DIRECTORS ROUNDTABLE

WORLD RECOGNITION of DISTINGUISHED GENERAL COUNSEL

GUEST OF HONOR:

John Cannon

Executive Vice President, General Counsel
and Chief Public Affairs Officer, WellPoint

THE SPEAKERS

John Cannon
Executive Vice President, General Counsel and Chief Public Affairs Officer, WellPoint

Michael Tuteur
Partner, Foley & Lardner LLP

Craig Hoover
Partner, Hogan Lovells U.S. LLP

David Deaton
Partner, O'Melveny & Myers LLP

Kurt Peterson
Partner, Reed Smith LLP

Daniel Dufner, Jr.
Partner, White & Case LLP

(The biographies of the speakers are presented at the end of this transcript. Further information about the Directors Roundtable can be found at our website, www.directorsroundtable.com.)

TO THE READER

General Counsel are more important than ever in history. Boards of Directors look increasingly to them to enhance financial and business strategy, compliance, and integrity of corporate operations. In recognition of our distinguished Guest of Honor's personal accomplishments in his career and his leadership in the profession, we are honoring John Cannon, General Counsel of WellPoint, with the leading global honor for General Counsel. WellPoint is one of the largest health benefits companies in the United States. His address will focus on key issues facing the General Counsel of a national health care corporation. The panelists' additional topics include health care regulation; private health care system management; opportunities and challenges under the Affordable Care Act; governance; corporate dealmaking; and dispute resolution.

The Directors Roundtable is a civic group which organizes the preeminent worldwide programming for Directors and their advisors including General Counsel.

Jack Friedman
Directors Roundtable
Chairman & Moderator

John Cannon

Executive Vice President, General Counsel and Chief Public Affairs Officer WellPoint, Inc.

WELLPOINT℠

John Cannon served as WellPoint's Executive Vice President, General Counsel and Chief Public Affairs Officer, overseeing legal strategy, legal compliance, litigation, regulatory and board matters, government affairs, corporate communications, the WellPoint Foundation and corporate security. He also supported the Board in developing and maintaining best practices in governance policies and procedures. Mr. Cannon joined WellPoint on December 10, 2007. He recently served as WellPoint's Interim President and CEO from August 2012 through March 2013.

Prior to joining WellPoint, Mr. Cannon spent 19 years with CIGNA Corporation in a variety of increasingly responsible roles, including senior vice president and deputy General Counsel. He was also responsible for public affairs at CIGNA, which included government affairs, communications and corporate branding strategy. Mr. Cannon also served as president of the CIGNA Foundation, as well as chief counsel for CIGNA Healthcare and CIGNA International.

Earlier in his career, Mr. Cannon was an attorney with Rawle & Henderson in Philadelphia, where he specialized in litigation and securities law. He is a graduate of Denison University in Ohio and The Dickinson School of Law at Pennsylvania State University.

Mr. Cannon is currently a member of the U.S. Chamber of Commerce's Board of Directors and the Boards of Directors of the Indianapolis Symphony Orchestra, Street Law, Inc., and BCS Financial, Inc.

In 2011, WellPoint's Legal department was named as one of the Best Legal Departments in America by Corporate Counsel.

WellPoint, Inc.

WellPoint, Inc. is one of the nation's largest health benefits companies serving nearly 36 million — or one in nine — Americans through its affiliated health plans and nearly 68 million individuals through its subsidiaries, including Medicaid beneficiaries in 19 states served by its Amerigroup subsidiary. A Fortune 50 company, WellPoint employs more than 48,000 associates nationwide and generated a 2013 operating revenue of $70 billion.

WellPoint, Inc. was formed when WellPoint Health Networks Inc. and Anthem, Inc. merged in 2004.

Through its networks nationwide, the company delivers a number of leading health benefit solutions through a broad portfolio of integrated health care plans and related services, along with a wide range of specialty products such as life and disability insurance benefits, dental, vision, behavioral health benefit services, as well as long term care insurance and flexible spending accounts.

Headquartered in Indianapolis, Indiana, WellPoint, Inc. is an independent licensee of the Blue Cross and Blue Shield Association serving members in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin; and specialty plan members in other states through UniCare.

JACK FRIEDMAN: Welcome, everyone! Many of you have been with us before; we are now in our twenty-third year. We started in Los Angeles, and have gone to 14 countries all over the world and the United States. We've done 800 programs and have never charged anyone to attend. Our goal is to do the finest programming that we can for Boards of Directors and their advisors.

We're very proud to honor John Cannon, the General Counsel of WellPoint, as our Guest of Honor today. John has had numerous jobs at WellPoint. Not only does he run the Legal Department; he also does Public Affairs, and keeps the Board out of trouble, and I don't know if they pay him more than one salary or not.

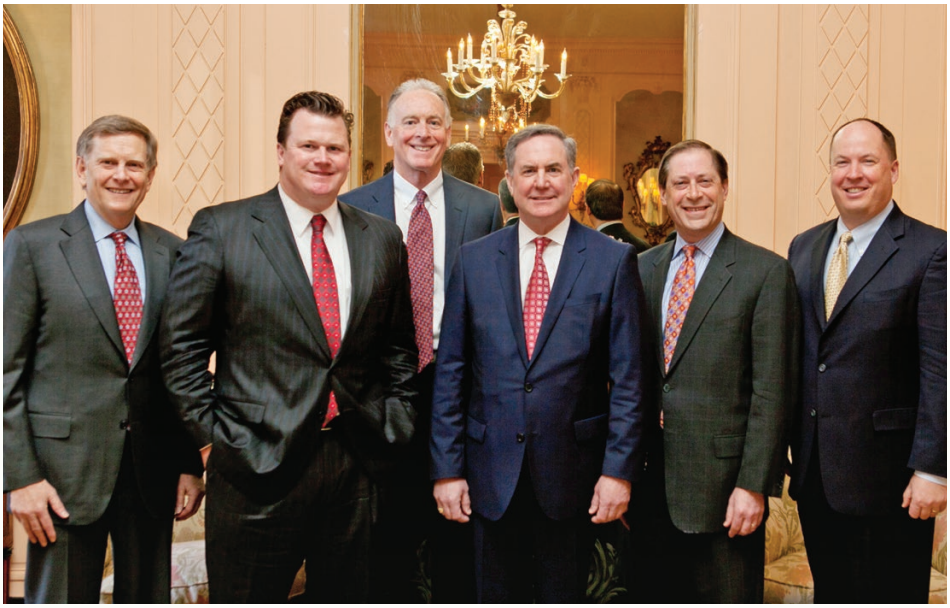
JOHN CANNON: Not! [LAUGHTER]

JACK FRIEDMAN: He's come in for this program from Indianapolis, Indiana. He has been in the private sector for decades; for a length of time he was with Cigna, and is now with WellPoint. He has been very active in all the various issues that have to do with the Affordable Care Act.

John had the special experience for a General Counsel, to be the interim CEO for about seven months while they were selecting a new CEO. He will share some of his observations about what it is like being a CEO and what it's like in contrast to being a General Counsel.

I would like to briefly introduce the Distinguished Panelists. There is Craig Hoover of Hogan Lovells; David Deaton of O'Melveny & Myers; Michael Tuteur of Foley & Lardner; Daniel Dufner of White & Case; and Kurt Peterson of Reed Smith. They will introduce themselves and their topics later. Several of them have come from the East Coast, so I also want to thank them for making the trip to be here.

Let us start with our Guest of Honor, John Cannon.



JOHN CANNON: Thank you, Jack, for that fine introduction. Let me first express my deep appreciation to all of you, particularly my colleagues at WellPoint and those of you who have represented us so ably over the years, for being here today. It is nice to see a lot of friendly faces from my present and my past.

On behalf of the entire WellPoint team, I would also like to thank the Directors Roundtable for this recognition. I'm deeply humbled and honored to accept it.

I'll start by saying what is probably obvious to everyone: there has never been, and may never be, a more exciting time to be a health care lawyer. [LAUGHTER] It is most fitting that this event is being held here in California, which many people believe is the true epicenter of health care reform. Certainly, WellPoint has been, for better or worse, on center stage for much of that dialogue.

It also goes without saying that our industry, and the entire health care delivery system, are both undergoing a transformation unlike anything we've ever previously experienced. These changes have been brought about by a confluence of events and circumstances — some economic, some political, some just out of a desire to try something new. Many have described it as a perfect storm. From my vantage point, I certainly will not disagree with that.

Whatever you might think of the Affordable Care Act — how it was passed; how it's being implemented; whether it will reduce costs or expand coverage — the fact of the matter is, I believe that the most major elements of it are here to stay — even if the law is altered at some point. Although the focus of the ACA has been expansion of coverage, it has key elements which have the effect of promoting further consolidation and integration within the health care delivery system, as well as changing the mode of payments for health care services.

We believe it is our obligation to do our best to implement the law as it stands, and to seize the many opportunities that are emerging from this current situation; to become a trusted, valued health care partner to our customers.

As many of you know, our new CEO, Joe Swedish, came from the provider community. He has already helped us sharpen our focus on the consumer, as well as on our obligation to add value to the entire system. I will talk a little bit more about that later.

Let me briefly describe WellPoint – what it is we do, and for whom. I will also discuss my background and role, and then provide some perspective from the various positions I have held over the years.

Headquartered in Indianapolis, Indiana, WellPoint is a Fortune 40 company with operating revenue of over $70 billion and assets of approximately $60 billion as of the end of last year. In 14 states, we operate as an independent licensee of the Blue Cross Blue Shield Association, and here in California, we're known as Anthem Blue Cross. Our affiliated health plans serve nearly 36 million medical members, or one in nine Americans, including over 4 million Medicaid beneficiaries in 19 states. Our other subsidiaries provide non-medical health care-related services to an additional 32 million people, for a total customer base of about 68 million customers. In 2013, we answered more than 58 million service calls, and processed over 581 million claims, which represent more than $178 billion in health benefits.

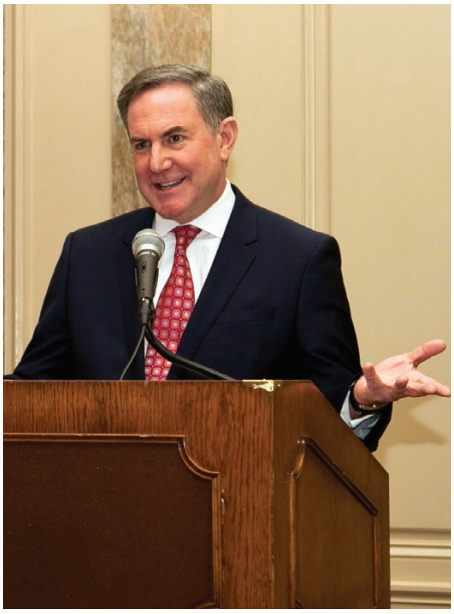
As I will discuss in a moment, we're using this information in our claim database – so-called "big data" – to understand more deeply how health care services are delivered, and to whom. Our most valued asset is our associates, and we have 48,000 of them in all 50 states working every day to improve the lives of our members. The Legal & Public Affairs Division, which I have the privilege to lead, has approximately 400 associates, including 100 attorneys in 39 locations.

What role does a company like WellPoint play in our health care system? The traditional moniker applied to our industry is "insurer." But that really fails to capture much of what we do as a modern health care company. Unlike property and casualty insurers, which can't reduce the number of earthquakes or hail storms you experience, we can and do have a positive and fundamental impact on your health. Our ability to do so will only increase over time. In fact, I believe that we *must* do this in order to prosper and survive as a company. Simply put, the company that can provide the highest-quality care at the lowest price will be the most valued partner for their customers.

Of course, all of this discussion must take place against the backdrop of the Affordable Care Act. As I mentioned, the ACA is creating – or at least accelerating – tremendous change in our industry. While we are well-positioned as the nation's largest provider of Blue Cross Blue Shield plans to do well through this transition, it won't be easy, and it *hasn't* been easy. Many of the new regulations are vague and subject to change. The federal government and state regulators are changing the rules quickly and often, sometimes for political rather than market-based reasons. They frequently expect implementation in compressed and, frankly, unrealistic timeframes which don't allow for adequate systems testing or for the development of associated business processes. We are witnessing some of the impact of this in the rollout of the exchanges, which are now known as the federal insurance marketplaces.

So given all the uncertainty, we have to focus our efforts on where we have clarity, and make our best judgments concerning compliance in many areas where we have little or no guidance. I would say this task is not for the faint of heart, because the risks of guessing wrong include potential enforcement actions, class action litigation, and potential damage to our corporate reputation.

I believe that the Legal Department and our Public Affairs and Communications teams have to be embedded in every step of the implementation process to mitigate these risks. We have the responsibility to ensure that the regulatory environment exists to allow us to continue to innovate our products and services for our customers, a large number of whom are shopping in a retail environment for the first time in their lives. Fortunately, my role gives me the ability to pull many of the levers that affect



these outcomes by overseeing public policy, government relations, communications, corporate security and our corporate foundation, in addition to the Law Department. I do believe that the integration of these functions enhances our ability to succeed, given all of the uncertainties.

I noted earlier that our measure of success is to provide the highest quality care at the lowest possible price, just like any company in any competitive environment. However, if you are like most Americans, the question you are probably asking yourself is, "What does it mean to provide the best care, when WellPoint doesn't actually provide care? That is what doctors, nurses and hospitals do." Well, that is true, but what we do is create the conditions under which care can more effectively be delivered. That is probably counterintuitive to many, since few people today think about health insurers as one of the keys to improving our health care system. However, things are changing.

There is a critical need for someone to stand at the hub of our health care system and manage the tremendous amount of information that it generates – the big data that I mentioned before – and we're taking up that challenge. There is an almost unlimited number of conditions, acute episodes, lifestyle behaviors, that

affect one's health and wellbeing. Multiply that by several hundred million unique individuals, and you can begin to imagine the complexity of helping our fellow citizens make better health care decisions.

In 2012, the United States spent $2.8 trillion on health care. That is 17.2% of our GDP, which is twice as much per capita versus other economically developed countries. Seven hundred billion dollars of it represents waste across the system, including $210 billion in unnecessary services, $45 billion in avoidable complications — mostly infections — and $55 billion in missed prevention opportunities.

Consider also the fact that 45% of care delivered in this country is inconsistent with established clinical guidelines. So whether you receive the right care or not is subject to nearly the flip of a coin.

Americans pay twice as much, and get less quality, than the citizens of many other developed countries.

We also know that we have a serious problem with health disparities. Researchers at Johns Hopkins released a study several years ago estimating that between 2003 and 2006, $230 billion in additional health care costs were incurred due to health disparities, and that if minority populations had the same health status and received the same level of care as non-minorities, we could save nearly 30 cents of every dollar spent on their care. But because minorities frequently *don't* receive the same level of care, illnesses are caught at a later and a more advanced stage, which often results in more expensive treatment options.

By analyzing the vast amount of data resident within our claims system, we can identify these gaps in clinical care and help physicians close them. For example, we use analytic models that link demographic, race and ethnicity data to quality and outcomes data. We then use geocoding software to pinpoint hotspots of health disparities down to the census block level. This helps us to focus our prevention programs on specific providers, members and communities where we can have the greatest impact.

> "It also goes without saying that our industry, and the entire health care delivery system, are both undergoing a transformation unlike anything we've ever previously experienced. These changes have been brought about by a confluence of events and circumstances — some economic, some political, some just out of a desire to try something new. Many have described it as a perfect storm. From my vantage point, I certainly will not disagree with that." – *John Cannon*

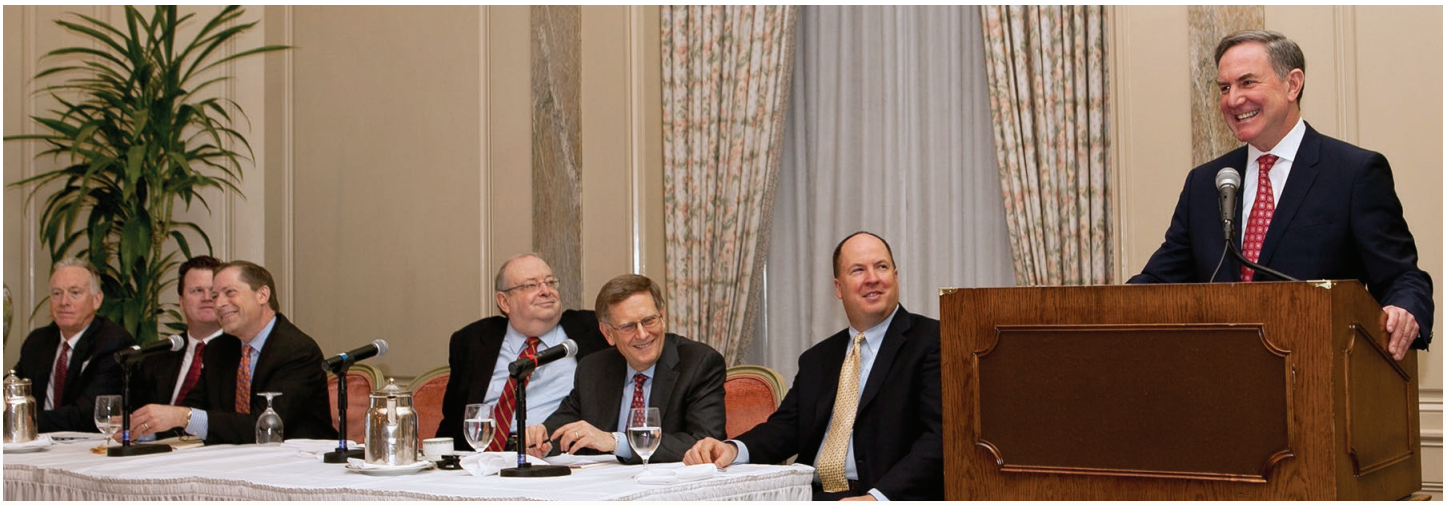
We also convene on a regular basis — leading physicians and academic medical centers across the country — to share our data, to understand and better support optimal care delivery. We're a major contributor to the nation's drug safety program, working with the FDA and the CDC to assess the safety of drugs and vaccines once they're introduced and in use.

The goal of data and technology, combined with a payment system that works, is to eliminate variability where there should be no variability, through the use of clearly established best-practice guidelines, and to increase variability where it makes sense; for example, targeted diagnostic tests and more personalized therapy, that will improve the quality of care. We do this by employment measures that further empower physicians to make better treatment decisions while harnessing their skills, to help them manage the inevitable variations that occur within their patient populations.

Doctors are very receptive to these new approaches, because it helps them do what they want to do, and that is to heal people who are ill, and keep healthy people healthy.

Another very basic way that we can improve care is by treating patients as whole people rather than just as their illness. I'd like to share with you the true story of Steve Foster. After having a motorcycle accident about four years ago, he was told that he'd have to go to a nursing home that was eight hours away from his wife and home. This obviously wasn't what Steve or his wife, Debbie, wanted, but fortunately, he was able to transition to one of our health plans. We worked hand-in-hand with Debbie, Steve and his doctors to understand his health needs, to assess what care would be needed to let him stay at home, and even to retrofit his house. We did not just make suggestions; we actually helped him pick the contractor to do the renovations.

Now, no doubt, you're probably thinking, "What kind of health plan does this guy have that we would do all these services for him?" Well, the fact of the matter is, Steve is dual-eligible for Medicaid and Medicare, and his care is provided by Amerigroup, which is a part of WellPoint that focuses on the most vulnerable Americans through state-funded health plans. Not only is this the right kind of care to do for people like Steve, but we also know it saves money. Because of our intervention, we not only helped manage the *long-term* costs of Steve's care, but we also took some of the pressure off of his wife, Debbie, who said, "Amerigroup helped us keep him at home. They widened the doors and put a ramp out back. They built a shower. They come in and take care of him for so many hours a day, and I can go to work without worrying about Steve."



Of course, Medicaid and Medicare are not the only areas where innovation is occurring; it's occurring across the board. Another thing we're doing — perhaps the most important — is changing the way doctors are paid. We are all familiar with the concept of pay for performance. But in health care, the degree of difficulty in assessing performance is quite high. Our approach is to pay for doing things that are clearly supported by clinical data as effective in providing support for long-term health care management, as we did for Steve. To do that, we are entering into partnerships with physicians — over 80,000 of them at this point — to ensure they have the best data to inform their treatment decisions. Through these arrangements, doctors share in the financial rewards of keeping their patients healthy. The reception from physicians for this program has also been overwhelmingly positive, and we have developed strong partnerships with several of the leading primary care organizations in the country, including the American Academy of Family Physicians.

I should also mention another example here in California. The Patient Safety First Partnership that we were doing in collaborations with hospitals across the state to save lives and improve quality by focusing on reducing avoidable medical errors.

Three years ago, we joined with three regional hospital associations to collaboratively determine the areas of focus for the program, the appropriate metrics, and the best way to implement the protocols. WellPoint then invested $6 million and worked hand-in-hand with hospitals across the state to make the initiative a success. Three years later, we engaged UCLA to study the program, and found that together, we had avoided 3,576 deaths and more than $63 million in unnecessary hospital costs between 2009 and 2012. There was a 74% reduction in early elective deliveries prior to 39 weeks, reducing complications and unnecessary NICU stays for newborns; a 57% reduction in cases of ventilator-associated pneumonia; a 43% reduction in cases of central line blood system infections; and a 26% reduction in sepsis mortality.

I'm very proud to say that this program was just recognized, literally today, by being awarded the John M. Eisenberg Patient Safety & Quality Award — [APPLAUSE] — thank you! — which is one of the most prestigious health care awards, and it was awarded by the National Quality Forum and the Joint Commission.

There is so much more we can do. These are just some of the accomplishments that we have achieved, working together with doctors, hospitals and patients. For me, they are among the most meaningful reward after 38 years — and still counting, hopefully! — of working in this field.

Now, my own journey in health care began in 1976, when I took a position in sales with a small securities brokerage firm that also marketed life, accident and health insurance. While there are many ways to gain perspectives on an industry, I found my years moving through a wide variety of roles — including 12 years of doing international mergers and acquisitions — particularly rewarding, because it gave me a diverse window into leadership, as well as the necessity to understand something about virtually every part of the business.

As Jack mentioned, I did have the privilege to serve as the interim President and CEO of WellPoint while our Board conducted a search for our new CEO. Those seven months, which I fondly refer to as my "seven-month reign of terror" — and it was for some people! — reinforced for me a lifetime of lessons. It greatly expanded my horizons. I did things I never thought I could or would do; it was exhilarating and exhausting. Now I take those experiences back into my role as General Counsel. When you've walked in the shoes of your client, it does help you provide more thoughtful advice.

On August 28, 2012, when I walked into my office as General Counsel, I had absolutely no expectation or desire to leave that day as the CEO of a Fortune 40 company — but that's what happened. As I have often said, I could write a book about the

events leading up to that day, but unfortunately, I can't do that without destroying the attorney-client privilege. I won't be writing it; maybe someone else will.

I did tell our Board at the time that I did not want the job permanently, and that I would only do it – on an interim basis – if I could be free to act like the job *was* mine permanently. Our company was facing the most tremendous marketplace changes in its history, and I knew that I couldn't just be a caretaker. We had to meet our financial commitments; we had to close one of the largest acquisitions that we ever made, which was the purchase of Amerigroup for $4.9 billion; and we had to develop our strategy to implement health care reform.

Fortunately, the Board agreed and allowed me to make a number of organizational realignments, which I am happy to say, our current CEO has built upon.

One of my main objectives during those seven months was to keep the company moving forward, ahead of the competition, while giving the Board the latitude and time it needed to make a thoughtful choice for the new CEO, without feeling like they had a gun to their heads.

What is it like to be suddenly CEO? Well, it is nice not to have a boss, I have to tell you! [LAUGHTER] It was a nice seven months in many ways. The first thing I learned, almost immediately, was that somehow, miraculously, my IQ skyrocketed! [LAUGHTER] Virtually every statement I made and every suggestion I advanced was acclaimed as "brilliant" or "innovative." [LAUGHTER] Some of you who did that are in this room! [LAUGHTER] We're still friends! Seven months later, however – the date I stepped down from the role – I was equally stunned to learn that my IQ had suddenly dropped precipitously; my comments were challenged; my ideas were greeted with lukewarm enthusiasm, at best. In short, I had reverted to mortal status! [LAUGHTER]

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>
> – *John Cannon*

The takeaway for me was pretty straightforward. If no one else in the room is questioning your judgment, then you had better. *Everyone*, no matter how brilliant, can always benefit from other perspectives.

The second lesson I learned confirmed what I already strongly suspected: You can never know your client's business too well. I have been fortunate to come up through the ranks in one industry, albeit in a variety of roles. If you haven't had the opportunity to do that, I would strongly encourage you to make the investment and take the time to learn as much as you can about your client's business, and how your client succeeds in the marketplace.

The third lesson I learned was to appreciate what I call "horizon thinking." Anyone can tell you what's already happened; as CEO, I wanted and needed to know what was likely to happen, so that we could prevent it if need be, or better yet, shape it to our advantage.

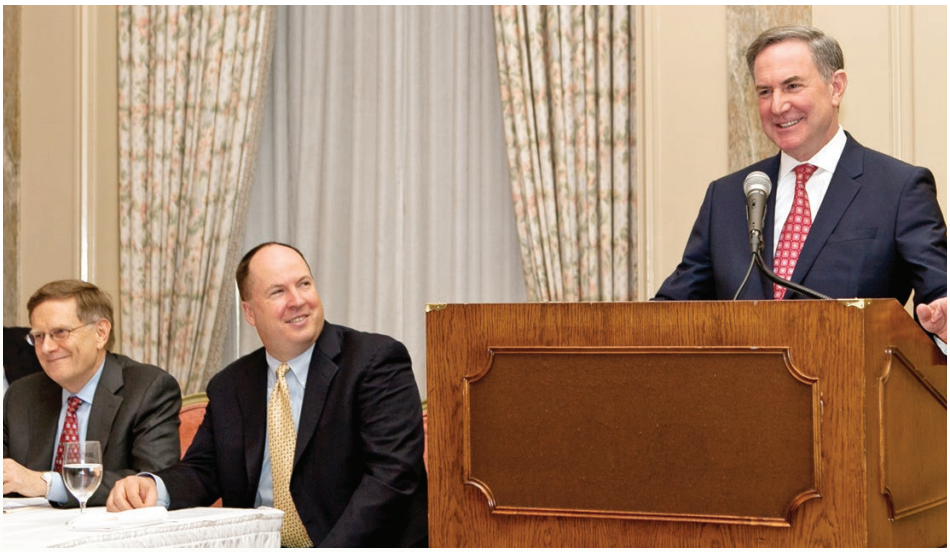
A General Counsel who has a deep understanding of the business, is uniquely positioned to provide that type of advice objectively and without some of the conflicts that a P&L owner might have. I always insist that the lawyers – and indeed, everyone in our department – think like business owners first, and then use the lens of their particular expertise, whether it be legal or otherwise, to address whatever issue has arisen. I'm happy to say that our associates are viewed as full business partners of their clients' teams, and I believe there is a direct correlation between that and the fact that our associate satisfaction levels are among the highest in the company.

The fourth lesson I learned was also a reinforcement of something I always knew to be the case: bad news does not get better with age. You need to build a culture that rewards bringing difficult issues forward early, without shooting the messenger. You cannot address a problem if you do not know about it, and getting to the whole truth is obviously critical. It requires you to be diligent and to ask the right questions and to not accept the first answer. You do need to trust, but you also need to verify.

The General Counsel should be just that: a counselor, more than a good lawyer, more than a good sounding board, and always a consistently strong voice for the ethics and culture of a company. The board, the CEO and members of management should be able, literally, to bare their souls to the General Counsel, knowing that their confidences will be kept and that they will receive the benefit of objective, fair-minded advice and guidance.

Another lesson reinforced for me was the importance of surrounding yourself with the best talent, particularly talent that can fill in your capability gaps. To do that requires an honest assessment of yourself, and having the humility to acknowledge that those gaps exist and that you cannot do it alone. At this point, I have to acknowledge my long-suffering Chief of Staff, Linda Marx – [APPLAUSE] – who has, for the last 26 years, filled in my many capability gaps. So, Linda, thank you for the *first* 26 years, and I deeply appreciate all that you've done!

The final lesson I learned was how quickly some people – in this case, it was me – can flip into a different role and a mindset.



While CEO, I was presented with an overseas opportunity that seemed to me, at the time, to contain little downside risk, while offering significant long-term returns. Our interim General Counsel cautioned against it, noting the level of corruption in that area of the world, the difficulty of doing a due diligence, and our relative lack of political influence *vis-à-vis* the other players. Nevertheless, to me, the potential rewards outweighed the dangers, and I gave it the green light. My tenure as CEO, sadly, ended before the deal could close. Our new CEO was, at first, also intrigued with the opportunity. But back in my role as General Counsel — [LAUGHTER] — I assessed the transaction from a different perspective, and eventually persuaded him to kill the deal because of the risks! [LAUGHTER] I'm nothing if not flexible!

My takeaway is simple: As lawyers, we are taught to identify and mitigate, or even better yet, eliminate, all risk. Most successful businesspeople understand that risk is often the other side of reward. Striking the right balance between the two is one of the hallmarks of success in the business world, and the General Counsel should strive to ensure that that delicate balance is appropriately achieved.

Having served as CEO has given me a greater appreciation for how to serve a CEO, and certainly an understanding of just how challenging and multifaceted the job could be for anyone. As I said at the beginning, all of us at WellPoint have the same purpose: to transform our health care system, and improve the quality of care for all Americans.

I'd like to close by asking that you think about our industry as a partner with a unique role to play in the health care system, and a partner that can and will change the system for the better. Hopefully, I've given you a few insights into how we're doing just that.

Thank you again, and I look forward to our discussion. [APPLAUSE]

JACK FRIEDMAN: I'd like to ask John a couple of preliminary questions.

One of the aspects of health care is the idealism of employees. What types of volunteer work do your people get involved with beyond the money side of health care?

JOHN CANNON: There's a lot that goes beyond the money side of health care. I just wish that people could walk the halls of our offices and facilities and feel the enthusiasm for what we do, and how we do it, and for whom we do it. Our Amerigroup subsidiary is really quite incredible, in terms of how they take care of the most vulnerable Americans and really view them as our valued customers and clients.

We also have a very robust charitable arm. Our foundation is well-funded, and we have, at any given time, about $43 million worth of grants in process, so that we do give back quite significantly to our communities. We target those activities in the health care arena where we feel that we can add the most value and create a better environment for our customers and for our businesses. There is a wide variety of things that we do in terms of community service across the country that addresses that. To get back to where I started, if you could just experience the enthusiasm and the zeal with which our employees and associates execute their jobs every day for the benefit of our customers, the humanity issue that you raised would fall by the wayside, because it's there in everything we do.

JACK FRIEDMAN: Thank you. In terms of your experience as the CEO, there was a famous story by a Harvard professor who wrote a biography of Eisenhower. He said there was a meeting where people came in and talked with the President about what they hoped would be done. He said, "I agree with you, but I'm only the President and I can't necessarily make the bureaucracy implement what I want." As the CEO, what limitations did you experience in getting things implemented in a mega-organization?

JOHN CANNON: That's a great question. In one respect, I'd go back to something I said earlier, and that is that bad news does not get better with age. If you don't know about a problem, you can't fix it. One of the first things you have to do is to make sure that everyone's encouraged to bring the difficult issues forward so they *can* be addressed; get people together, get them focused on what it is and what we need to do about it. I would say that was one of the major things that I felt I had to accomplish in terms of our culture at the time. Once people realized that it was okay to make a mistake and to bring it forward, and that we were all on the same team, working together, and it wasn't about pointing fingers or witch hunts — there was a

real change in terms of the attitude of our associates and the enthusiasm and willingness to move forward. It may sound like a little thing, but it was quickly and easily accomplished. It was a great team effort that started the company moving forward fairly rapidly as soon as that was evident.

JACK FRIEDMAN: Did you have problems building a consensus among the management team to get the job done?

JOHN CANNON: I agree that trying to build a consensus is necessary to the extent that you can, but at the end of the day, it is not a democracy. I described it as a benevolent dictatorship, and at some point, someone has to make a decision. If the management team can't do it, then the CEO will do it. There were times when I had to do it.

JACK FRIEDMAN: It is unusual for a General Counsel to have this unique experience. What are your observations about relations between the CEO and the Board?

JOHN CANNON: It's an interesting relationship, and obviously, in our case, the CEO is also a board member, so he straddles those two worlds. There are very difficult legal obligations, obviously, associated with each role. It is my job to make sure that the lines between those two roles are clearly delineated. It's also necessary to make sure that the Board doesn't step over the line and start trying to manage the company. It sometimes happens when you have some fairly forceful Board members that feel that they would like to exert their influence more. You have to gently brush them back into their proper role.

Our CEO is a very effective manager of the Board. Our management team has a very good relationship with the Board. We have had some turnover in our Board of Directors over the last year. We've brought on three new Directors with relevant expertise, and they've already hit the ground running. One of the CEO's main jobs, in conjunction with the Governance Committee, is to make sure that our Board is performing at a level that would be commensurate with a company of our size and impact.

> "In 2012, the United States spent $2.8 trillion on health care. That is 17.2% of our GDP, which is twice as much per capita versus other economically developed countries. Seven hundred billion dollars of it represents waste across the system, including $210 billion in unnecessary services, $45 billion in avoidable complications — mostly infections — and $55 billion in missed prevention opportunities." *– John Cannon*

JACK FRIEDMAN: Can you tell us about who owns WellPoint, and the variety of different ways in which you try to communicate with them whether they are individual investors or institutional investors?

JOHN CANNON: Yes. Our shareholder base is mostly institutional investors, and primarily value-based investors. During the seven months I was CEO, dealing with the investors was probably my biggest challenge, because it was something that I had never had to do before. They are expecting the CEO to be very facile with every aspect of the business strategy. I can remember having to discuss premium yields in our New York market with investors. Prior to that, I barely knew what a "premium yield" was or why it mattered, in New York or anywhere else! [LAUGHTER] So, there was a learning curve there. We are a publicly traded company and because we have owners who do care about how we deploy our resources and what our long-term strategy is, there needs to be a fairly continuous and clear dialogue with them about what we feel our future prospects are, and why. We have, obviously, an Investor Relations area that communicates regularly, individually, with investors, or during conferences. We need to get our story out there, because our competitors are competing for capital with the same investors that we are.

JACK FRIEDMAN: Do you have long- and short-term debt?

JOHN CANNON: Both! It's a mixture, and I'd have to say that our CFO is actually brilliant, in my view, and has, over the course of my association with him, done a masterful job with capital management.

JACK FRIEDMAN: Do you also have a long-term portfolio investment so that you get a long-term income stream?

JOHN CANNON: Yes, we have a portfolio; it is not weighted in the long-term, just because of our business mix. We have different buckets of investments, including for our pension plan and for our financing activities, but it would not look like a life insurance investment portfolio.

JACK FRIEDMAN: Thank you. Our first panelist is Craig Hoover of Hogan Lovells.

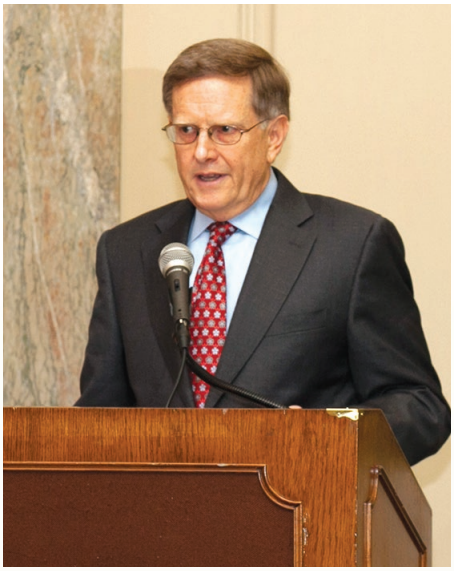
CRAIG HOOVER: Good morning, everyone. I'm Craig Hoover from Hogan Lovells. I am a litigation partner in the Washington, D.C. office. My colleagues from Hogan Lovells and I are thrilled to be here, to help honor our friend and colleague, John Cannon. Our firm has worked with WellPoint for 18 years, and it truly has been a great partnership.

Let's talk about the politics of health care. It's clear from John's remarks and from reading the headlines in the newspaper day in and day out that health care reform has become the biggest political football in our nation. Perhaps because I practice in Washington, or maybe because our firm works with WellPoint on these issues, or maybe because this panel is chock-full

of litigators, who will be talking about litigation, I've been asked to talk about the political skirmishes that have occurred around the Affordable Care Act for the last five years. In particular, the challenge that congressional investigations and hearings present for companies like WellPoint.

The ACA's potential impact on the health care system is immense, and as the nation's largest Blue Cross Blue Shield company, WellPoint is at center stage. WellPoint's CEO, Joe Swedish, recently told the *New York Times*, "We have got the most to win." In his remarks today, John touched on some of the challenges the company faces in dealing with the new regulations, the rollout of the exchanges in very compressed timeframes, and other issues. Between the changes related to grandfathering rules, the extension of the deadline to sign up for coverage, and yet another delay announced this week in the employer mandate, health care companies like WellPoint have no choice but to adapt and play catch-up.

As if the task of implementing the law were not difficult enough, these companies must do so in a highly charged political environment, one in which every success is trumpeted – or maybe "oversold" – by supporters of the law, and every failure is attacked and exaggerated by opponents of the law. This is nothing new; health benefits companies have been a main attraction for congressional inquiries since Congress first began debating the ACA in 2009. Since that time, no fewer than eight different congressional committees have issued inquiry letters. These letters often request that the company turn over emails and documents; sometimes they request that company personnel brief congressional staffers; and on occasion, they demand that the company's executives march up to Capitol Hill, sit in front of the cameras, and answer every question every congressperson has to ask. It doesn't seem to matter which party controls Congress; these requests have come from the House and Senate when the Democrats were in power prior to November, 2010, and then since January, 2011, from the Republicans in the House.



Just as an example, when the ACA was being debated in 2009 and 2010, the Democrat-controlled House Energy & Commerce Committee summoned CEOs from WellPoint and other companies to come and testify about issues ranging from premium rate-setting to coverage of particular treatments to company profits. John Cannon and his GC counterparts at WellPoint's competitors – they were there, sitting in the seats immediately behind their CEOs, but still squarely in the range of CSPAN cameras. John learned this the hard way when he received a call from his mother later that day, who remarked that he appeared to be irritated by the questioning. [LAUGHTER]

JOHN CANNON: I didn't even know my mother watched CSPAN! [LAUGHTER] She called me up and said, "I saw you on CSPAN today." I responded, "Really? What did you think?" She said, "Well, I thought you looked really old and annoyed." [LAUGHTER] She was half-right; I was very annoyed! [LAUGHTER]

CRAIG HOOVER: That was a day to remember, for sure. It's great to be counseled by your mother on facial expressions! [LAUGHTER]

JOHN CANNON: She never stops! [LAUGHTER]

CRAIG HOOVER: Congressional inquiries have continued since the Republicans took control of the House in January of 2011, focusing first on the impact of the ACA on large businesses, and then on how the Administration has executed, or failed to execute, in implementing the law. For example, when the ACA's primary website, healthcare.gov, wasn't ready to meet the October 1 launch deadline, the House oversight committee, headed by Darrell Issa, summoned Secretary Sebelius up to the Hill. She was publicly grilled in front of that committee – the same committee, by the way, which had grilled the CEO of WellPoint and other CEOs a few years before. All you can say is, "All is fair in politics and health care," because it doesn't matter what party is in there – there's going to be scrutiny!

In more recent months, the committees have focused their shift to enrollment numbers and demographics, and they have also sought information about whether health insurers warned the Administration of the coming turbulence with the website. The Congressional Budget Office, as you have probably read, released a study on the potential impact of the ACA on the workforce. Pundits on both sides raced to the Sunday morning talk shows, each with their own partisan take on the significance of the report and what it meant.

These congressional inquiries come as the industry – John and his colleagues – are working feverishly to implement the key provisions of the law, to help the government make the website and other enrollment functionalities work, and to grow the newly created insurance marketplaces so that coverage can be accessible and affordable for their members.

Changes in the regulatory and political landscape happen every day, and John and his Public Affairs, Government Relations and Legal teams have the job of keeping company executives well informed and well advised in this ever-changing environment.

As some of us were discussing at dinner last night, it's not really anything that any of us were taught in law school, but it's a lot more interesting than Trusts and Estates or Contracts 101.

In closing, health care reform will almost certainly be the number-one issue leading up to the November elections. Members of both parties on Capitol Hill will be looking at every single step of ACA implementation closely. As John and his counterparts in the GC chairs within the industry look ahead to the rest of 2014 and beyond, they know that throughout the process, their companies are going to be in the political crossfire.

John, as you and your team confront this challenge, we hope it gives you at least a bit of comfort that many of us here in this room today will be standing there with you.

Thank you very much. [APPLAUSE]

JACK FRIEDMAN: We had Congressman Oxley, of Sarbanes-Oxley fame, speak at one of our programs. He was asked, "Why were some parts of the law well-conceived and drafted, and other parts seemed like they were just thrown together and shoved in there?" He said the following: As a Republican in the House, and Sarbanes a Democrat in the Senate, they had worked very carefully to craft what they thought was a good middle-of-the-road bill. The week it hit the floor of the House, WorldCom collapsed, and there was hysteria about regulating companies and boards. Congressmen would run in and say, "I have to have an amendment to the bill to show my voters." His staff were sitting there with amendments that had not been approved by the Committee and people were running to the Floor to enter them. That is where the worst parts of the bill came from.

Given that we have this kind of process in Congress, I wanted to ask if the health care reform bill, the ACA, also represents the camel that comes from a committee designing a horse. Is health care reform so complicated that it is impossible to have a well-crafted bill?

CRAIG HOOVER: I will start, and then John can be more eloquent.

Everyone knows the vote was incredibly close. Nobody got everything they wanted in the bill, and we're seeing some of the results of last-minute compromises that were made in putting it together. Very few bills that I know of, any time recently, have been enacted as designed, because Capitol Hill, and really politics across the country is so divisive right now; it's so partisan. In some ways, it's amazing that the bill passed in the first place, because a few months later, it wouldn't have, when the composition in Washington changed. We're seeing the incredibly complex result of the compromises that were made. That doesn't make it a lot different than many other pieces of legislation that we're all dealing with — this one just happens to be the most important.

JOHN CANNON: Yes, describing it as a camel might be diplomatic. Putting that aside, I would agree with what Craig has to say. The last piece of major health care legislation that was probably crafted pretty well was the Medicare Part D legislation, which was approached differently, more thoughtfully, and in a less politically charged environment. It can be done, but I would agree with Craig that the current environment just doesn't lend itself to bipartisan, thoughtful analysis, and what the real public policy issue is behind crafting the legislation.

JACK FRIEDMAN: From the standpoint of industry as a whole, what was the difference in Part D's negotiation? How did the climate, or economics of the bill, give it a better chance of being carefully crafted?

JOHN CANNON: Certainly, there was contention, and I was observing it from afar, but I would say that there was a belief, or at least an effort to allow the private sector into this government space. It has over

time, created fairly stable premiums and marketplaces. The first couple of years were a little rocky, but it has done pretty much what it was intended to do. I wasn't close to the political process at the time; I can only say that the result was better than what we're seeing now with the ACA.

JACK FRIEDMAN: Thank you. Our next speaker is David Deaton of O'Melveny & Myers.

DAVID DEATON: Thank you. I'm here on behalf of any number of civil litigators, enforcement lawyers, and deal lawyers at O'Melveny, who focus not only on health care and life sciences, but, in particular, managed care. As John said, this is truly an exciting time to be a health care lawyer, but also to be focused in this particular area — in the managed care sector. My career started more than a decade ago, and I actually had the honor of working with John at Cigna. It has been truly inspirational to watch John in all of his various capacities over the years, at Cigna and now at WellPoint. This is a much-deserved honor, and I'm honored to be here to do the honoring.

That's all upbeat. I'll now talk a little bit about health care enforcement. [LAUGHTER] I got the short end of the stick because I'm going to take us down a road that is a bit of a downer, but we'll pick it up at the end.

Managed care, for years, has been in a relatively unique position in the health care industry. It has not been a target of enforcement agencies, by and large. Managed care companies have had their fair share of civil litigation matters, of various other things that have cropped up; but by and large, the Department of Justice, the Office of Inspector General and others out there — have not looked to managed care in quite the same way as they've looked at the hospital, pharmaceutical, or device industries. Frankly, that is beginning to change. If you look at the health plan in Florida, four of their executives have been put to trial, convicted and are now awaiting sentencing for statements that their managed care organization made to state regulators. That's just one example of many where these enforcement agencies are really starting to ask the question, "You have managed care; you've made certain commitments. Are you honoring those commitments?"

It is easier to step back and say, "Why the interest here?" Some of that has to do with the change in customer base that the managed care companies have seen. Historically, managed care has been the provider of health care services to employer-sponsored plans. Most of us in this room probably receive our health care through our employer; our employer often contracts with a company like WellPoint. Historically, that has been the mainstay of the industry's business. What the industry has seen, though, is a change in customer base. The employer-sponsored plans are still a very important component of managed care, but what the managed care companies have seen is a steep rise in governments as their clients.

Of course, with the number of enrollees that are now managed under the government, and beneficiaries who are now receiving health care through managed care, and the dollars involved — that starts to attract some attention. Not through any fault of the industry — as a famous bank robber once said, "Why do you go to banks? That's where the money is!" There is a lot of money; there are

a lot of enrollees here; and so the prosecutors tend to look and say, "There are a lot of premium dollars being spent."

Let us look at the rise in managed care in government in particular. Currently, 55 million Medicare beneficiaries are receiving their care through companies like WellPoint and their competitors — $150 billion in premiums. That's a three-fold increase in the last decade. In terms of Medicaid, we've gone from 30 million beneficiaries receiving their care in 2006 through managed care to 40 million, with over $100 billion in premiums.

Those numbers are before we factor in the Affordable Care Act and the expansion of Medicaid, and the policies offered under the exchanges. We are going to see yet another steep rise. With the public attention that Craig talked about, combined with these numbers, you start to see enforcement agencies asking questions.

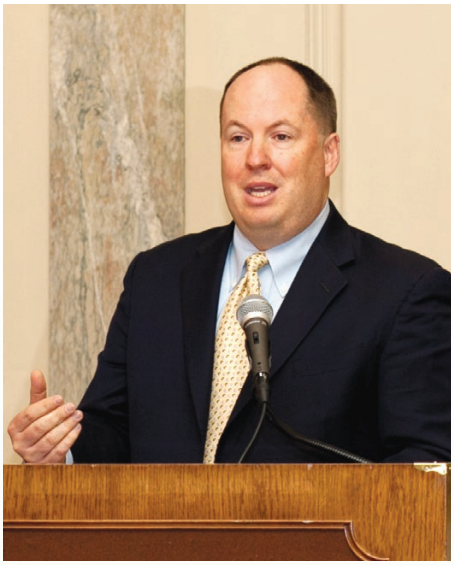
With this kind of shift in client base, how does a managed care organization need to change in that setting, if you think about the employer-sponsored health care plan? Generally speaking, the payor is just that — they're paying out claims, and a lot of their systems are designed more to pay the provider rather than to assimilate information from the provider and make a claim to a governmental agency. It's a fundamentally different equation when you start taking systems that were designed to do one thing, try and harvest some of the data that comes from that function, and then make claims to a federal government agency or a state governmental agency.

That's just one example. Another example is the Special Investigations Unit at a managed care company. That unit, generally speaking, is a safeguard for the managed care plan, to make sure that providers aren't taking advantage of the managed care plan by billing for services that should never have been provided, or overbilling. They're looking for loss to the managed care plan; that's historically how those units were constructed.

In today's environment, where you have so much government money and enrollees that are being provided care through the managed care company, that SIU is now receiving potential complaints from members, and other folks that could, in the hands of a prosecutor, be used to say, "You knew about this five years ago when this customer called up the SIU." The SIU looks at it and says, "It doesn't appear to have any harm to the plan, but in fact, it has an effect of possibly a potential false claim to a governmental agency." Something like that can be used in the hands of the prosecutor.

What you see here is really a need for shifting the focus of some of these business units at granular levels within the managed care organization. Some of what a managed care company is able to do, and some of what WellPoint *has* done under John's leadership, is go to the business unit. How do you solve some of this problem? If you take the legal and compliance function, as John has done, and you integrate it with the actual business unit, you can more effectively change with the environment. That is critically important here. As you are embarking here, and you're well under way in this transformative change in health care broadly, as your company changes, being able to affect that change at the granular level is very important.

Another critical component to being able to survive in this environment — John's touched on it — have a culture of openness. What's



the tone from the top of your organization? Bad news doesn't get better with time! That's a great message. Let's flush this up into an open discussion so that we can actually talk about the issues, wrestle with them. An issue today will be much more easily dealt with than an issue when you're trying to answer questions before a governmental entity.

There is yet another function that, in this environment, will be quite interesting as we go. What makes it exciting to be a health care lawyer, and particularly, a lawyer that's focused in this managed care sector — is watching the enforcement agencies with their knee-jerk reaction. Managed care has traditionally been a lightning rod for public scrutiny, as Craig mentioned. With these congressional investigations, there's a fair amount of skepticism that a prosecutor is able to bring to bear. Unfortunately, they bring with that skepticism an even greater lack of knowledge and ignorance as to what the industry is all about.

At this juncture, when regulators and enforcement agencies are just starting to pay attention to managed care, the critical function of the health care lawyer is to be able to inform those enforcement agencies on how the premiums are set. How the industry is actually using big data and some of the other items that John mentioned, to improve care. How they are actually complying with the obligations that are set out before them, in accomplishing those objectives. That educational function is critically important, and it will continue to be important over this next decade.

It is an exciting time. Thank you very much for allowing me to honor you today, John, and I very much appreciate all that you have done over the years, and the inspiration you've been for my own career.

JACK FRIEDMAN: David, I'd like to ask you as well as the other panelists a question.

You had mentioned that the government regulators and enforcement people are attracted to the field because it is affecting so many citizens. What types of enforcement actions are government agencies taking?

DAVID DEATON: It is a great question. The arsenal tends to be in the administrative area — the Office of Inspector General obviously can levy civil monetary penalties with corporate integrity agreements, which work more like consent decrees. On the civil fraud side, you have the civil False Claims Act; that seems to be the favorite of many of the civil prosecutors out there. That carries with it potential treble damages and penalties.

Let us suppose for a moment that the managed care plan makes certain claims with respect to its medical loss ratio, or how its premiums should be calculated. If the government comes back and says, "We don't think those claims are accurate, and we believe that you proceeded with reckless disregard or deliberate ignorance." It's not a very high intent standard. In fact, it is an uncomfortably low intent standard and it allows them to throw about some allegations. As John said, when you're talking about 580 million claims, to be able to have certainty in the truth and accuracy of those claims is difficult. There's no way that you can ensure truth and accuracy when you're receiving much of your information from independent providers over whom you have no real control.

I would add to that that you also have criminal penalties. The folks in Florida will file criminal false claims type actions. You also have the Anti-Kickback Statute, which can regulate the manner in which the managed care company is going out to seek to enroll patients, your broker relationships, and how you are increasing enrollment.

JACK FRIEDMAN: Can one of the other panelists join in?

MICHAEL TUTEUR: As someone who also works in the False Claims Act area, I certainly agree that the clients are changing, and the government is more than ever becoming the customer. As a result, the possibility of False Claims Act liability has really increased, and that's coupled with the fact that, as many of you may know, the False Claims Act is one of the rare exceptions in legislation, in which a private citizen — which we refer to as a "relator" — can bring an action essentially as a bounty hunter purportedly on behalf of the United States. Since 1986, when the False Claims Act was amended, the number of actions brought by relators has skyrocketed.

When I began working in this area, though, the goal of the relators and their counsel was to get the government to intervene in the case and to take it over, and then the bounty for the bounty hunter would be approximately 10 or 15%. The bounty hunter didn't need to do any work, having brought the action to the United States. If the United States didn't pick up the case, the relators would drop the matter. Today, however, there is a well-financed group of contingency fee lawyers who do False Claims Act work on behalf of relators. They are just as happy to have the government *not* get involved, because the bounty goes up to 25 or 35%, and as contingency fee lawyers often do, they have a long string of matters that keep the money coming in to the office, and they wait for a very big score. As you mentioned, with the number of claims — every claim can be the basis of

a penalty — in the thousands or hundred thousands or millions that are allegedly false, the numbers can get very large.

There are big dollars at stake, and it is a ripe area for litigation.

DAVID DEATON: I would add that it is critically important to be able to educate that enforcement agency, because we've had success in talking to the DOJ, explaining to them how this payment model works, for example, in Medicare or in Medicaid. Then convincing the DOJ, "Look, not only do you want to decline your intervention, so don't join this case, but you actually want to talk this relator down, because if we proceed on this, you're going to have some bad press in an emerging area." The ability to go in and inform the agency as to what might be a righteous case and what might be an unrighteous case — and, of course, "the one you're involved with is just not the right one for you, and for the following reasons"; to be able to understand what's really going on in the industry is important to that discussion.

JACK FRIEDMAN: Let me ask, then, the parallel question: When it's not the government on the other side of the case, but it's the private sector companies that you might be arguing with — class actions, individual suits and so forth — what are examples of the type of things that non-governmental people or groups sue for?

KURT PETERSON: Certainly as a California litigator, for better or worse, we're the hot bed, and the claims are only limited by creativity. Certainly all things having to do with claims practices, rate setting, and benefits decisions are subject to challenge via litigation. There is a well-funded group of class action lawyers in the State of California who bring a tremendous percentage of all the cases brought in the United States, mostly in Los Angeles County. The climate is particularly tricky when the law is so unsettled and in transition in terms of the Affordable Care Act rollout. In other states, the plaintiffs' bar seems to be waiting to see how many of those issues will shake out. In California, that hesitance to file before things shake out is not evident, and we're dealing with those issues while the landscape is totally unsettled and the rules are still being formulated. It is certainly something that John and his team have to deal with in real time every day. Mike is planning to talk about some of the litigation, too, so I don't want to cut off his remarks.

JOHN CANNON: I'll just give a quick little overview here. Just over 50% of our litigation relates to disputes with providers over reimbursements, so pretty much straight contractual disputes. Member disputes are probably in the range of slightly less than 20%, and then the rest of the litigation, it just runs the gamut across the board. Most of the litigation is here in California. [LAUGHTER]

JACK FRIEDMAN: It's good to keep the California Bar busy, particularly for this audience! Michael Tuteur has come in from Boston and he will be speaking next.

MICHAEL TUTEUR: Good morning. My name is Michael Tuteur, and I'm a partner and chair of the Litigation Department at Foley & Lardner, and as Jack says, I'm in from Boston, where the weather is distinctly less favorable than it is right here, so it's nice to be here!

Let me begin by thanking Jack Friedman and the Directors Roundtable for this terrific occasion, and for affording my firm and me the opportunity to share the dais with John Cannon, who richly deserves the global honor for General Counsel. I also want to take a moment to thank John and his legal team, some of whom I see here, for allowing Foley & Lardner to work with them on some of the most interesting and challenging legal work that exists in this country. It's a real privilege to work with such a talented, creative and forward-looking team of lawyers.

This morning, I'll be talking very briefly on litigation as it relates to corporations, including health insurance companies like WellPoint, which are facing greater litigation threats every day as the ACA is implemented. As John noted, the entire health care industry is facing a major evolution, and the ACA and its implementing regulations have created a legal landscape that is ripe for litigation. In fact, as everybody in this room knows, the birth pangs of the ACA involved litigation, beginning with the direct challenge to the ACA's individual mandate in *National Federation of Independent Business v. Sebelius*, which was ultimately decided by the Supreme Court in a splintered 5 to 4 decision. Yet, while the partisan wrangling continues — including on Capitol Hill, as Craig Hoover mentioned — it often spills into the courtroom. Employers, ordinary members, and companies like WellPoint, are faced with uncertainty as the ACA's effect continues on the litigation landscape.

In spite of the recent successes that WellPoint and other insurance companies have begun to see under the ACA from a business perspective, there are many litigation risks and challenges facing the industry. Some of these are hot button issues at the social and political level. This spring, for example, in *Sebelius v. Hobby Lobby*, the Supreme Court will again weigh in on an important aspect of the ACA – the law's requirement that an employer health plan cover the full range of FDA-approved contraceptives for their employees. The *Hobby Lobby* case is unique, in that it asks the High Court to determine whether a private, for-profit business can claim a religious exemption from federal laws that protect the reproductive rights of their employees.

In another hot button issue that is currently pending, in the *Halbig v. Sebelius* case – and Secretary Sebelius appears to be the defendant in many of these cases, doesn't she? – the plaintiffs have challenged the IRS's rule authorizing the federal health insurance exchanges to issue subsidies and impose tax penalties in the 34 states that did not opt to establish a state insurance exchange. The case is based on a couple of clauses in the ACA which, taken literally, can be interpreted as saying that only exchanges established by a *state*, as opposed to the federal government, can grant premium tax credits to subsidized low-income families seeking insurance on the exchanges. The plaintiffs in the case are all from states that opted out of creating their own state exchanges, and the thrust of the plaintiffs' argument is that consumers in the *federal* exchanges aren't eligible for those federal subsidies, which would, in turn, make coverage unaffordable for many of the Americans that the ACA was supposed to protect.

Just two weeks ago, the judge in Washington, D.C., hearing the *Halbig* case ruled for the government, and held that all exchanges, whether federal or state, can grant the tax credits to poorer customers. The ruling has already been appealed to the D.C. Circuit, and it's fair to say that it's likely to head up to the Supreme Court.

Looking in a more focused way to the health insurance industry itself, health insurers, like WellPoint, who are participating in the exchanges are permitted to establish networks that are referred to as "narrow networks" – that is, the list of participating providers will be less comprehensive than has been the case in the typical employer plan. The economic driver is that health insurers will sign up the most efficient and least costly providers for their network and their members, leaving the expensive leviathans behind. As you could imagine, providers that have been left out of the narrow networks are unhappy, and it has been in the news that doctors in Connecticut sued one of WellPoint's competitors to stop it from dropping about 1,000 doctors from their narrow network, and the doctors obtained a sweeping injunction in the U.S. District Court in Connecticut. Just this past week, the 2nd Circuit of the U.S. Court of Appeals modified the injunction significantly, giving the physicians just 30 days to challenge their removal from the network, and then only through arbitration.

Of course, narrower networks often run the risk of making certain members unhappy as well. We heard President Obama say, a number of years ago, that under the ACA, if you like your doctor, you can keep your doctor – words I suspect he wishes he could take back. In various states, members are complaining to regulators about certain of the choices that insurers have made in slimming down the network of hospitals, even though there ultimately may be considerable savings. We can expect litigation to follow.

Similarly, there is litigation – and it's here, as everyone says, in the "epicenter" of litigation: California – over the cancellation of old insurance policies and requiring policyholders to get new plans. Another allegedly broken promise made by the President, according to the litigation. In the California case, the plaintiffs have sued their health insurers, and not the government, for failing to tell the policyholders that their old policies, if re-upped, might have been deemed to be "grandfathered." That would have shielded them from the regulatory requirements of the ACA.

The truth is that many of the new ACA-compliance policies are substantially better and have more coverage than the old individual plans, and of course, these individual plans could have been terminated at the end of their terms anyway. Nevertheless, the plaintiffs' class action bar has seen these changes, and the President's own words as an opportunity to make mischief and perhaps some money.

Finally, it's worth briefly noting that consumer protection statutes all over the country are a fertile field for class action lawyers. For example, in Missouri right now, a policyholder class action is underway, alleging that a health insurer took advantage of the new ACA requirements to hike premiums on existing individual policies, while not giving policyholders an option to cancel these plans and shop on the exchange if they preferred. In the Missouri case, the plaintiffs allege that the insurer's customer service hotline would not process the consumers' cancellation requests in the months leading up to the premium rate hike, and indeed wouldn't even answer the phone. Well, as is often the case

in litigation, the real facts will only come out after considerable time, money and energy have been expended by the parties.

There are, frankly, countless other issues that will arise as ACA implementation moves forward, including lawsuits over physician choice and alleged benefit discrimination under ERISA. We've just talked about the expansion of the False Claims Act – not just federally, but on the state side; and issues regarding fraud and abuse. These are just a few fertile areas for more litigation. As John indicated earlier, one of the biggest challenges facing a General Counsel of a major American health insurer is to make the right judgment call on ACA compliance, when there is little or no guidance from the agency, or where, in fact, the guidelines change at the drop of a hat.

Given our years of working with John Cannon and his highly professional team, it's easy for me to say that no one else in the industry has more skill and talent to make those judgment calls correctly and consistently. All of us here, both from my own firm and in the firms represented here in this room, are very fortunate to work with a legal team and a leader like John when we enter the courtroom on WellPoint's behalf.

Thank you very much.

JACK FRIEDMAN: Daniel Dufner of White & Case is our next speaker.

DANIEL DUFNER, JR.: Thank you, Jack. I also am honored to be here, and thrilled! John, thank you for the opportunities over the years to work with you on so many of the most important M&A transactions for WellPoint. Also, I'm honored to be part of such an esteemed panel of fellow practitioners. I, however, was either lucky or smart – or both – and avoided practicing as a litigator! I'm the token M&A lawyer on the panel.

The Affordable Care Act has been very good for M&A lawyers. WellPoint is a company, along with many of the other insurance companies, that has been built by M&A. I've been fortunate and privileged to have worked with WellPoint on many of its M&A transactions since about 2003, when Anthem, based in Indianapolis, acquired WellPoint Health Networks here in Thousand Oaks, California, and created the combined Anthem/WellPoint – Anthem renamed itself "WellPoint."

> "The goal of data and technology, combined with a payment system that works, is to eliminate variability where there should be no variability, through the use of clearly-established best-practice guidelines, and to increase variability where it makes sense; for example, targeted diagnostic tests and more personalized therapy, that will improve the quality of care." – *John Cannon*

Back then, each of WellPoint and Anthem had built themselves through M&A, mostly buying other Blue Cross and Blue Shield plans in different states. As John said, WellPoint operates in 14 states as the licensee of the Blue Cross and Blue Shield association.

Beginning in the middle part of 2007, and continuing through 2008 and 2009, we saw WellPoint doing deals in what we call the "specialty areas," such as dental, radiology benefits management and data analytics. In March of 2010, the Affordable Care Act was signed into law. Some of the other panelists and John have alluded to the fact that even prior to the adoption of the Affordable Care Act, as a result of demographics and other factors, the business mix for companies like WellPoint was shifting to Medicare and Medicaid. Medicaid covers the poor; Medicare, the elderly and the dual eligible market, people who qualify for both Medicare and Medicaid. This was something that companies and their Boards of Directors and management teams saw as a strategic opportunity where the growth opportunities would be.

In 2011, WellPoint led the way, by doing the first Medicare Advantage transaction, when they bought a company based in California called "CareMore." In 2012, we did the first Medicaid transaction when we acquired Amerigroup, which was a $4.9 billion deal.

Additionally, Cigna bought a company called "HealthSpring" in 2011. UnitedHealth, one of our business competitors – all of these are the big competitors – bought a company called XLHealth for approximately $2 billion; and Aetna, in 2012, bought Coventry Health Care, again to expand into the government business.

Since then, the industry has been undergoing what we refer to as "provider consolidation," and there have been a lot of hospital mergers. In fact, hospital deals more than doubled from 2009 to 2012. In 2013, there were a number of mega-mergers, as several large health systems combined to create multi-hospital networks. Hospitals and insurance companies have also been acquiring physician practices. Some interesting stats: in 2005, 5% percent of doctor specialists were hospital employees, and 57% of doctors were independent. Today, 25% of specialists are hospital employees, and only 33% of doctors are independent.

Insurance companies have also been investing in providers, and mainly as a result of trying to drive down cost. Physicians directly influence over $530 billion, or 25% of total health care spending. Owning or partnering with doctors allows insurance companies to maintain greater control over the delivery of coordinated care, thereby increasing the likelihood that they can keep the members out of the hospital and keep costs down.

In terms of M&A transactions in this space, Humana acquired a company called "Concentra" in 2010. Concentra operates urgent and occupational care clinics. UnitedHealth has been very aggressive in buying physician practices, the largest example being its acquisition of Monarch Healthcare in 2011, which is a major Southern California physician group that includes approximately 2,300 physicians in a range of specialties. WellPoint acquired CareMore, which has clinics in California, Nevada and Arizona specializing in care for seniors. Another one to note: Highmark in Pennsylvania acquired West Penn Allegheny Health System, a five-hospital operator.

There's a chart which really shows all of the acquisitions of what I would call the five biggest managed care operators, and you'll see, in some of the deals that I've mentioned, there has been this shift towards provider consolidation. In fact, the provider convergence has been led by the managed care operators.

There are different ways in which the five major managed care operators have approached this notion of engaging with providers. The two most aggressive have been Humana and United-Health, actually buying physician groups and making that a real strategic priority. WellPoint is in the middle. As John said, they have lots of partnerships with physician groups, but they really haven't been acquiring them, other than the CareMore deal. Cigna and Aetna are also included in the managed care operators.

There's a quote here from John, when he was interim CEO, but I changed it last night to a quote from Joe Swedish, the new CEO. [LAUGHTER]

JOHN CANNON: Back to mortal status, like I said!

DANIEL DUFNER, JR.: In that quote — this was on January 29th of this year — he said, "We now have 60 ACOs [which are accountable care organizations]; 80,000

providers engage with us through value-based payments which total something on the order of $300 million in payment streams." The CEO of United Health estimates that they've set an aggressive target of having more than $65 billion in value-based contracts with care providers by 2018. We are at the forefront of this move to provider consolidation that we've been seeing.

Payer-provider convergence has been led by companies like WellPoint, United-Health, Humana, Cigna and Aetna.

There is another deal that was in May of 2012 that many of you might be familiar with: DaVita, which is a dialysis company in Denver, bought Healthcare Partners, which was the largest group of independent physicians in the country. That was a little short of a $5 billion transaction, and just another example of payer-provider convergence.

Just to note: we don't have anyone on the panel from the antitrust perspective — it is part and parcel of the M&A practice, and there has been increased scrutiny from the government. Hospital-to-hospital mergers have received increased scrutiny. There have been a number of challenges, and successfully litigated challenges, where the government has prevented transactions from being consummated. In addition to hospital merger transactions, the FTC — which is the government agency that is involved with hospital antitrust and other provider antitrust — has also recently challenged a number of acquisitions of physician groups by hospitals. There was a recent case, where St. Luke's Health System tried to acquire a physicians group in Idaho — and this was not even a reportable transaction for HSR purposes — so the deal closed as scheduled. The government attacked it post-closing and is now forcing them to unwind the transaction, because they were concerned that there would not be enough competition at the local level as a result of that transaction.

I want to close by saying there's an interesting slide at the very end, and the title is, "Beyond Managed Care Operators and Hospitals — Who Else May Pursue an Integrated Care Model?" You'll see companies like Wal-Mart and Target, Walgreens, CVS Caremark, Express Scripts; there is enormous opportunity outside of your traditional insurance companies who have expressed interest in this. Wal-Mart and Target have clinics inside their stores, and they have been aggressive in this area and may become more aggressive. There is a huge M&A opportunity for companies like WellPoint, as they continue to navigate the Affordable Care Act and the implementation of it — already many signs that payer-provider convergence is here to stay.

Thank you very much.

JACK FRIEDMAN: What are the criteria by which deals are valued? There must be other things than just the cash flow that comes in.

DANIEL DUFNER, JR.: The investment banks in almost every transaction that we have done — using them as a financial advisor — use an accepted range of valuation techniques, including discounted cash flow. Another big one is EBITDA [Earnings Before Interest, Taxes, Depreciation and Amortization]; what multiple of EBITDA is the company worth? How much should you pay for it; is it eight or nine times?

One of the interesting things that we're finding is that the health insurance companies and hospitals have been trading at much lower multiples than the specialty providers. The reason for that is everyone knows and expects that there will be more acquisitions by insurance companies of providers, and therefore, they trade at a higher multiple and they have a higher valuation as a result.

JACK FRIEDMAN: In some industries, such as the cable industry or the media, for example — they say, "How much per eyeball?" Each customer is estimated to be worth "X," so if you have 500,000 customers, your value is this; it's not even the cash flow, *per se*. Is there anything similar in the health care field, where a patient, or a pool of patients, is worth so much per patient?

DANIEL DUFNER, JR.: Not really. WellPoint has about 36 million members. It is the first or second biggest health insurance company in the country. Obviously, their valuation is influenced and affected by how large they are, but it really comes down to tried and true investment banking techniques, in terms of valuation.

JACK FRIEDMAN: What specifically, is driving the deals? Why do people think that more is necessarily better? Such as being in ten states is better than being in five, or being in six areas is better than two areas. Not every industry benefits by being bigger.

DANIEL DUFNER, JR.: One of the things that I mentioned is Medicare and Medicaid. WellPoint has been on the cutting edge and the forefront of these transactions. If we go back to 2010 or 2011, when they bought CareMore; that was a Medicare Advantage deal. Clinics, providers — it was our first acquisition of a provider group. That was a hotly contested auction that involved many of our competitors, and we were fortunate to prevail in the auction. That was Medicare, and then everyone looked at Medicaid as the next obvious choice. There were four publicly traded Medicaid companies. We bought Amerigroup, and there are three left. It's actually interesting that none of the other three have yet to be bought by our competitors, because Wall Street analysts assumed that they would be next.

Molina is one that is based here in California. Molina is a family-controlled company and a bit harder to purchase, although I'm sure there are companies that would love to buy Molina. Medicare and Medicaid are being driven by demographics, the Affordable Care Act, and that's why now you're seeing the trend to either buying or partnering with providers of health care. The model is really changing for a company like WellPoint.

JOHN CANNON: I would add to what Dan's saying is, as a managed care company, you're not going to be able to survive without having a decent segment of government business going forward. You have these business lines within managed care being strengthened and enhanced for Medicare and Medicaid. The acquisitions of a physician group within a managed care company, that's often in order to better sync up the quality of care and the expense of care. There's a concern that if you just leave it to a contractual relationship on traditional terms, then you're not going to be able to sync up those quality of care initiatives that you're tasked with performing, but also your cost of care is going to be too expensive.

There are either contractual ways of dealing with that, or you buy the provider.

MICHAEL TUTEUR: One quick point on that — if you read the Idaho case with St. Luke's Hospital, which is really a fascinating read for anybody, the court says quite clearly that the consolidation of the hospital and the physician group is likely to improve care and bring better service to the patients. Yet, because of the antitrust concerns, it goes so far as to derail and completely undo the deal — a remarkable result, especially in a case where the merger didn't hit HSR limits.

JOHN CANNON: We are dealing with a schizophrenic patient. On the one hand, you've got the Affordable Care Act, where these companies are being charged to reduce care, and sometimes the best way to do that is to align with the various segments within the community. Then you have the antitrust laws being enforced in this way, that makes it very difficult to achieve the initiatives set out in ACA.

JACK FRIEDMAN: We have had Goldman Sachs partners speak about deals. They said deals may go awry not just because of the economic negotiations. You can't believe how many times two companies will come to an agreement on the economics, and because of the controversy between the two CEOs, the deals fall apart. There's a lot more to a deal than straight economic rationality.

JOHN CANNON: We call those the social issues! [LAUGHTER] The question is, "Who's going to be the CEO?" [LAUGHTER]

DANIEL DUFNER, JR.: I would like to pose one other idea. One of the directions that I would expect the industry will take over time, as you have more of these

value-based payment systems developed, is that you will start to see referrals to specialty groups. If Grandma has a broken hip, she goes to the hospital, the hospital company provides care, sends her on to the skilled nursing facility, on to the rehab, then home health. Without seeing any evidence of this, I would expect that over time, we would see instead of hospitals merging with hospitals, consolidating across the continuum of care, that hospital companies would look down that continuum.

JACK FRIEDMAN: It is an interesting idea. I would also like to mention that there is a huge, looming national question that I don't think the press has even begun to start reporting on. If we keep the Affordable Care Act, what do we have to change to make it more successful?

We have Kurt Peterson of Reed Smith who will speak next.

KURT PETERSON: I'm Kurt Peterson, a litigation partner in the Reed Smith firm in Century City in Los Angeles. I'm here on behalf of our team of lawyers and other colleagues that want to join in congratulating John and thanking the WellPoint team for the privilege to work with them throughout the country.

I am more nervous than usual coming up here. One, as you can imagine, because this is such a distinguished group. My real fear, for the last two hours, was that I would shoot off the end of the riser into that urn that appears to be from the Ming Dynasty! [LAUGHTER]

I've been worried, so this is actually very liberating to move over here.

In addition to litigating, I have been involved in law firm management for many years, first as the managing partner of a California firm called Crosby Heafey. Then for the last ten years, after we joined with Reed Smith, which is a large, international firm, I've been on the Executive Committee of Reed Smith.

I was asked to make some comments — away from the health care issues — about another area in which John has been a real innovator. I am going to speak about the changing landscape in the way legal services are being delivered and priced. Then I will make some general comments and observations about the legal marketplace.

A century and a half ago, a wise gentleman said, "It is not the strongest or the most intelligent who will survive, but those who can best manage change." That quote comes not from a nineteenth century version of McKinsey or Bain or BCG; it's from Charles Darwin, and I'm pretty sure he wasn't talking about Fortune 40 health care companies or major law firms. Nonetheless, in the legal marketplace in which we find ourselves, those words seem right on the mark.

In the last ten years, and at a much greater pace, in my view, since the economic downturn in 2008, the legal marketplace has been impacted by at least three major undeniable market trends.

The first general trend I would categorize as a premium on value. When I say premium on value, I mean increased pressure on in-house legal departments to deliver services more efficiently and more economically. Coupled with that is an oversupply of lawyers which, to some extent, has shifted pricing power to clients. At the same time, this has spawned a whole range of alternative fee agreements, which are all geared to meet client desires and needs for predictability, risk sharing and partnering. From my firm's point of view, ten years ago, very little of our revenue was derived from anything other than the traditional hourly billing model. At this stage, roughly 30% — more than $300 million, in our firm's case — of revenue in 2013 came from pricing models other than an hourly fee — whether that's a flat fee, a capped fee, or a reduced fee with a success component. It is a very rapidly changing marketplace.

The second major trend that is undeniable is the geographic expansion of clients nationally and internationally, and industry consolidation. The reality is that our clients are bigger; they're doing business in more places; and there is tremendous consolidation within most industries. You've heard a lot about that today in the health care industry, as the major players within those industries consolidate and expand.

Law firms have responded by attempting to grow their capabilities wherever the clients have needs, and to provide quality and value consistently across the places where they deliver services, so that they can hold on to those remaining players in a given industry.

The third major trend that we've seen is the rise of convergence programs. The fact is, clients are working with fewer outside firms that best service their needs. Clients feel that this simplifies and makes more efficient their management of outside firms, and allows clients to deal with firms that have a deeper knowledge of the client itself and the industry in which that client engages in business.

In addition, the clients want to deal with firms that leverage the assets and work together with other firms — something that was not very common ten years ago. More and more, you're seeing a premium on firms that can work with other firms and,

again, leverage assets and bring more to bear in terms of the delivery of services. It all comes back to the goal and the pressure to deliver high-quality legal services more efficiently and more economically.

We all read the papers, and we've seen lots of stories about law firms and businesses that were ostensibly strong and intelligent, that are no longer with us. Unfortunately, those were entities that were not able to manage the tremendous change that John talked about in his remarks, and is a reality both in the legal marketplace and the health care marketplace.

At the same time John was helping to guide WellPoint through a quickly shifting industry landscape, he was also at the helm in positioning his legal department within the company and within the industry — with *many* innovative programs — to again meet the goals and challenges that I have highlighted. It would be fascinating — especially with the different hats that John has talked about — to hear his views on these market trends that have been so dramatic in changing the landscape of the legal marketplace.

Thank you very much.

JACK FRIEDMAN: Thank you. I would like the Speakers to address a big central question raised earlier.

Whether you agree with it or not, what are some of the changes to Obamacare that might be coming down the pike later? Maybe John will start us with that.

JOHN CANNON: I will start with one thing about the Affordable Care Act, which would be the elimination of the health insurance tax. It really does nothing but add cost, because it gets passed on to the consumer for the most part, and it affects most lines of business unevenly throughout the industry. The tax is not imposed on all health insurers in quite the same way or in the same amount. That would be quick thing that we could eliminate to lower the costs two or three percent, depending on the product. It flies in the face of the name of the statute being the "Affordable" Care Act.

CRAIG HOOVER: Eventually, it's going to be necessary to do more to control medical costs. Certainly from the health plan perspective — that's an issue that wasn't adequately addressed the first time around. There are reasons for that, and as we talked about earlier, it was a true sausage-making process in terms of the compromises that were struck. That is an aspect that will need to be addressed.

If it's possible, turning the political heat down on the issue, from both sides of the aisle, is going to be necessary for things to ultimately work better. It has been, for the last five years, and continues to be, such a political hot button in both parties, and it makes it difficult to step back and try to come up jointly with solutions that make sense. It is the number one issue, when someone is running for the House or running for governor. For example, in the Virginia gubernatorial race, the race was not even close in the polls, but the problems with the healthcare.gov web-site, by all commentators who were looking closely at the race, made it very close at the end. The Republican candidate for governor of Virginia really closed the gap just by hammering on the problems with the website and implementation of health care.

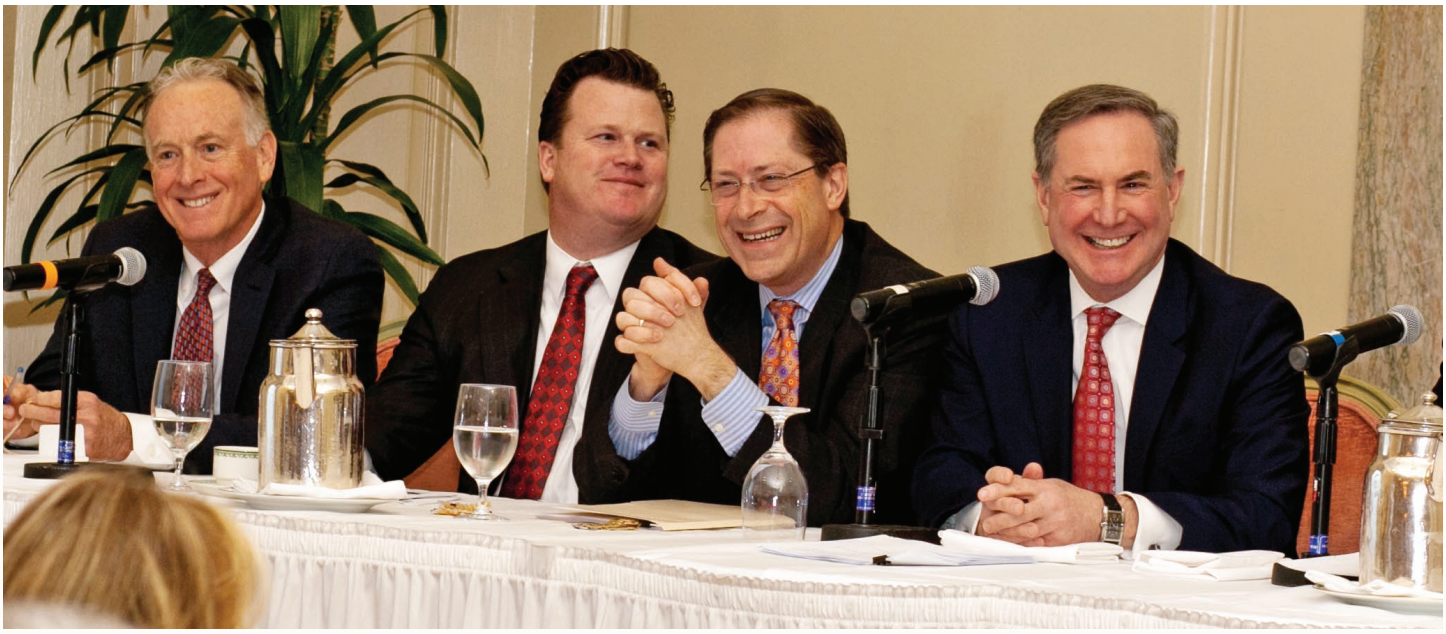
Turning down the political heat will eventually be necessary, and hopefully will happen.

KURT PETERSON: Do you think we'll live long enough to see that happen, Craig? [LAUGHTER]

MICHAEL TUTEUR: One potentially — and I have to stress "potentially" — hopeful sign is that there is a group among somewhat more moderate Republicans who have recognized that the call of "Repeal Obamacare" is not an acceptable answer. There are aspects of the ACA that are very important, and very appealing to a vast majority

of Americans. One is now seeing, at least among certain segments in the Republican community, the notion that there has to be some alternative to the repeal; that it's not simply "get rid of it"; there has to be some other plan. Once that happens — and again, this may be an utter pipe dream — the idea that maybe some alternatives, and at least tinkering with some of the mechanisms, changing some of the ways things are done, may be possible, and maybe the heat could be turned down a bit. Kurt asked the right question: Is it going to turn out in the coming Congressional election that hammering Obamacare is a successful mechanism for gaining higher office? If that's so, then, frankly, I'm very concerned about what the final outcome of this is going to be.

DAVID DEATON: In part, we're framing the debate in a way around the Affordable Care Act that misses much of the issue; the Affordable Care Act was really health insurance reform, if you will. It provided for, perhaps, greater access to health care, but there are still fundamental questions to be resolved in our health care system that are going to further increase the problems, as we go through. These problems are not going away.



The very best things about the Affordable Care Act, potentially, are the things that the Affordable Care Act sought to study, which is how to better improve care, and how to better reduce costs. The unique position that managed care is in to actually assist the country in that is truly an opportunity.

JACK FRIEDMAN: Thank you. Let's go back to Kurt's question for John. How in the world can a General Counsel and a law firm negotiate a guaranteed cost for a serious piece of litigation?

JOHN CANNON: It can be done. Certainly, for a very complex case, it's very difficult to do, and usually is not done. But there are categories of litigation that we can negotiate a flat case rate for, and have done that, and have done it quite successfully; sometimes we win, sometimes the law firm wins; we all do it in the spirit of cooperation and partnership, but it has been done.

KURT PETERSON: I would agree with that. It is very difficult, but lawyers are the only profession that for many years, got away with undertaking their work with absolutely no idea how much it was going to cost. Those days are gone.

JOHN CANNON: They are! [LAUGHTER]

KURT PETERSON: In my mind, John hit on the most important points: there *is* a need for cost predictability in these big companies; there *is* a need to know that your law firm partner is as conscious of trying to drive down costs as the client is; and you have to do the best you can to get creative to create win-win partnerships. These types of arrangements must be built on mutual respect, genuine trust and each side must be willing to take a long view, since the dynamics will always be changing, resulting in short-term inequities.

JACK FRIEDMAN: Let me thank everyone, and thank John particularly for joining us.

Michael J. Tuteur

Partner,
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FOLEY

FOLEY & LARDNER LLP

Michael J. Tuteur is a partner with Foley & Lardner LLP and chair of the firm's Litigation Department and Business Litigation & Dispute Resolution Practice. Mr. Tuteur concentrates his practice on complex commercial litigation for clients in a broad range of industries, including healthcare, software, biotechnology, insurance, education, advertising, banking and mutual funds. His litigation experience includes ERISA and RICO class actions, payor/provider disputes and False Claims Act cases involving Medicare, Medicaid and the Federal Employee Health Benefit programs. He also has substantial experience in white collar criminal and regulatory investigations involving alleged health care fraud.

Earlier in his career, Mr. Tuteur was appointed special assistant attorney general to represent then-Massachusetts Governors William F. Weld and A. Paul Cellucci in four constitutional cases involving the scope and effect of the governor's veto power. Mr. Tuteur was also named special master by a United States District Court to investigate allegations of document destruction and attorney misconduct. In addition, Mr. Tuteur was appointed an expert witness to the Royal Court of Justice in London, England, to give opinion evidence on the application of U.S. law to the Latin American syndicated debt market. Mr. Tuteur served as an Assistant U.S. Attorney for the District of Massachusetts, practicing in the Major Crimes Unit and Organized Crime Strike Force.

Mr. Tuteur earned his J.D. (magna cum laude), from Harvard Law School (1984) and his A.B. from Harvard College (summa cum laude, 1980), where he was named to Phi Beta Kappa. Mr. Tuteur is admitted to practice in the state of Massachusetts and before the U.S. Courts of Appeals for the First, Second, Fifth, Sixth, Seventh, D.C. and Federal Circuits, and the U.S. Supreme Court.

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Craig Hoover

Partner, Hogan Lovells U.S. LLP

Hogan Lovells

Craig Hoover is a member of the Hogan Lovells Board and serves as co-head of the firm's Litigation area. Craig's practice focuses primarily on class actions and other complex litigation, and he heads Hogan Lovells' class action group.

Craig has successfully defended Hogan Lovells clients in class action cases in federal and state courts across the country. He currently serves as lead counsel in several major class action matters, including two federal multidistrict litigation proceedings, and has been described in *Chambers USA* as "a smart strategist who is great on paper and on his feet in the courtroom." In addition to his class action work, Craig regularly represents foreign governments in suits filed against them in U.S. courts, as well as Hogan Lovells clients raising constitutional and statutory challenges to federal agency actions. He also handles litigation involving the Racketeer Influenced and Corrupt Organizations (RICO) Act, the Employee Retirement Investment Security Act (ERISA), the Alien Tort Statute, antitrust, false advertising, unfair competition, insurance, deceptive trade practices, business torts, defamation, breach of fiduciary duty, and other general commercial matters.

Prior to joining Hogan Lovells, Craig served as a law clerk to The Honorable Robert J. Kelleher of the U.S. District Court for the Central District of California. He was also an editor of the *Duke Law Journal*.

Hogan Lovells

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David Deaton

Partner, O'Melveny & Myers LLP

O'MELVENY & MYERS LLP

David Deaton, a nationally recognized leader in health care law, is Co-Chair of O'Melveny's Health Care and Life Sciences Practice and a member of the White Collar Defense and Corporate Investigations Practice. Named one of the country's "Outstanding Healthcare Fraud & Compliance Lawyers" by Nightingale's Healthcare News, David represents major health care organizations in complex, high-stakes regulatory, enforcement, and business matters. He conducts internal investigations for health care companies and audit committees, and he defends them in federal and state enforcement inquiries. He also counsels buyers and sellers in mergers and acquisitions, lenders and borrowers in loans and workouts, and health care companies facing strategic business challenges and opportunities. In 13 years at the firm, David has assembled a record of expertise in the increasingly contested fields of state and federal anti-kickback and self-referral law (e.g., the Stark laws), Medicare and Medicaid reimbursement law, state and federal privacy law, and managed-care regulation. He frequently writes and speaks on these issues for national audiences.

Government Inquiries
Defending a **national managed-care organization** in a *qui tam* False Claims Act investigation into compliance with Medicare Advantage regulations, including allegations related to inflated premiums resulting from inaccurate risk-adjustment submissions.

Internal Investigations
Conducting an internal investigation into whistleblower allegations related to a **national managed-care organization**'s compliance with Medicare Advantage regulations and the federal anti-kickback statute, which has led to disclosures to the U.S. Department of Justice, the Centers for Medicare and Medicaid Services, the Office of the Inspector General of the U.S. Department of Health and Human Services, and state regulatory and enforcement authorities.

Strategic Counseling
Advising a **pharmaceutical manufacturer** in connection with its compliance program, sales and marketing practices, and issues related to the Medicaid Rebate Program.

Transactional Diligence and Structuring
Representing a **private equity fund** in its $455 million sale of a national dental practice management company.

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Our clients come from many industries, nations, and developmental stages. Their diversity spurs our own diversity and reach. We were one of the first U.S. law firms to open offices in Beijing and Tokyo. O'Melveny has a leading China practice with offices in Shanghai, Beijing, and Hong Kong. Moreover, we opened an office in Singapore in 2008, established an association with an Indonesian law office in Jakarta in 2011, and most recently opened a foreign legal consultant office in Seoul. Our European offices are in the key economic and political centers of London and Brussels. Our lawyers' outstanding work regularly garners international awards and recognition.

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In 2014, we will continue to enhance O'Melveny's internal resources that help us bring our best game to overcoming clients' challenges: sophisticated legal technology, greater lawyer diversity, and professional development. We are optimistic about the future — for our clients, our communities, and our world.

Kurt Peterson

Partner, Reed Smith LLP

ReedSmith

The business of relationships.

Kurt has practiced exclusively in civil litigation, with an emphasis on legal malpractice, health care, entertainment, class actions, business disputes and complex insurance issues. He has successfully tried cases to verdict in each of these areas. He has litigated lawsuits and controversies for entertainment industry clients dealing with profit participation agreements, motion picture and television financing, breach of contract claims, and employment-related issues.

A true "lawyer's lawyer," Kurt is a nationally recognized authority on professional liability, ethics and risk management issues. He has consulted and testified in trial as an expert on standard of care and ethical issues. He has represented over 250 law firms ranging from sole practitioners to some of the largest and best known national and international firms in California and throughout the United States.

He was featured in *California Law Business* articles as one of the top 25 lawyers under age 45 in the state (1993), in an article on "The Lawyers' Lawyers" (1998), in an article on "Top 10 Defense Verdicts of 2003" (2004), in the annual feature on "The Rainmakers." He is listed in *The Best Lawyers in America*, as well as *Southern California Super Lawyers*. Kurt is a frequent speaker on issues relating to law firm management and participated in a management program at Columbia Business School.

He has served on the Executive Committee of Reed Smith from 2003 to the Present and has been Chairman of the Strategy Committee and a Member of the Audit Committee. At Crosby, Heafey, Roach & May (which combined with Reed Smith in 2003) he opened the Los Angeles office and served as its first Managing Partner. In May of 1997, he opened the Century City office for the firm and served on the Executive Committee and Compensation Committee. In March of 2000, he was elected Managing Partner of the firm. Prior to his law firm experience he was law clerk to the Honorable Robert Kane of the California Court of Appeal, First District.

Reed Smith LLP

Reed Smith represents many of the world's leading companies in complex litigation and other high-stakes disputes, cross-border and other strategic transactions, and crucial regulatory matters.

With lawyers from coast to coast in the United States, as well as in Europe, Asia and the Middle East, Reed Smith is known for its experience across a broad array of industry sectors. Reed Smith counsels 13 of the world's 15 largest commercial and savings banks; eight of the world's 15 largest oil and gas companies; and the world's three largest pharmaceutical distribution and wholesale companies. Reed Smith's shipping practice has been designated among the most preeminent in the world, and its advertising law practice is regarded as among the legal industry's finest.

Reed Smith has grown in large part because of its uncommon commitment to delivering high-quality service and developing long-term client relationships. Our lawyers' approach to service begins by understanding clients' business goals, then applying the resources necessary to help achieve them.

Based on the results of a survey of large and Fortune 1000 in-house counsel, the BTI Consulting Group has ranked Reed Smith among the top firms for client service ten years running. Reed Smith has been identified as one of the few large law firms with a strategic focus on client satisfaction.

Reed Smith's work has been noted by industry observers. *The Lawyer* named Reed Smith its runner-up for U.S. Law Firm of the Year, and *The American Lawyer* named the firm "Litigation Department of the Year" in the product liability category. *The Deal* highlighted Reed Smith's commercial restructuring and bankruptcy practice as among the most active. *Asian-Counsel* named Reed Smith's Hong Kong office "Firm of the Year" in two categories, Commercial Transactions and M&A.

Daniel Dufner, Jr.

Partner, White & Case LLP

WHITE & CASE

Daniel G. Dufner, Jr. is a partner in the Mergers & Acquisitions Practice Group and is resident in the New York office. Dan's practice has focused on representing US public companies in a significant number of public and private M&A transactions, including numerous transactions for longstanding clients Dish Network Corp., EchoStar Corp. and WellPoint, Inc. Dan's M&A practice has included US domestic transactions as well as cross-border transactions throughout Europe, Asia and Australia. In addition to mergers & acquisitions, Dan has counseled his clients on dispositions, leveraged buyouts, spin-offs, joint ventures, unsolicited/hostile transactions, takeover defenses, capital markets transactions, general corporate matters and corporate governance.

Dan is a leading member of our top-ranked US M&A practice which is currently ranked Band 1 for Corporate/M&A in both the latest *Chambers USA* and the latest *Legal500* guides which are the two leading independent law firm ranking publications.

Dan has also been recently recognized by *The American Lawyer* as "Dealmaker of the Week" and "Dealmaker in the Spotlight" as well as being named in the *Lawdragon 500* list of "Leading Lawyers in America."

Recent matters include the representation of:

- WellPoint, Inc., one of the nation's largest health benefits companies, in its sale of 1-800 CONTACTS, INC., a leading contact lens retailer, to Thomas H. Lee Partners, its related sale of 1-800 CONTACTS' glasses.com business to Luxottica and its prior acquisition of 1-800 CONTACTS, sold by private equity firm Fenway Partners.
- WellPoint, Inc. in its US$4.9 billion acquisition of Amerigroup Corporation, one of the country's leading managed care companies that is focused on meeting the health care needs of financially vulnerable Americans.
- WellPoint, Inc. in its acquisition of CareMore Health Group, a leading Medicare Advantage and Senior clinical care provider, which was sold by private equity firm CCMP Capital Advisors.
- WellPoint, Inc. in its US$6.5 billion acquisition of WellChoice, the parent company of Empire Blue Cross Blue Shield.
- Anthem, Inc. in its US$16.4 billion acquisition of WellPoint Health Networks, Inc.

White & Case LLP

White & Case LLP is a leading global law firm with lawyers in 39 offices across 26 countries. Among the first U.S.-based law firms to establish a truly global presence, we provide counsel and representation in virtually every area of law that affects cross-border business. Our clients value both the breadth of our global network and the depth of our U.S., English and local law capabilities in each of our regions and rely on us for their complex cross-border transactions, as well as their representation in arbitration and litigation proceedings.

We guide our clients through difficult issues, bringing our insight and judgment to each situation. Our innovative approaches create original solutions to our clients' most complex domestic and multijurisdictional deals and disputes.

By thinking on behalf of our clients every day, we anticipate what they want, provide what they need and build lasting relationships. We do what it takes to help our clients achieve their ambitions.

White & Case's Global M&A Practice
White & Case built its reputation completing groundbreaking domestic and cross-border M&A and strategic private equity transactions with precision and speed. Leading multinationals, major commercial and investment banks, private equity funds, entrepreneurs and smaller visionaries alike have turned to our global team to complete thousands of complex transactions, including many high-profile multibillion-dollar deals involving multiple jurisdictions.

Our Global Mergers & Acquisitions Practice has devised creative deal structures, designed acquisition programs, and planned and implemented strategies for both acquirers and potential acquisition targets in domestic and cross-border transactions around the world.

Awards & Recognitions
International Law Firm of the Year
The Lawyer 2013

Global Citizenship Award
The American Lawyer 2013

Law Firm of the Year
The M&A Advisor 2012

Global Elite in Antitrust/Competition
Global Competition Review 2013

Second-Most Diverse Large U.S. Law Firm
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