use for each of these inputs.

3. I set the **bargaining weight** to 0.5, which means that Magellan and a seller of healthcare financing services to which it provides behavioral-specific healthcare financing services choose a price that equally shares the gains from contracting. Rogerson notes that a bargaining weight of 0.5 was used by the DOJ in AT&T/Time Warner and by the FCC in Comcast/NBCU.[159]

4. I set the **departure rate** to Reda percent, which means that if Magellan does not contract with a seller of healthcare financing services that Reda percent of the seller of healthcare financing services' enrollees would switch sellers of healthcare financing services.[160] The departure rate would be low because there are many good substitutes to Magellan for behavioral-specific healthcare financing services. One confirmation that there are many good substitutes to Magellan for behavioral-specific healthcare financing services is that Magellan earns about Redacte percent of the margin from healthcare financing services and behavioral-specific healthcare financing services on its non-public commercial

---

159 Rogerson, William P., "Modelling and Predicting the Competitive Effects of Vertical Mergers: The Bargaining Leverage Over Rivals Effect," *Canadian Journal of Economics* Vol. 53, No. 2, 2020, pp. 407–436. The justification for 0.5 differed between the cases. In AT&T/Time Warner, the choice was made because of an absence of evidence on what the bargaining weight should be. In Comcast/NBCU, an estimate from the academic literature was used to support the choice of 0.5.

160 For the purposes of the redacted version of this report, the departure rate I use is between 0 percent and 10 percent.

enrollees.[161] I use the same departure rate for all of Magellan's customers in all segments.

5. I calculate the **diversion ratio** from one of Centene's competitors to Centene under the assumption that diversion ratios are proportionate to enrollee shares in California for the segment in question. I calculate shares using the California Health Insurance Enrollment Database ("Almanac").[162] The underlying assumption for such a calculation is that the first choices of enrollees who did not choose seller of healthcare financing services A are reflective of what the second choices of enrollees who did choose seller of healthcare financing services A would be if they could not choose seller of healthcare financing services A.[163]

6. I calculate Centene's **percent margin** on healthcare financing services using the Center for Consumer Information and Insurance Oversight ("CCIIO") Medical Loss Ratio ("MLR") data.[164] The CCIIO MLR data only contains non-public commercial margins; I use the weighted average margin from individual, small, and fully insured large group in all calculations—the CCIIO MLR data does not report an ASO margin.[165] I approximate

---

161 Appendix Exhibit B.1 calculates the margin that Magellan earns per non-public commercial enrollee divided by the margin that Magellan's non-public commercial customers earn per non-public commercial enrollee. I do not calculate different margins and therefore do not use different departure rates by segment because I cannot calculate Magellan's margin by segment and do not wish to introduce false precision.

162 "California Health Insurers, Enrollment, 2021 — Data (ZIP)," California Health Care Almanac, California Health Care Foundation, July 30, 2021, available at https://www.chcf.org/publication/2021-edition-california-health-insurance-enrollment/#related-links-and-downloads ("Almanac")

163 Calculating diversion ratios that are proportionate to share abstracts from the possibility that some sellers of healthcare financing services are particularly close or particularly distant substitutes to Centene. A seller of healthcare financing services could be a particularly close or particularly distant substitute to Centene because they are attractive to enrollees in the same area of California or have other features that make them attractive to the same enrollees.

164 Center for Consumer Information and Insurance Oversight (CCIIO) Medical Loss Ratio (MLR) data, October 20, 2020, available at https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.

165 I use a weighted average margin because I use the same departure rate across these segments, and the departure rate is informed by this average margin.

for Centene's Medicare and Medicaid margin for PHC and Health Plan of San Mateo using Centene's non-public commercial margin of 15 percent. Centene's margin on enrollees who might switch from a competitor seller of healthcare financing service if it did not contract with Magellan is likely substantially lower than Centene's margin on all enrollees because enrollees who use behavioral healthcare services have higher than average medical spending.[166]

7. I calculate a **price ratio** of Centene's price divided by Magellan's price. I obtain Centene's price for BSC and WHA from the CCIIO MLR data. I obtain Magellan's price for BSC (WHA) by dividing Magellan's revenue from BSC (WHA) for behavioral-specific healthcare financing services by BSC's (WHA's) enrollment. I approximate for Centene's Medicare and Medicaid price ratio for PHC and Health Plan of San Mateo using Centene's commercial price ratio for BSC. I use this price ratio to produce an upper bound estimate of the proposed acquisition's effect on vertical market power because it is the one that will lead to the largest estimated vGUPPI.

[166] Enrollees who would switch from a competitor seller of healthcare financing services if it did not contract with Magellan are more likely than typical enrollees to be enrollees who use and therefore value behavioral-specific healthcare financing services.

B. Results

Exhibit B.1 - Margin of Magellan as a Seller of Behavioral-Specific Healthcare Financing Services Divided by Sum of the Margin of Magellan as a Seller of Behavioral-Specific Healthcare Financing Services and the Margin of Sellers of the Full Set of Healthcare Financing Services[167]

Description	Value
[1] Margin of Magellan on Behavioral-Specific Healthcare Financing Services	Redacted
[2] Margin of Sellers of Healthcare Financing Services that Magellan Provides Behavioral-Specific Healthcare Financing Services to	8.5%
[3] Ratio of Magellan's Price for Behavioral-Specific Healthcare Financing Services and the Price of the Full Set of Healthcare Financing Services	Redacted
[4] Margin of Magellan as a Seller of Behavioral-Specific Healthcare Financing Services Divided by Sum of the Margin of Magellan as a Seller of Behavioral-Specific Healthcare Financing Services and the Margin of Sellers of the Full Set of Healthcare Financing Services	Redacted

Notes:
[1] I calculate this margin from Magellan's 2020 Income Statement, with reference to Magellan's subsidiary Human Affairs International of California.
[2] I calculate this margin as one minus a revenue-weighted average of Blue Shield of California and Western Health Advantage MLRs from their respective 2019 MLR Reports.
[3] I calculate this ratio using the 2019 Center for Consumer Information and Insurance Oversight (CCIIO) Medical Loss Ratio (MLR) data. It is the revenue weighted average of Magellan's price with Blue Shield of California and Western Health Advantage in the commercial segments divided by an enrollment-weighted average of the premiums of Blues Shield of California and Western Health Advantage in the fully insured commercial segments.
[4] = [3] × [1] / ([2] + [3] × [1]).

[167] "MLR_Template_California_BSCL.xlsx," Blue Shield of California MLR Report, 2019, available at https://www.cms.gov/cciio/mlr; "MLR_Template_California.xlsx," Western Health Advantage MLR Report, 2019, available at https://www.cms.gov/cciio/mlr Redacted

Center for Consumer Information and Insurance Oversight (CCIIO) Medical Loss Ratio (MLR) data, October 20, 2020, available at https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr; Redacted

Exhibit B.2 - Gross Price Effect for Magellan for Behavioral-Specific Healthcare Financing Services [168]

Segment	Bargaining Weight [A]	Departure Rate [B]	Diversion [C]	Centene Margin [D]	Price Ratio [E]	First-Order Approximation Gross Price Effect [F]
Blue Shield of California	0.5	Redacted	6.4%	15.0%	Redacted	0.9%
Individual	0.5	Redacted	18.1%	15.0%	Redacted	2.5%
Small	0.5	Redacted	6.0%	15.0%	Redacted	0.8%
Large (Fully Insured + ASO)	0.5	Redacted	2.3%	15.0%	Redacted	0.3%
Western Health Advantage	0.5	Redacted	3.8%	15.0%	Redacted	0.3%
Individual	0.5	Redacted	12.4%	15.0%	Redacted	0.9%
Small	0.5	Redacted	4.6%	15.0%	Redacted	0.3%
Large (Fully Insured + ASO)	0.5	Redacted	2.0%	15.0%	Redacted	0.1%
Positive Healthcare	0.5	Redacted	12.0%	15.0%	Redacted	1.7%
Managed Medicare	0.5	Redacted	5.4%	15.0%	Redacted	0.7%
Managed Medi-Cal	0.5	Redacted	18.4%	15.0%	Redacted	2.5%
Health Plan of San Mateo	0.5	Redacted	18.6%	15.0%	Redacted	2.6%
Managed Medi-Cal	0.5	Redacted	18.6%	15.0%	Redacted	2.6%
Weighted Average						**0.9%**

Note: [F] = [A] × [B] × [C] × [D] × [E]

[168] Almanac; "2019 Reporting Year/Public Use File for 2019 (as of October 20, 2020) (ZIP)," Center for Consumer Information and Insurance Oversight (CCIIO) Medical Loss Ratio (MLR) data, Centers for Medicare & Medicaid Services, October 20, 2020, available at https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr; Redacted ealth Net Community Solutions, Inc. Annual HMO/Health Plan Financial Statement, California Department of Managed Health Care, 2020, available at https://wpso.dmhc.ca.gov/fe/search/, at sheet "4 - Write-Ins."

Exhibit B.3 - Gross Price Effect for Magellan for Behavioral-Specific Healthcare Financing Services, Excluding Kaiser from Diversions[169]

Segment	Bargaining Weight [A]	Departure Rate [B]	Diversion [C]	Centene Margin [D]	Price Ratio [E]	First-Order Approximation Gross Price Effect [F]
Blue Shield of California	0.5	Redacted	12.5%	15.0%	Redacted	1.7%
Individual	0.5	Redacted	37.0%	15.0%	Redacted	5.1%
Small	0.5	Redacted	11.8%	15.0%	Redacted	1.6%
Large (Fully Insured + ASO)	0.5	Redacted	3.8%	15.0%	Redacted	0.5%
Western Health Advantage	0.5	Redacted	5.9%	15.0%	Redacted	0.4%
Individual	0.5	Redacted	19.0%	15.0%	Redacted	1.4%
Small	0.5	Redacted	7.4%	15.0%	Redacted	0.6%
Large (Fully Insured + ASO)	0.5	Redacted	3.1%	15.0%	Redacted	0.2%
Positive Healthcare	0.5	Redacted	14.2%	15.0%	Redacted	2.0%
Managed Medicare	0.5	Redacted	9.6%	15.0%	Redacted	1.3%
Managed Medi-Cal	0.5	Redacted	18.6%	15.0%	Redacted	2.6%
Health Plan of San Mateo	0.5	Redacted	18.8%	15.0%	Redacted	2.6%
Managed Medi-Cal	0.5	Redacted	18.8%	15.0%	Redacted	2.6%
Weighted Average						**1.7%**

Note: [F] = [A] × [B] × [C] × [D] × [E]

169 Almanac; "2019 Reporting Year/Public Use File for 2019 (as of October 20, 2020) (ZIP)," Center for Consumer Information and Insurance Oversight (CCIIO) Medical Loss Ratio (MLR) data, Centers for Medicare & Medicaid Services, October 20, 2020, available at https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr; Redacted ealth Net Community Solutions, Inc. Annual HMO/Health Plan Financial Statement, California Department of Managed Health Care, 2020, available at https://wpso.dmhc.ca.gov/fe/search/, at sheet "4 - Write-Ins."

Exhibit B.4 - Diversions from Blue Shield of California to Centene on California Health Insurance Exchange by Rating Area[170]
California, 2019

Rating Area	Centene Enrollee Share [A]	BSC Enrollee Share [B]	Diversion of BSC to Centene [C] = [A] / (1 - [B])	Share of Total BSC Enrollees in Rating Area [D]	Contribution to Weighted Average Diversion [E] = [C] × [D]
1	0.0%	47.5%	0.0%	5.3%	0.0%
2	0.4%	9.7%	0.4%	1.2%	0.0%
3	2.1%	30.1%	3.0%	6.6%	0.2%
4	0.3%	20.1%	0.3%	1.7%	0.0%
5	0.6%	16.0%	0.7%	1.9%	0.0%
6	0.0%	17.5%	0.0%	2.9%	0.0%
7	0.0%	7.9%	0.0%	1.3%	0.0%
8	0.4%	14.9%	0.4%	0.9%	0.0%
9	2.8%	68.4%	8.7%	4.2%	0.4%
10	0.5%	7.5%	0.6%	1.4%	0.0%
11	0.0%	74.1%	0.0%	6.8%	0.0%
12	0.0%	84.8%	0.0%	12.5%	0.0%
13	0.0%	17.7%	0.0%	0.5%	0.0%
14	5.1%	67.0%	15.5%	3.5%	0.5%
15	33.8%	25.7%	45.5%	10.9%	5.0%
16	10.1%	17.1%	12.2%	10.4%	1.3%
17	25.2%	36.3%	39.6%	12.7%	5.0%
18	30.8%	31.3%	44.8%	10.4%	4.7%
19	17.7%	16.1%	21.1%	4.9%	1.0%
Total					**18.1%**

Notes:
[1] The data come from the 2019 Covered California Open Enrollment Profile, which shows counts of enrollees who have selected a plan through Covered California during the open enrollment period (not including renewing enrollees).
[2] California is comprised of 19 standardized geographic rating areas, and each area can have different pricing and health insurance options.
[3] The diversion from Blue Shield of California to Centene is the likelihood that Blue Shield of California enrollees would switch to Centene if they switched from Blue Shield of California.

170 "CC_Open_Enrollment_Profile_2019.xlsx," Covered California Open Enrollment Plan Selection Profile data, 2019, available at https://hbex.coveredca.com/data-research/.

APPENDIX C: ADDITIONAL ANALYSES

Exhibit C.1 - Centene and Magellan Shares for Behavioral-Specific Healthcare Financing Services
Non-Public Commercial[171]
California, 2019–2020

Description	2019	2020
[1] Total Enrollment	20,007,615	19,989,040
[2] Centene Behavioral-Specific Healthcare Financing Enrollment	757,265	764,717
[3] Magellan Behavioral-Specific Healthcare Financing Enrollment	2,789,926	2,674,887
[4] Centene Behavioral-Specific Healthcare Financing Share	3.8%	3.8%
[5] Magellan Behavioral-Specific Healthcare Financing Share	13.9%	13.4%
[6] ΔHHI	**106**	**102**

Notes:

[2] I calculate Centene's enrollment using data provided by Centene. This enrollment consists of Centene's full-service commercial enrollment and roughly 80,000 external, commercial behavioral health enrollees in California. I assume that Centene sells behavioral-specific healthcare financing services for all of its full-service commercial enrollees.
[3] I calculate Magellan's enrollment using data provided by Magellan. This enrollment consists of Magellan's fully insured and ASO enrollment from Blue Shield California, and fully insured enrollment from Western Health Advantage. Includes 21,000 additional ASO enrollees from Blue Shield of California that Magellan was not able to find zip code data for.[172]
[4] = [2] / [1]
[5] = [3] / [1]
[6] = 2 x [4] x [5] x 10,000

171 Redacted

Almanac.

172 Redacted

Exhibit C.2 - Centene and Magellan Shares for Behavioral-Specific Healthcare Financing Services
Managed Medicare[173]
California, 2019–2020

Description	2019	2020
[1] Total Enrollment	2,688,030	2,856,478
[2] Centene Behavioral-Specific Healthcare Financing Enrollment	213,586	204,814
[3] Magellan Behavioral-Specific Healthcare Financing Enrollment	1,078	1,056
[4] Centene Behavioral-Specific Healthcare Financing Share	7.9%	7.2%
[5] Magellan Behavioral-Specific Healthcare Financing Share	0.04%	0.04%
[6] ΔHHI	**0.6**	**0.5**

Notes:

[2] I calculate Centene's enrollment using data provided by Centene. This enrollment consists of Centene's full-service Medicare enrollment. I assume that Centene provides behavioral-specific health financing services for all of its full-service Medicare enrollees.
[3] I calculate Magellan's enrollment using data provided by Magellan. This enrollment consists of Magellan's total enrollment from Positive Healthcare. Note Positive Healthcare has both managed Medicare and managed Medi-Cal enrollees, according to data Almanac. Since Magellan's data does not specify which of their Positive Healthcare enrollees are managed Medicare enrollees and which are managed Medi-Cal enrollees, I assume all Positive Healthcare enrollees are managed Medicare enrollees.
[4] = [2] / [1]
[5] = [3] / [1]
[6] = 2 x [4] x [5] x 10,000

[173] Redacted

Almanac.

Exhibit C.3 - Centene and Magellan Shares for Behavioral-Specific Healthcare Financing Services
Managed Medi-Cal[174]
California, 2019–2020

Description	2019	2020
[1] Total Enrollment	10,050,835	10,978,183
[2] Centene Behavioral-Specific Healthcare Financing Enrollment	1,926,528	2,014,057
[3] Magellan Behavioral-Specific Healthcare Financing Enrollment	1,278	1,256
[4] Centene Behavioral-Specific Healthcare Financing Share	19.2%	18.3%
[5] Magellan Behavioral-Specific Healthcare Financing Share	0.01%	0.01%
[6] ΔHHI	**0.5**	**0.4**

Notes:

[2] I calculate Centene's enrollment using data provided by Centene. This enrollment consists of Centene's full-service Medi-Cal enrollment. I assume that Centene provides behavioral-specific healthcare financing services for all of its full-service Medi-Cal enrollees.
[3] I calculate Magellan's enrollment using data provided by Magellan. This enrollment consists of Magellan's total enrollment from Positive Healthcare and 200 enrollees from Health Plan of San Mateo.[175] Note Positive Healthcare has both managed Medicare and managed Medi-Cal enrollees, according to data from Almanac. Since Magellan's data does not specify which of their Positive Healthcare enrollees are managed Medicare enrollees and which are managed Medi-Cal enrollees, I assume all Positive Healthcare enrollees are managed Medi-Cal enrollees.
[4] = [2] / [1]
[5] = [3] / [1]
[6] = 2 x [4] x [5] x 10,000

174 Redacted

Almanac.

175 Redacted

Exhibit C.4 - Centene and Magellan Shares for Behavioral-Specific Healthcare Financing Services
Total[176]
California, 2019–2020

Description	2019	2020
[1] Total Enrollment	32,746,480	33,823,701
[2] Centene Behavioral-Specific Healthcare Financing Enrollment	2,897,379	2,983,588
[3] Magellan Behavioral-Specific Healthcare Financing Enrollment	2,792,282	2,677,199
[4] Centene Behavioral-Specific Healthcare Financing Share	8.8%	8.8%
[5] Magellan Behavioral-Specific Healthcare Financing Share	8.5%	7.9%
[6] ΔHHI	**151**	**140**

Notes:

[2] I calculate this enrollment as the sum of Centene's enrollment in Appendix Exhibit C.1, Exhibit C.2, and Exhibit C.3.
[3] I calculate this enrollment as the sum of Magellan's enrollment in Appendix Exhibit C.1, Exhibit C.2, and Exhibit C.3.
[4] = [2] / [1]
[5] = [3] / [1]
[6] = 2 x [4] x [5] x 10,000

[176] Appendix Exhibit C.1, Exhibit C.2, and Exhibit C.3.

Exhibit C.5 - Centene and Magellan Shares for EAPs
Exempt and Non-Exempt EAPs[177]
California, 2019–2020

Description	2019	2020
[1] Number of Civilian Workers	18,629,682	16,957,019
[2] Percent of Civilian Workers with Access to EAPs	54.0%	55.0%
[3] Estimated Total EAP Enrollment	10,060,028	9,326,360
[4] Centene EAP Enrollment	744,565	628,131
[5] Magellan EAP Enrollment	1,361,245	1,303,673
[6] Centene EAP Share	7.4%	6.7%
[7] Magellan EAP Share	13.5%	14.0%
[8] ΔHHI	**200**	**188**

Notes:

[2] This is the percentage for civilian workers (public and private sector) in the West region and comes from data from the National Compensation Survey (U.S. Bureau of Labor Statistics).
[3] = [1] x [2]
[4] I calculate Centene's EAP enrollment using data provided by Centene.
[5] I calculate Magellan's EAP enrollment using data provided by Magellan.
[6] = [4] / [3]
[7] = [5] / [3]
[8] = 2 x [6] x [7] x 10,000

177 "Economy at a Glance: California," Civilian Labor Force Back Data, U.S. Bureau of Labor Statistics, 2011–2021, available at https://www.bls.gov/eag/eag.ca.htm; "National Compensation Survey: Employee Benefits in the United States," 2010–2020 Excel dataset, U.S. Bureau of Labor Statistics, March 2020, available at https://www.bls.gov/ncs/ebs/benefits/, at series ID NBU16400000000001833354; Redacted

Exhibit C.6 - Centene and Magellan Shares for Behavioral-Specific Healthcare Financing Services by CBSA[178]
California, 2020

CBSA [A]	Total Population [B]	Centene Enrollment [C]	Magellan Enrollment [D]	Centene Share [E] = [C] / [B]	Magellan Share [F] = [D] / [B]
Bakersfield	900,202	Redacted			
Chico	219,186	Redacted			
Clearlake	64,386	Redacted			
Crescent City	27,812	Redacted			
El Centro	181,215	Redacted			
Eureka-Arcata-Fortuna	135,558	Redacted			
Fresno	999,101	Redacted			
Hanford-Corcoran	152,940	Redacted			
Los Angeles-Long Beach-Anaheim	13,214,799	Redacted			
Madera	157,327	Redacted			
Merced	277,680	Redacted			
Modesto	550,660	Redacted			
Napa	137,744	Redacted			
Oxnard-Thousand Oaks-Ventura	846,006	Redacted			
Red Bluff	65,084	Redacted			
Redding	180,080	Redacted			
Riverside-San Bernardino-Ontario	4,650,631	Redacted			
Sacramento--Roseville--Arden-Arcade	2,363,730	Redacted			
Salinas	434,061	Redacted			
San Diego-Carlsbad	3,338,330	Redacted			
San Francisco-Oakland-Hayward	4,731,803	Redacted			
San Jose-Sunnyvale-Santa Clara	1,990,660	Redacted			
San Luis Obispo-Paso Robles-Arroyo Grande	283,111	Redacted			
Santa Cruz-Watsonville	273,213	Redacted			
Santa Maria-Santa Barbara	446,499	Redacted			
Santa Rosa	494,336	Redacted			
Sonora	54,478	Redacted			
Stockton-Lodi	762,148	Redacted			
Susanville	30,573	Redacted			
Truckee-Grass Valley	99,755	Redacted			
Ukiah	86,749	Redacted			
Vallejo-Fairfield	447,643	Redacted			
Visalia-Porterville	466,195	Redacted			
Yuba City	175,639	Redacted			
CBSA Unknown	298,889	Redacted			
Total	**39,538,223**	Redacted			

178 Redacted

Notes:
[1] Total population (column [B]) data by CBSA come from the U.S. Census Bureau.
[2] I calculate Centene's enrollment (column [C]) by CBSA using zip code-level data provided by Centene. I include all of Centene's full-service enrollees, as well as all enrollees Centene covers for behavioral-specific healthcare services through contracts with other sellers of healthcare financing service, in Centene's enrollment.
[3] I calculate Magellan's enrollment (column [D]) by CBSA using zip-code level data provided by Magellan. I exclude roughly 21,000 ASO enrollees from Blue Shield of California and 200 enrollees from the Health Plan of San Mateo for whom zip code-level data were unavailable.
[4] I map zip codes to counties using data from the U.S. Census Bureau and map counties to CBSAs using data from the Office of Policy Development and Research.
[5] The "CBSA Unknown" group consists of enrollees whose zip codes did not map to any CBSAs in the data from note [4].

Redacted

"Core Based Statistical Areas (CBSAs), Metropolitan Divisions, and Combined Statistical Areas (CSAs)," Delineation Files, July 2015, U.S. Census Bureau, available at https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html; "HUD USPS Zip Code Crosswalk Files," Office of Policy Development and Research, accessed October 1, 2017, available at https://www.huduser.gov/portal/datasets/usps_crosswalk.html; "Metropolitan and Micropolitan Statistical Area Population Estimates and Estimated Components of Change," CBSA-EST2019-alldata, U.S. Census Bureau, April 1 2010–July 1, 2019, available at https://www.census.gov/data/datasets/time-series/demo/popest/2010s-total-metro-and-micro-statistical-areas.html; "QuickFacts: California," U.S. Census Bureau, April 1, 2020, https://www.census.gov/quickfacts/CA, at "Population, Census."

Exhibit C.7 - Centene and Magellan Shares for EAPs by CBSA[179]
California, 2020

CBSA [A]	Estimated Employed Population [B]	Centene EAP Enrollment [C]	Magellan EAP Enrollment [D]	Centene Share [E] = [C] / [B]	Magellan Share [F] = [D] / [B]
		Redacted			
Chico	94,908	Redacted			
		Redacted			
Crescent City	8,823	Redacted			
		Redacted			
Eureka-Arcata-Fortuna	60,970	Redacted			
Fresno	400,175	Redacted			
Hanford-Corcoran	53,217	Redacted			
		Redacted			
Madera	57,799	Redacted			
		Redacted			
Modesto	222,532	Redacted			
Napa	70,888	Redacted			
Oxnard-Thousand Oaks-Ventura	412,228	Redacted			
		Redacted			
Redding	72,392	Redacted			
		Redacted			
Sacramento--Roseville--Arden-Arcade	1,039,935	Redacted			
		Redacted			
San Diego-Carlsbad	1,564,930	Redacted			
San Francisco-Oakland-Hayward	2,451,211	Redacted			
San Jose-Sunnyvale-Santa Clara	1,014,669	Redacted			
		Redacted			
Santa Cruz-Watsonville	134,904	Redacted			
Santa Maria-Santa Barbara	211,751	Redacted			
Santa Rosa	253,421	Redacted			
		Redacted			
Stockton-Lodi	305,509	Redacted			
		Redacted			
Truckee-Grass Valley	43,368	Redacted			
		Redacted			
Vallejo-Fairfield	202,713	Redacted			
		Redacted			
Yuba City	67,618	Redacted			
		Redacted			
Total	**18,309,012**	Redacted			

179 Redacted

"Core Based Statistical Areas (CBSAs), Metropolitan Divisions, and Combined Statistical Areas (CSAs)," Delineation Files, July 2015,

Notes:
[1] Estimated employed population (column [B]) data by CBSA come from the Area Health Resource Files and are based on U.S. Census Data from 2014 to 2018.
[2] I calculate Centene's EAP enrollment (column [C]) by CBSA using zip code-level data provided by Centene. Note, in some cases, Centene's enrollees were assigned to the zip code of their employer.
[3] I calculate Magellan's EAP enrollment (column [D]) by CBSA using zip code-level data provided by Magellan. Note Magellan's enrollees were assigned zip codes based on providers' utilization in each zip code.
[4] I map zip codes to counties using data from the U.S. Census Bureau and map counties to CBSAs using data from the Office of Policy Development and Research.
[5] The "CBSA Unknown" group consists of enrollees whose zip codes did not map to any CBSAs in the data from note [4].

U.S. Census Bureau, available at https://www.census.gov/geographies/reference-files/time-series/demo/metro-micro/delineation-files.html; "HUD USPS Zip Code Crosswalk Files," Office of Policy Development and Research, accessed October 1, 2017, available at https://www.huduser.gov/portal/datasets/usps_crosswalk.html; "Area Health Resource Files," 2019–2020 County Level Data, Health Resources and Services Administration, 2019–2020, available at https://data.hrsa.gov/data/download.

Exhibit C.8 - Evaluating Potential for Centene to Benefit from Magellan Weakening Its Customers[180]
California, 2020

Organization	Magellan Sells Behavioral-Specific Healthcare Financing Services to Organization?	Organization and Centene have Enrollees in Segment?	Potential for Centene to Benefit from Magellan Weakening Its Customers?	If Potential for Centene to Benefit, Organization Segment Share
Non-Public Commercial				
Blue Shield of California	✓	✓	✓	16.0%
Western Health Advantage	✓	✓	✓	0.5%
Positive Healthcare				-
Health Plan of San Mateo				-
Managed Medicare				
Blue Shield of California		✓		-
Western Health Advantage				-
Positive Healthcare	✓	✓	✓	0.02%
Health Plan of San Mateo				-
Managed Medi-Cal				
Blue Shield of California		✓		-
Western Health Advantage				-
Positive Healthcare	✓	✓	✓	0.01%
Health Plan of San Mateo	✓	✓	✓	1.1%

Notes:
[1] The organizations listed in this exhibit are the four sellers of health care financing services that Magellan sells behavioral-specific healthcare financing services to in California, according to data provided by Magellan.
[2] Centene and the other organizations are considered to have enrollees in each segment if they have at least one enrollee in that segment according to data from Almanac.
[3] The non-public commercial segment includes both fully insured and ASO enrollees.
[4] I determine the segments for which Magellan sells behavioral-specific healthcare financing services to each organization using data provided by Magellan.
[5] Potential for Centene to benefit from Magellan weakening its customers exists if both Centene and another organization have enrollees in a given segment, and Magellan sells behavioral-specific healthcare financing services to that other organization within that segment.
[6] Organization segment shares data come from Almanac.

180 Redacted

Almanac.