UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
(DALLAS DIVISION)

UNITED STATES OF AMERICA, and the STATE OF TEXAS, Plaintiffs, v. AETNA INC., and THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, Defendants.	Civil Action No.: 3-99CV1398-H Judge Sanders

REVISED COMPETITIVE IMPACT STATEMENT

Pursuant to Section 2(b) of the Antitrust Procedures and Penalties Act ("APPA"), 15 U.S.C. § 16(b)-(h), the United States submits this Competitive Impact Statement to assist the Court in assessing the proposed Revised Final Judgment submitted for entry in this civil antitrust proceeding.

I.

NATURE AND PURPOSE OF THIS PROCEEDING

The United States filed a civil antitrust Complaint under Section 15 of the Clayton Act, 15 U.S.C. § 25, on June 21, 1999, alleging that the proposed acquisition by Aetna Inc. ("Aetna") of The Prudential Insurance Company of America's ("Prudential") health care business would violate Section 7 of the Clayton Act ("Section 7"), 15 U.S.C. § 18. The State of Texas, by and through its Attorney General, is co-plaintiff with the United States in this action.

The Complaint alleges that Aetna and Prudential compete head-to-head in the sale of health maintenance organization ("HMO") and HMO-based point-of-service ("HMO-POS") health plans in Houston and Dallas, Texas; that such competition has benefitted consumers by keeping prices low and quality high; and that the proposed acquisition would end such competition and give Aetna sufficient market power to increase prices or reduce quality in the sale of HMO and HMO-POS plans in these geographic areas. (Complaint ¶ 26.) The Complaint also alleges that the acquisition would enable Aetna to unduly depress physicians' reimbursement rates in Houston and Dallas, resulting in a reduction of quantity or a degradation in quality of physicians' services in these areas. (Complaint ¶ 33.)

When the Complaint was filed, the plaintiffs also filed a proposed settlement that would permit Aetna to complete its acquisition of Prudential but would require divestitures of certain assets sufficient to preserve competition in the sale of HMO and HMO-POS plans and the purchase of physicians' services in Houston and Dallas. This settlement consisted of a proposed Final Judgment, Hold Separate Stipulation and Order, and Stipulation. To further clarify certain aspects of the proposed Final Judgment, on August 4, 1999, the parties made a joint motion to the Court for entry of a Revised Hold Separate Stipulation and Order, as well as a joint motion to file a Revised Final Judgment and Revised Stipulation.

The proposed Revised Final Judgment requires Aetna to divest its interests in the Houston-area commercial HMO and HMO-POS businesses of NYLCare Health Plans of the Gulf Coast, Inc. ("NYLCare-Gulf Coast"), a previously acquired health plan serving Houston and other areas in south and central Texas, and the commercial HMO and HMO-POS businesses of NYLCare Health Plans of the Southwest, Inc. ("NYLCare-Southwest"), a previously acquired

health plan serving the Dallas area. If Aetna does not complete the divestitures within the time frame established in the proposed Revised Final Judgment, a trustee appointed by the Court will be empowered to sell NYLCare-Gulf Coast and NYLCare-Southwest. If the assets are not sold within six (6) months after the appointment of the trustee, the Court shall enter such orders as it shall deem appropriate to carry out the purpose of the trust. (Revised Final Judgment ¶ V.A., F.)

The Revised Hold Separate Stipulation and Order ensures that NYLCare-Gulf Coast and NYLCare-Southwest function as independent, economically viable, ongoing business concerns and that competition is maintained prior to the divestitures. It requires Aetna to immediately take steps to preserve, maintain, and operate NYLCare-Gulf Coast and NYLCare-Southwest as independent competitors until the completion of the divestitures ordered by the Revised Final Judgment, with management, sales, service, underwriting, administration, and operations held entirely separate, distinct, and apart from those of Aetna. In addition, Aetna is obligated to cause NYLCare-Gulf Coast and NYLCare-Southwest to maintain contracts or agreements for coverage of approximately two hundred sixty thousand (260,000) commercially insured HMO and HMO-based POS plan enrollees in Houston and contracts or agreements for coverage of approximately one hundred sixty seven thousand (167,000) commercially insured HMO and HMO-based POS plan enrollees in Dallas through the date of signing the definitive purchase and sale agreement(s) for the divestiture of the two NYLCare entities. Until the plaintiffs, in their sole discretion, determine that NYLCare-Gulf Coast and NYLCare-Southwest can function as effective

competitors, Aetna may not take any action to consummate the proposed acquisition of Prudential.[1] (Revised Final Judgment ¶ IV.I.)

The United States, the State of Texas, and the defendants have stipulated that the proposed Revised Final Judgment may be entered after compliance with the APPA. Entry of the proposed Revised Final Judgment would terminate this action, except that the Court would retain jurisdiction to construe, modify, or enforce the provisions of the proposed Revised Final Judgment and to punish violations thereof.

II.

THE ALLEGED VIOLATIONS

A. The Defendants

Aetna is a Connecticut corporation providing health and retirement benefits and financial services with its principal place of business in Hartford, Connecticut. Through its wholly owned subsidiary, Aetna U.S. Healthcare, Aetna offers an array of health insurance products, including indemnity ("fee-for-service"), preferred provider organization ("PPO"), POS, and HMO plans. Aetna also purchases physicians' services for its health plan members, which it offers to members through Aetna's health plans. In 1998, Aetna U.S. Healthcare reported revenues of over $14 billion and was the largest health insurance company in the country, providing health care benefits to approximately 15.8 million people in 50 states and the District of Columbia.

Prudential is a New Jersey mutual life insurance company with its principal place of business in Newark, New Jersey. Like Aetna, Prudential offers indemnity, PPO, POS, and HMO

[1] In the event plaintiffs are unable to agree on a course of action within seven (7) days, the United States may, in its sole discretion, act alone (or decline to act) with respect to the relevant course of action. (Revised Final Judgment ¶ XII.)

plans and also buys physicians' services, which it offers to its enrollees through Prudential's health plans. In 1998, Prudential HealthCare reported total revenues of approximately $7.5 billion and was the nation's ninth largest health insurance company, serving approximately 4.9 million health insurance beneficiaries in 28 states and the District of Columbia.

B. Description of the Events Giving Rise to the Alleged Violations

Aetna and Aetna Life Insurance Company, a wholly owned subsidiary of Aetna, entered into an Asset Transfer and Acquisition Agreement ("Agreement") dated December 9, 1998, with Prudential and PRUCO, Inc., a wholly owned subsidiary of Prudential. Under the terms of the Agreement, Aetna would acquire substantially all of Prudential's assets related to issuing, selling, and administering group medical, dental indemnity, and managed care plans, including HMO and HMO-POS plans. The purchase price stated in the Agreement is $1 billion, consisting of $465 million in cash, $500 million in three-year promissory notes, $15 million in cash payable under a Coinsurance Agreement, and $20 million in cash to be paid under a Risk-Sharing Agreement.

C. Anticompetitive Effects of the Proposed Acquisition

1. <u>The Sale of HMO and HMO-POS Plans</u>

Aetna's proposed acquisition of Prudential would be likely to substantially lessen competition in the sale of HMO and HMO-POS plans in Houston and Dallas, Texas, in violation of Section 7.

a. Product Market

Managed care companies, such as Aetna and Prudential, contract with employers and other group purchasers to provide health insurance services or to administer health care coverage

to employees and other group members. There are a variety of managed care products available to employers and other group purchasers which provide health care services at an agreed-upon rate, subject to certain utilization review and management requirements. These products, which include HMO, PPO, and POS plans, have become increasingly popular options for employers, largely because of the managed care companies' ability to obtain competitive rates from health care providers and to control utilization of health care services.

As the Complaint alleges, HMO and HMO-POS products differ from PPO or indemnity plans in terms of benefit design, cost, and other factors. (Complaint ¶ 15.) For example, HMOs provide superior preventative care benefits, but they place limits on treatment options and generally require use of a primary care physician "gatekeeper." PPO plans, which do not require enrollees to go through a "gatekeeper" and do not emphasize preventative care, are generally more expensive than HMOs. POS plans can be based on either an HMO or PPO network and fall between HMO and PPO plans in terms of access and cost. That is, POS plans offer patients more flexibility at a higher cost relative to HMOs. In general, then, PPOs and indemnity options are more expensive, provide better benefits with respect to coverage when ill, and allow greater access to providers. In contrast, HMO and HMO-based POS options are generally less expensive, provide better benefits with respect to health maintenance or preventative care, place greater limits on treatment, and restrict access to providers. (Id.)

Not only do these plans in fact differ by cost and benefit configuration, they are perceived as different by purchasers; neither employers nor employees view PPO plans as

adequate substitutes for HMO or HMO-POS plans.[2] Instead, they view them as distinct products, meeting different needs and appealing to different types of enrollees. Indeed, enrollees who leave an HMO disproportionately select another HMO (or HMO-POS), not a PPO, for their next health care benefit plan. (Complaint ¶ 17.)

Moreover, analyses of the data obtained from the parties and from other plans strongly indicate that consumers -- employers and employees -- view HMO and HMO-POS plans as distinct from other health plans and that PPO or indemnity plans are not thought to be ready substitutes for HMO and HMO-POS plans. These analyses demonstrate that the elasticity of demand for HMO and HMO-POS plans is sufficiently low that a small but significant price increase for all HMO and HMO-POS plans would be profitable because consumers would not shift to PPO and indemnity plans in sufficient numbers to render such an increase unprofitable.

Together with consistent evidence from numerous witnesses interviewed, these analyses support the conclusion that HMO and HMO-POS plans constitute the relevant product for analysis of the proposed transaction. (Complaint ¶ 18.)

b. Geographic Markets

Virtually all managed care companies establish provider networks in the areas where employees work and live, and they compete on the basis of these local provider networks. The relevant geographic markets in which HMO and HMO-POS plans compete are thus generally no larger than the local areas within which HMO and HMO-POS enrollees demand access to

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[2]Other health plans, along with many brokers and consultants, agree, noting the difference in networks, benefits, regulatory requirements, administrative systems, medical management requirements, and cost of HMO and HMO-based POS plans as opposed to PPO plans and indemnity coverage. Indeed, Aetna's and Prudential's own marketing materials strongly suggest that they view them as different products as well.

providers. More specifically, a small but significant increase in the price of HMO and HMO-POS plans would not cause a sufficient number of customers to switch to health plans outside of these regions to make such a price increase unprofitable. For this reason, the Department's analysis focused on MSAs in and around Houston and Dallas as the relevant geographic markets. (Complaint ¶ 20.)

c. Competitive Effects

Aetna and Prudential are among each other's principal competitors in the sale of HMO and HMO-POS plans in Houston and Dallas, and employers currently view them as close substitutes based on product design and quality. Maintaining Prudential as a competitor to Aetna in Houston and Dallas has become particularly important since Aetna's 1998 acquisition of NYLCare, a transaction that propelled Aetna's HMO and HMO-POS market share from 13% to 44% in Houston and from 11% to 26% in Dallas. (Complaint ¶ 22.) The proposed acquisition of Prudential would further enhance Aetna's position by eliminating competition between the two companies, giving Aetna market shares of 63% in Houston and 42% in Dallas.[3] (Id.)

As the Complaint alleges, potential or current competitors will not be able to constrain Aetna's exercise of its post-merger market power in the defined geographic markets. (Complaint

[3] The Department looked carefully at the various geographic markets around the country where Aetna and Prudential compete with each other. In most cases, it determined that Aetna's share of the HMO and HMO-POS market following the transaction did not raise competitive concerns. Depending on the MSA, this was because Prudential was not a significant competitor in the area and the acquisition would add little, if anything, to Aetna's market power, because Aetna itself was too insignificant a competitor to warrant concern, or because there were significant remaining competitors such that the acquisition would not likely harm competition. In contrast, the proposed transaction would significantly increase Aetna's share of the HMO and HMO-POS market in Houston and Dallas, and neither entry nor expansion would prevent Aetna from profitably increasing its prices in these areas.

¶ 25.) Effective new entry for a HMO or HMO-POS plan in Houston or Dallas typically takes two to three years and costs approximately $50 million.[4] (Complaint ¶ 23.) In such an environment, de novo entry is unlikely to defeat a price increase over the short term. (Id.) Furthermore, companies currently offering PPO or indemnity plans are unlikely to shift their resources to provide HMO or HMO-POS plans in Houston or Dallas in the event of a small but significant price increase. A number of managed care providers have stated during interviews that such a shift would be difficult, expensive, and time consuming, and that they would not enter the HMO or HMO-POS markets even if Aetna were to raise its prices a "small but significant amount." (Merger Guidelines ¶ 1.11.) Finally, managed care companies that presently offer HMO or HMO-POS plans in Houston and Dallas are unlikely to be able to expand or reposition themselves sufficiently to restrain anticompetitive behavior by Aetna in either area following the transaction. (Complaint ¶ 24.) Not only would these companies face some of the costs and difficulties of a new entrant, they would be unable to contend successfully with Aetna's advantages in national reputation, quality accreditation, product array, and provider network. (Id.) It is therefore unlikely that either new entry or expansion by competitors could counteract a post-merger price increase. (Complaint ¶ 25.)

For all of these reasons, the proposed transaction would enable the merged entity to increase prices or reduce the quality of HMO and HMO-POS plans available to consumers in these areas, in violation of Section 7.

[4]Indeed, Aetna has acknowledged that on average it costs between $600 and $1000 per enrollee to build membership in a HMO.

2. The Purchase of Physicians' Services

As alleged in the Complaint, Aetna's acquisition of Prudential will also consolidate its purchasing power over physicians' services in Houston and Dallas, enabling the merged entity to unduly reduce the rates paid for those services. [5]

a. Product Market

Physicians' services are those medical services provided and sold by physicians, and the only purchasers are individual patients or the commercial and government health insurers that purchase their services on behalf of individual patients. (Complaint ¶ 27.) As a result, physicians cannot seek other purchasers in the event of a small but significant decrease in the prices paid by these buyers. (Id.) Nor will such a price decrease cause physicians to stop providing their services or shift towards other activities in numbers sufficient to make such a price reduction unprofitable. (Id.) Physicians' services thus constitute the relevant product market within which to assess the likely effect of Aetna's acquisition of Prudential. (Id.)

b. Geographic Markets

The geographic markets for the purchase and sale of physicians' services are localized. In Houston and Dallas, as elsewhere, patients seeking medical care generally prefer to have access to treatment close to where they work or live. As a result, commercial and government health insurers -- the primary purchasers of physicians' services -- seek to have in their provider networks physicians whose offices are convenient to where their enrollees work or live.

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[5] Section 7 prohibits mergers or acquisitions that are likely to lessen competition or tend to create a monopoly in the purchase, as well as the sale, of any line of commerce in any area of the country. See U.S. v. Syufy Enters., 903 F. 2d 659, 663 (9th Cir. 1990); U.S. v. Rice Growers Ass'n, 1986-2 Trade Cases ¶ 67,288 (E.D. Cal. 1986); U.S. v. Pennzoil Co., 252 F. Supp. 962 (W.D. Pa. 1965); see generally R. Blair & J. Harrison, Monopsony 81-84 (1993).

(Complaint ¶ 19.) Consequently, physicians could not shift their services towards purchasers outside of these areas in numbers sufficient to make a price reduction unprofitable in the event of a small but significant decrease in the prices paid to physicians practicing in Houston or Dallas.

Furthermore, an established physician who has invested time and expense in building a practice in Houston or Dallas (or any other locale) would incur considerable costs in moving his or her practice to a new geographic area, including the substantial costs of building new relationships with hospitals, other physicians, employees, and patients in the new area. (Complaint ¶ 28.) For these reasons, a small but significant decrease in the prices paid to physicians practicing in Houston or Dallas would not cause physicians to relocate their practices in numbers sufficient to make such a price reduction unprofitable. (Complaint ¶ 29.)

For all of these reasons, the MSAs in and around Houston and Dallas constitute the relevant geographic markets. (Id.; Merger Guidelines ¶ 1.21.)

c. Competitive Effects

In Houston and Dallas, as elsewhere, the contract terms a physician can obtain from a managed care company such as Aetna or Prudential depend on the physician's ability to terminate, or to credibly threaten to terminate, his or her relationship if the company demands unfavorable contract terms. (Complaint ¶ 30.) Since physicians' services, unlike certain tangible products, cannot be stored until the physician finds a more acceptable buyer, failing to replace lost business expeditiously imposes an irrevocable loss of revenue upon a physician. Consequently, a physician's ability to terminate, or credibly threaten to terminate, a provider relationship depends on his or her ability to make up that lost business promptly. (Id.)

Physicians, however, generally have only a limited ability to encourage patients to switch health care plans or providers. (Complaint ¶ 31.) To retain a patient after terminating a plan requires the physician to convince the patient either to switch to another employer-sponsored plan in which the physician participates (which might not be an option) or to pay considerably higher out-of-pocket costs, either in the form of increased copayments for use of an out-of-network physician (if allowed) or by absorbing the total cost of the physician's services as unreimbursed medical expenses. As a result, a physician who discontinues his or her relationship with Aetna could expect to lose a significant share of his or her Aetna patients.

A physician's ability to replace, in a timely manner, such lost business is significantly diminished when a large number of patients need to be replaced. (Complaint ¶ 32.) Because of Aetna's "all products clause" -- which requires a physician to participate in all of Aetna's health plans if he or she participates in any Aetna plan -- a physician would lose patients from all Aetna plans if he or she rejects the rates or other terms of any one Aetna plan. Thus, the cost of replacing Aetna patients will be greater when Aetna plans collectively account for a larger share of a physician's total revenue.

Furthermore, the ability to replace a given number of Aetna patients is diminished when a physician's non-Aetna sources of patients are more limited. Consequently, the cost of replacing Aetna patients will be greater the larger Aetna's share of all patients in a locality.

Aetna's proposed acquisition of Prudential, following its recent acquisition of NYLCare, will give it control over both a large share of the revenue of a substantial number of physicians in Houston and Dallas and a large share of all patients in those areas. (Complaint ¶ 33.) In light of the limited ability of physicians to encourage patient switching, a significantly larger number of

physicians in Houston and Dallas would be unable to reject Aetna's demands for more adverse contract terms if Aetna were allowed to acquire Prudential. (Id.) The proposed acquisition thus would give Aetna the ability to unduly depress physician reimbursement rates in Houston and Dallas, likely leading to a reduction in quantity or degradation in the quality of physicians' services. (Id.; see also Merger Guidelines ¶ 0.1.)

III.

EXPLANATION OF THE PROPOSED REVISED FINAL JUDGMENT

The proposed Revised Final Judgment orders and directs Aetna to divest its interests in the Houston operations of NYLCare-Gulf Coast and the Dallas operations of NYLCare-Southwest, consisting of, among other assets, approximately 260,000 and 167,000 commercially insured HMO and HMO-POS enrollees in Houston and Dallas, respectively.[6] (Revised Final Judgment ¶ II.E, F.)

The provisions of the proposed Revised Final Judgment are designed to eliminate the two anticompetitive effects of the proposed acquisition. First, the divestitures will preserve competition and protect consumers from higher prices for HMO and HMO-POS plans by establishing a new, independent, and economically viable competitor -- or by significantly strengthening the existing competitors -- in the development, marketing, and sale of HMO and HMO-POS plans in the Houston and Dallas areas. Second, the divestitures will prevent the consolidation of purchasing power over

[6] The proposed Revised Final Judgment requires the divestiture of certain NYLCare assets rather than certain Prudential assets because of the legal and regulatory difficulties of divesting Prudential's Houston and Dallas HMO and HMO-POS businesses. However, the required divestiture of NYLCare's business will have an effect comparable to the divestiture of Prudential's business in these areas. Prudential has approximately 172,400 HMO and HMO-POS enrollees in the Houston area, while the proposed Revised Final Judgment requires Aetna to divest approximately 260,000 NYLCare enrollees in that area. In Dallas, Prudential has approximately 171,000 HMO and HMO-POS enrollees. The proposed Revised Final Judgment requires Aetna to divest approximately 167,000 NYLCare enrollees there.

physicians' services in Houston and Dallas and thereby deny Aetna the ability to unduly depress physician reimbursement rates.

In order to meet these two objectives, the proposed Revised Final Judgment requires that Aetna promptly make NYLCare-Gulf Coast and NYLCare-Southwest available for purchase. (Revised Final Judgment ¶ IV.A.) Aetna must give all prospective purchasers reasonable access to all NYLCare-Gulf Coast's and NYLCare-Southwest's personnel, physical facilities, and any and all financial, operational, or other documents and information customarily provided as part of a due diligence process. (Revised Final Judgment ¶ IV.F.) At the same time, Aetna must immediately cease all actions directed at the integration of NYLCare-Gulf Coast and NYLCare-Southwest into Aetna and must take all steps necessary to ensure that NYLCare-Gulf Coast and NYLCare-Southwest are maintained and operated as independent, on-going, economically viable, and active competitors until completion of the divestitures ordered by the Revised Final Judgment. (Revised Final Judgment ¶ IV.G, H.) Such steps must include the appointment of experienced senior management to run NYLCare-Gulf Coast and NYLCare-Southwest until the divestitures required by the Final Judgment have been accomplished, as well as the creation of a separate and independent sales organization, provider relations organization, patient management/quality management organization, commercial operations organization, network operations organization, and underwriting organization. (Revised Final Judgment ¶ IV.H.1-7.) To maintain the viability of the NYLCare entities, Aetna is also required to provide certain support services (i.e., legal, financial, actuarial, software, and computer operations support) to NYLCare-Gulf Coast and NYLCare-Southwest until the divestitures are completed. (Revised Final Judgment ¶ IV.H.8, 9.)

Aetna is obligated to cause NYLCare-Gulf Coast and NYLCare-Southwest to maintain contracts or agreements for coverage of approximately two hundred sixty thousand (260,00) commercially insured HMO and HMO-based POS plan enrollees in Houston and contracts or agreements for coverage of approximately one hundred sixty-seven thousand (167,000) commercially insured HMO and HMO-based POS plan enrollees in Dallas through the date of signing the definitive purchase and sale agreement for the divestitures of the two NYLCare entities. (Revised Final Judgment ¶ IV.B.) Aetna is required to use its best efforts to accomplish the the divestiture as expeditiously as possible and will accelerate the timetable for executing the definitive purchase and sale agrement(s) for the divestiuture of the NYLCare entitites to a target date of October 1, 1999. (Revised Final Judgment ¶ IV.C.) In addition, Aetna will request that the NYLCare entities provide bi-weekly reports on total enrollment to the plaintiffs until the divestitures are complete. (Revised Final Judgment ¶ IV.J.) Aetna will also fund an incentive pool of at least $500,000, which will be available to the management of the NYLCare entities if they meet the membership targets described above as of the closing date for the sale of the entities. (Revised Final Judgment ¶ IV.H.10.)

Finally, Aetna may offer PPO related business as part of the sale of the NYLCare entities. (Revised Final Judgment IV. B.) The actual number of such PPO enrollees as of the signing date of the definitive purchase and sale agreement for the divestitures of the NYLCare entities will be taken into account in determining compliance with the membership targets described in Section IV.B of the proposed Revised Final Judgment. (Id.) This last provision in no way lessens Aetna's obligation to divest itself of all of the assets of NYLCare-Gulf Coast and NYLCare-Southwest, excepting only the Excluded Assets.

The proposed Revised Final Judgment prohibits Aetna from taking any action to consummate the proposed acquisition until such time as plaintiffs, in their sole discretion, are satisfied that NYLCare-Gulf Coast and NYLCare-Southwest are independent and viable competitors and that Aetna has complied with the terms of the Revised Hold Separate Stipulation and Order or until the divestitures required by this Revised Final Judgement are completed. (Revised Final Judgment ¶ IV.I.) The divestitures must be accomplished by selling or conveying NYLCare-Gulf Coast and NYLCare-Southwest to a purchaser(s) in such a way as to satisfy the plaintiffs, in their sole discretion, that the entities conveyed can and will be used by the purchaser(s) as part of a viable, ongoing business engaged in the sale of HMO and HMO-POS plans in Houston and Dallas. (Revised Final Judgment ¶ IV.K.) The divestitures may be made to one or more purchasers provided that in each instance it is demonstrated, to the sole satisfaction of the plaintiffs, that the acquirer(s) will remain viable competitors. (Id.) The divestitures must be made to a purchaser(s) which is shown, to the plaintiffs' sole satisfaction, to have (1) the capability and intent of competing effectively in the sale of HMO and HMO-POS plans in Houston and Dallas, (2) the managerial, operational, and financial capability to compete effectively in the sale of HMO and HMO-POS plans in Houston and Dallas, and (3) no limitation, through any agreement with Aetna or otherwise, in its ability to compete effectively in the sale of HMO and HMO-POS plans in Houston and Dallas. (Id.)

Aetna must file all required applications for regulatory approval of the divestitures within one-hundred twenty (120) calendar days after June 21, 1999, the date on which the original proposed Final Judgment was filed, and must complete the divestitures within five (5) business days after it receives all necessary regulatory approvals, or five (5) business days after notice of the entry of this Revised Final Judgment by the Court, whichever is later. (Revised Final Judgment ¶ IV.C.) The

plaintiffs may extend the time period for the divestitures by no more than sixty (60) calendar days and may, in their sole discretion, grant any further time extension needed by Aetna to obtain regulatory approval of the divestitures. (Revised Final Judgment ¶ IV.D.)

If Aetna cannot accomplish these divestitures within the above-described period, the proposed Revised Final Judgment provides that, upon application by the plaintiffs, the Court will appoint a trustee to effect the divestitures. (Revised Final Judgment ¶ V.A.) After the trustee's appointment becomes effective, the trustee will file monthly reports with the parties and the Court, setting forth the trustee's efforts to accomplish the divestitures. (Revised Final Judgment ¶ V.E.) If the trustee has not accomplished such divestitures within six (6) months after its appointment, the trustee and the parties will make recommendations to the Court, which shall enter such orders as it deems appropriate to carry out the purpose of the trust, including, if necessary, extending the trust and the term of the trustee's appointment by a period requested by the plaintiffs. (Revised Final Judgment ¶ V.F.)

The proposed Revised Final Judgment also requires Aetna to deliver affidavits to plaintiffs as to the fact and manner of its compliance with the Revised Final Judgment within twenty-five (25) calendar days of the Court's June 21, 1999 entry of the original Hold Separate Order and Stipulation, and every thirty (30) calendar days thereafter, until the divestitures have been completed. (Revised Final Judgment ¶ VII.A.) Aetna must also submit, within twenty-five (25) calendar days of the Court's entry of the original Hold Separate Order and Stipulation, an affidavit that describes in detail all actions Aetna has taken and all steps Aetna has implemented on an on-going basis to preserve NYLCare-Gulf Coast and NYLCare-Southwest, describing Aetna's efforts to maintain and operate

NYLCare-Gulf Coast and NYLCare-Southwest as active competitors, and the plans and timetable for Aetna's integration of Prudential's health care assets. (Revised Final Judgment ¶ VII.B.)

The relief sought has been tailored to safeguard Houston and Dallas consumers from an increase in price or a reduction in quality of HMO and HMO-POS products. The relief sought also ensures that physicians in these markets will be protected from an undue depression of reimbursement rates, which could have led to a reduction in the quantity or a degradation in the quality of physicians' services.

IV.

REMEDIES AVAILABLE TO POTENTIAL PRIVATE LITIGANTS

Section 4 of the Clayton Act (15 U.S.C. § 15) provides that any person who has been injured as a result of conduct prohibited by the antitrust laws may bring suit in federal court to recover three times the damages the person has suffered, as well as costs and reasonable attorney's fees. Entry of the proposed Revised Final Judgment will neither impair nor assist the bringing of any private antitrust damage action. Under the provisions of Section 5(a) of the Clayton Act (15 U.S.C. § 16(a)), entry of the proposed Revised Final Judgment has no prima facie effect in any subsequent private lawsuit that may be brought against Aetna or Prudential.

V.

PROCEDURES AVAILABLE FOR MODIFICATION OF THE PROPOSED REVISED FINAL JUDGMENT

The parties have stipulated that the proposed Revised Final Judgment may be entered by the Court after compliance with the provisions of the APPA, provided that the plaintiffs have not withdrawn their consent. The APPA conditions entry upon the Court's determination that the proposed Revised Final Judgment is in the public interest.

The APPA provides a period of at least sixty (60) days preceding the effective date of the proposed Revised Final Judgment within which any person may submit to the United States written comments regarding the proposed Revised Final Judgment. Any person should comment within sixty (60) days of the date this Competitive Impact Statement is published in the Federal Register. The United States will evaluate and respond to the comments. All comments will be given due consideration by the Department of Justice, which remains free to withdraw its consent to the proposed Revised Final Judgment at any time prior to entry. The comments and the response of the United States will be filed with the Court and published in the Federal Register.

Written comments should be submitted to:

Gail Kursh
Chief, Health Care Task Force
Antitrust Division
U.S. Department of Justice
325 Seventh St., N.W., Suite 400
Washington, D.C. 20530

The proposed Revised Final Judgment provides that the Court will retain jurisdiction over this action and that the parties may apply to the Court for any order necessary or appropriate for the modification, interpretation, or enforcement of the Revised Final Judgment.

VI.

ALTERNATIVES TO THE PROPOSED REVISED FINAL JUDGMENT

The Department considered, as an alternative to the proposed Revised Final Judgment, a full trial on the merits of the Complaint against the defendants. The Department is satisfied, however, that the divestitures of the assets and other relief contained in the proposed Revised Final Judgment will preserve viable competition in the sale of HMO and HMO-POS products and in the purchase of physicians' services in Houston and Dallas, Texas that otherwise would be affected adversely by

the acquisition. Thus, the proposed Revised Final Judgment would achieve the relief the Department would have obtained through litigation, but avoids the time, expense, and uncertainty of a full trial on the merits of the Complaint.

VII.

STANDARD OF REVIEW UNDER THE APPA FOR PROPOSED REVISED FINAL JUDGMENT

The APPA requires that proposed consent judgments in antitrust cases brought by the United States be subject to a sixty (60) day comment period, after which the Court shall determine whether entry of the proposed Revised Final Judgment "is in the public interest." In making that determination, the Court may consider:

> (1) the competitive impact of such judgment, including termination of alleged violations, provisions for enforcement and modification, duration of relief sought, anticipated effects of alternative remedies actually considered, and any other considerations bearing upon the adequacy of such judgment; [and]
>
> (2) the impact of entry of such judgment upon the public generally and individuals alleging specific injury from the violations set forth in the complaint including consideration of the public benefit, if any, to be derived from a determination of the issues at trial.

15 U.S.C. § 16(e).

As the United States Court of Appeals for the District of Columbia Circuit has held, this statute permits a court to consider, among other things, the relationship between the remedy secured and the specific allegations set forth in the plaintiff's complaint, whether the decree is sufficiently clear, whether enforcement mechanisms are sufficient, and whether the decree may positively harm third parties. See United States v. Microsoft Corp., 56 F.3d 1448, 1461-62 (D.C. Cir. 1995). In conducting this inquiry, "[t]he Court is nowhere compelled to go to trial or to engage in extended

proceedings which might have the effect of vitiating the benefits of prompt and less costly settlement through the consent decree process."[7] Rather,

> [a]bsent a showing of corrupt failure of the government to discharge its duty, the Court, in making its public interest finding, should . . . carefully consider the explanations of the government in the competitive impact statement and its responses to comments in order to determine whether those explanations are reasonable under the circumstances.

United States v. Mid-America Dairymen, Inc., 1977-1 Trade Cas. ¶ 61,508 at 71,980 (W.D. Mo. 1977).

Accordingly, with respect to the adequacy of the relief secured by the decree, a court may not "engage in an unrestricted evaluation of what relief would best serve the public." United States v. BNS, Inc., 858 F.2d 456, 462 (9th Cir. 1988) (citing United States v. Bechtel Corp., 648 F.2d 660, 666 (9th Cir. 1981)); see also Microsoft, 56 F.3d at 1460-62. The law requires that

> the balancing of competing social and political interests affected by a proposed antitrust consent decree must be left, in the first instance, to the discretion of the Attorney General. The court's role in protecting the public interest is one of insuring that the government has not breached its duty to the public in consenting to the decree. The court is required to determine not whether a particular decree is the one that will best serve society, but whether the settlement is "within the reaches of the public interest." More elaborate requirements might undermine the effectiveness of antitrust enforcement by consent decree.[8]

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[7] 119 Cong. Rec. 24598 (1973). See United States v. Gillette Co., 406 F. Supp. 713, 715 (D. Mass. 1975). A "public interest" determination can be made properly on the basis of the Competitive Impact Statement and Response to Comments filed pursuant to the APPA. Although the APPA authorizes the use of additional procedures, 15 U.S.C. § 16(f), those procedures are discretionary. A court need not invoke any of them unless it believes that the comments have raised significant issues and that further proceedings would aid the court in resolving those issues. See H.R. Rep. 93-1463, 93rd Cong. 2d Sess. 8-9 (1974), reprinted in 1974 U.S.C.C.A.N. 6535, 6538.

[8] Bechtel, 648 F.2d at 666 (citations omitted) (emphasis added); see BNS, 858 F.2d at 463; United States v. National Broad. Co., 449 F. Supp. 1127, 1143 (C.D. Cal. 1978); Gillette, 406 F.

A proposed final judgment, therefore, need not eliminate every anticompetitive effect of a particular practice, nor guarantee free competition in the future. Court approval of a final judgment requires a standard more flexible and less strict than the standard required for a finding of liability: "[A] proposed decree must be approved even if it falls short of the remedy the court would impose on its own, as long as it falls within the range of acceptability or is 'within the reaches of public interest.' "[9]

The proposed Revised Final Judgment here offers strong and effective relief that fully addresses the competitive harm posed by the proposed transaction.

Supp. at 716. See also Microsoft, 56 F.3d at 1461 (whether "the remedies [obtained in the decree are] so inconsonant with the allegations charged as to fall outside of the 'reaches of the public interest' ") (citations omitted).

[9] United States v. American Tel. and Tel. Co., 552 F. Supp. 131, 151 (D.D.C. 1982), aff'd. sub nom. Maryland v. United States, 460 U.S. 1001 (1983) (quoting Gillette Co., 406 F. Supp. at 716 (citations omitted)); United States v. Alcan Aluminum, Ltd., 605 F. Supp. 619, 622 (W.D. Ky. 1985).

VIII.

DETERMINATIVE DOCUMENTS

There are no determinative materials or documents of the type described in Section 2(b) of the APPA, 15 U.S.C. § 16(b), that were considered by the United States in formulating the proposed Revised Final Judgment. Consequently, none are filed herewith.

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Respectfully submitted,

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