U.S. & Plaintiff States

v.

Aetna Inc. & Humana Inc.
Five Key Questions

Is the relevant product market broader than Medicare Advantage?

Do CMS regulations eliminate the need for the antitrust laws?

Do the claimed efficiencies outweigh the competitive harm?

Can the proposed divestiture replace the lost competition?

Can Aetna avoid antitrust scrutiny by withdrawing from 17 counties?
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Seniors first choose the product segment that is best for them

**Original Medicare**
- includes Part A (Hospital Insurance) and/or Part B (Medical Insurance)
  - Medicare provides this coverage directly.
  - You have your choice of doctors, hospitals, and other providers that accept Medicare.
  - Generally, you or your supplemental coverage pay deductibles and coinsurance.
  - You usually pay a monthly premium for Part B.

**Medicare Advantage** (Part C) includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance)
- Private insurance companies approved by Medicare provide this coverage.
- In most plans, you need to use plan doctors, hospitals, and other providers or you may pay more or all of the costs.
- You may pay a monthly premium (in addition to your Part B premium), deductible, copayments, or coinsurance for covered services.
- Costs, extra coverage, and rules vary by plan.
Seniors choose Medicare Advantage based on a durable set of preferences

**Decision Tree – Brand, Network and Costs are Key Considerations.**

As consumers start to investigate they learn some plans have networks and that premiums and costs vary - the choice of an Advantage plan vs. a Med Supp plan is made on network and cost factors.

1. **What brands will I consider?**
   - Typically 2-3 brands - brand presence is important.

2. **Am I willing to accept network restrictions?**
   - **YES – Advantage Plan**
     - How restrictive a plan?
     - Are my current doctors on plan? Which hospitals? Well-known specialists? Do I have to get referrals?
     - How much will the premium cost?
     - Are my drugs covered? At what cost?
     - Co-pays, deductibles and other costs?
     - Are extra benefits included?

   - **PPO**
     - More flexibility
     - Higher cost

   - **HMO**
     - More restrictions
     - Lower cost

   - **NO – Medicare Supplement:**
     - How much will the premium cost?
     - Out of pocket costs vs. none?
     - Are extra benefits included?

   - **Plan Type**
     - Plan F, Plan N, etc.

   - **Choose PDP Plan**

**Source:** Humana Age In Longitudinal Study 2012, other qualitative research
Nancy Cocozza agrees that some seniors choose the Original Medicare “path” and others choose the Medicare Advantage “path.”

Q. When a senior is choosing his or her Medicare coverage for the first time, what are their basic options?

A. The first thing that a senior would do is decide -- the first level decision is between whether they want to get their Medicare benefits from the federal government through original Medicare, or if they want to take a different path and consider getting them through a private health plan. That would be Medicare Advantage.

- Nancy Cocozza, Head of Medicare at Aetna
Market definition focuses on consumer substitution

“Market definition focuses solely on demand substitution factors, i.e., on customers’ ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change such as a reduction in product quality or service.”

Horizontal Merger Guidelines § 4
Few Medicare Advantage Enrollees Change Plans

Only 2% of Medicare Advantage enrollees voluntarily switched to Original Medicare in 2013-2014.

December 5, 2016
See Medicare Advantage Plan Switching: Exception or Norm?, KFF Issue Brief, 20 September 2016.
Brown Shoe “practical indicia” show that Medicare Advantage is a relevant product market

<table>
<thead>
<tr>
<th>Aetna and Humana:</th>
<th>Regularly describe other Medicare Advantage plans as being their top competitors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regularly compare their Medicare Advantage plans against other companies’ Medicare Advantage plans</td>
</tr>
<tr>
<td></td>
<td>Regularly discuss the Medicare Advantage market and calculate their shares in the Medicare Advantage market</td>
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<tr>
<td></td>
<td>Price their Medicare Advantage plans separately</td>
</tr>
<tr>
<td></td>
<td>Have separate business units and profit &amp; loss statements for their Medicare Advantage businesses</td>
</tr>
<tr>
<td>Investors:</td>
<td>Recognize Medicare Advantage as being separate from Medicare Supplement and Part D Prescription Drug Plans</td>
</tr>
<tr>
<td>Medicare Advantage plans:</td>
<td>Have different characteristics than Original Medicare with or without Medicare Supplement and Part D Plans</td>
</tr>
<tr>
<td></td>
<td>Appeal to different consumers</td>
</tr>
<tr>
<td>Industry participants:</td>
<td>Acknowledge the differences in product characteristics and customers and recognize Medicare Advantage as a distinct market</td>
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</tbody>
</table>
The Defendants inserted Original Medicare into their trial demonstratives.
Defendants’ actual business documents focus on other Medicare Advantage insurers.
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**Kansas City Market Analysis**

- Today, Humana (~50k mbrs.) and Aetna (~34k mbrs.) dominate the Kansas City Market.
- United (~6k mbrs.) and Cigna (new to KC for 2016) aren’t strong competitors but are coming on strong in the KC market.
- United is taking advantage of a contract consolidation with a Stars bonus increase to significantly improve benefits on its existing premium HMO offering. Also, bringing to market a $0 HMO that has slightly better benefits than Humana’s $0 plan.
- Aetna is making moderate benefit improvements, maintaining their $0 HMO & LPPO plans.
- Cigna is entering the market with a strong $0 HMO offering the lowest cost shares across the 5 key benefits.

**MA Market Share**

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Plan Type</th>
<th>STARS</th>
<th>Premium</th>
<th>MOOP</th>
<th>PCP</th>
<th>SPC</th>
<th>Inpatient</th>
<th>Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humana</td>
<td>HMO</td>
<td>4</td>
<td>$0</td>
<td>$6,700</td>
<td>$25</td>
<td>$50</td>
<td>$350 Days 1-5</td>
<td>6/11/47/99/25%</td>
</tr>
<tr>
<td>Humana</td>
<td>HMO</td>
<td>4</td>
<td>$34</td>
<td>$6,500</td>
<td>$10</td>
<td>$45</td>
<td>$330 Days 1-5</td>
<td>6/11/47/99/29%</td>
</tr>
<tr>
<td>United</td>
<td>HMO</td>
<td>4</td>
<td>$39</td>
<td>$3900</td>
<td>$5</td>
<td>$40</td>
<td>$275 Days 1-6</td>
<td>2/8/45/95/28%</td>
</tr>
<tr>
<td>United</td>
<td>HMO</td>
<td>4</td>
<td>$0</td>
<td>$6,700</td>
<td>$20</td>
<td>$50</td>
<td>$335 Days 1-5</td>
<td>2/12/47/100/26%</td>
</tr>
<tr>
<td>Aetna</td>
<td>HMO</td>
<td>3.5</td>
<td>$0</td>
<td>$5,000</td>
<td>$5</td>
<td>$40</td>
<td>$300 Days 1-5</td>
<td>4/9/47/100/33%</td>
</tr>
<tr>
<td>Aetna</td>
<td>PPO</td>
<td>4</td>
<td>$0</td>
<td>$6,700</td>
<td>$10</td>
<td>$50</td>
<td>$3505 Days 1-5</td>
<td>4/9/47/100/33%</td>
</tr>
<tr>
<td>Cigna</td>
<td>HMO New</td>
<td></td>
<td>$0</td>
<td>$4,900</td>
<td></td>
<td>$40</td>
<td>$250 Days 1-6</td>
<td>1/3/45/95/30%</td>
</tr>
</tbody>
</table>

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Economic evidence shows that Medicare Advantage is a relevant product market.

**Academic Literature**
- Low pass-through rates imply market power
- Demand estimates show preference for MA

**Empirical Analysis of Demand**
- All estimates agree that many seniors have a distinct preference for MA

**Hypothetical Monopolist Tests**
- Medicare Advantage passes the test in all or almost all counties using any formulation of the test
Aetna is a particularly aggressive competitor

Overlap between Aetna and Humana

2011

2016

Red: Overlap between Aetna and Humana

PX0551, at 110 (Expert Report of Aviv Nevo, Ph.D., Oct. 21, 2016)
Aetna and Humana compete “everywhere”

“HUM was #1 in growth and is our most formidable competitor. We compete with them everywhere and they have momentum.”

- Nancy Cocozza,
  Head of Medicare at Aetna
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CMS sets the “contours” and “framework” for competition

Q. Does CMS regulation replace competition between Medicare Advantage plans?

A. No. I think we think of our work as creating the framework that competition will happen within.

- Sean Cavanaugh,
  Director of the Center for Medicare at CMS

But the way to think about [CMS regulation] is it’s setting the boundaries or the contours that the firms then would compete in.”

- Jonathan Orszag,
  Defendants’ economic expert
CMS regulations do not replace competition or preempt the antitrust laws

| Individual Bid Margins | • No rule capping individual bid margins  
|                       | • CMS requests margin reductions for a small number of plans per year  
|                       | • MA insurers negotiate and “push back” on CMS’s requests |
| Aggregate Margins | • MA insurers can choose the level of aggregation  
|                    | • Aetna uses a “parent organization” level of aggregation  
|                    | • Aetna and Humana file bids with margins as high as 30% |
| Total Beneficiary Cost | • Can increase by $32 per member per month annually  
|                       | • Annual price or quality change of $384 ($32 per month for 12 months) not prohibited by the TBC test |
| Medical Loss Ratio | • Measured at the contract level, not plan level  
|                    | • Aetna’s CMS contracts contain dozens of individual plans  
|                    | • Aetna has plans with MLRs below 85% |

Tr. 2003:17-2014:19 (Paprocki - Aetna); Tr. 574:7-18 (Wheatley - Humana)
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The claimed efficiencies do not outweigh the competitive harm

“Cognizable efficiencies are merger-specific efficiencies that have been verified and do not arise from anticompetitive reductions in output or service.”

Horizontal Merger Guidelines § 10
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The proposed divestiture is unprecedented and risky

“Any divestiture must contain the set of assets necessary to ensure the efficient current and future production and distribution of the relevant product . . . To best achieve this goal, the Division often will insist on the divestiture of an existing business entity that already has demonstrated its ability to compete in the relevant market.”

Molina has failed at individual Medicare Advantage in the past.

Number of Counties in which Molina Offered Individual Medicare Advantage Plans

PX0559, at ¶ 31 and Ex. 1 (Expert Report of Dr. Lawton R. Burns, Oct. 21, 2016)
Molina’s experience with Medicaid and dual-eligibles has not helped it with Medicare Advantage in the past

“Although Molina’s Medicare product is new in Utah, we’ve been a strong presence here, serving Medicaid members for 16 years and complex Medicare members through the Medicaid Special Needs Plans for eight years.”

Chad Westover,
President of Molina Healthcare, Utah
The Defendants’ expert agrees that Molina is “not a competitively significant market participant in Utah today.”

Less than 400 members

Less than 1% market share in each county

Never achieved a STAR score of more than 3.5
The proposed divestiture may never occur

Q. And it's also contingent upon Molina getting the novations that you talked about earlier. Right?
A. Yes.

Q. And on Molina getting the star scores transferred. Correct?
A. Yes.

Q. So it's not a done deal. Right?
A. No, it's not a done deal.

Dr. Mario Molina,
CEO of Molina Healthcare
The risk of the proposed divestiture falls on seniors

“A purchaser’s interests are not necessarily identical to those of the public, and so long as the divested assets produce something of value to the purchaser (possibly providing it with the ability to earn profits in some other market or to produce weak competition in the relevant market), it may be willing to buy them at a fire-sale price regardless of whether they cure the competitive concerns.”

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The probative value of post-acquisition conduct is “extremely limited” for the “obvious” reason that “violators [of Section 7] could stave off [enforcement] actions merely by refraining from aggressive or anticompetitive behavior when such a suit was threatened or pending.”


Post-complaint conduct should be given little to no weight “whenever such evidence could arguably be subject to manipulation.”

*Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 435 (5th Cir. 2008) (emphasis in original)
Public Exchanges: Business Reality

April 28: “[W]e see this as a good investment.”
- Mark Bertolini, PX0112

June 30: Aetna receives 2015 risk adjustment information from CMS
- Shawn Guertin, Tr. 2676:20-23

July 9: Bertolini receives Aetna’s 2Q financial results for the exchanges
- Mark Bertolini, Tr. 1382:5-1383:4

July 19: “Expansion of Individual to include 20 filed states for 2017”
- Fran Soistman, PX0120

July 20: Financial results show Florida on-exchange business is profitable
- DX009, Guertin Tr. 2755:14-2758:4
Public Exchanges: Manipulating the Evidence

**July 21:** Complaint is filed

**July 22:** “By the way, all bets are off on Florida and every other state given the DOJ rejected our transaction.”
- Fran Soistman, PX0121

**July 23:** “Most of this is a business decision except where DOJ has been explicit about the exchange markets. There we have no choice.”
- Steven Kelmar, PX0125

**July 24:** “Does this include the 17 places in the DOJ complaint[?]”
- Karen Lynch, PX0120

**July 24:** “I was told to be careful about putting any of that in writing. I will have the attorney-client privilege cc’d by tomorrow.”
- Jonathan Mayhew, PX0127
“[I]f the DOJ sues to enjoin the transaction, we will immediately take action to reduce our 2017 exchange footprint.”

“By contrast, if the deal proceeds without the diverted time and energy associated with litigation, we would explore how to devote a portion of the additional synergies (which are larger than we had planned for when announcing the deal) to supporting even more public exchange coverage over the next few years.”

- Mark Bertolini,
CEO of Aetna