U.S. & Plaintiff States

v.

Aetna Inc. & Humana Inc.
MEDICARE ADVANTAGE
Market Definition
Market definition is about *reasonable* interchangeability.

“The outer boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it/’

*Brown Shoe Co. v. United States*,
370 U.S. 294, 325 (1962)
Medicare Advantage has distinct characteristics and uses

**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?
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
Medicare Advantage plans have lower premiums

Estimated Average Monthly Premiums

Original Medicare + MediGap + PDP: $284

Medicare Advantage: $142

Includes Part B Premium
Aetna couldn’t attract MedSupp customers to MA when it tried

Q. [J]ust focusing on this plan that you designed to compete for Med Supp members, your view is that the plan has not been successful. Correct?

A. Not as successful as I thought it might be.

Q. The plan has low membership?

A. That's correct.

- Cynthia Follmer,
  Deep South General Manager at Aetna
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
- Analyzes real-world choices made by both new and existing consumers

### Hypothetical Monopolist Tests
- Test #1: Critical loss using Nevo and Orszag nesting parameters
- Test #2: Critical loss using nesting parameter from literature
- Test #3: Merger simulation using both Nevo and Orszag demand estimates
Both economists use a model that accounts for “age-ins”

Q. And is the nested logit approach appropriate to evaluate the choices of both new and existing customers in one model?

A. Yes, because it tells us what is the demand that the firm is facing. And that demand constitutes both age-ins in this case or people that have previously made choices.

So we both structure the model quite similarly. And that model produces estimates of diversion, which will take into account both switch-outs, age-ins, and switch-ins in response to price.
MA overwhelmingly passes the hypothetical monopolist test regardless of the margin level.

### Hypothetical Monopolist Tests Using Mr. Orszag’s Nesting Parameters

<table>
<thead>
<tr>
<th>Implied Economic Margin</th>
<th>Enrollment in Counties that Pass the Single-Product Test</th>
<th>Enrollment in Counties that Pass the Multi-Product Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99%</td>
<td>99%</td>
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<tr>
<td></td>
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<td>99%</td>
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<td>99%</td>
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</tr>
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</table>

MA passes even with very low implied margins.

PX0552, at Ex. 2, 3 & 12 (Supplemental and Rebuttal Report of Aviv Nevo, Ph.D.)
After Humana-Arcadian, prices went up despite the presence of Original Medicare, potential entry, CMS regulation, any efficiencies, “age-ins,” and divestitures.
Mr. Orszag’s Error #1: No standard application of the hypothetical monopolist test

Instead of looking at demand substitution as the Guidelines instruct, Mr. Orszag conducted supply-side regressions.

“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
Mr. Orszag’s Error #2: His regressions miss important competition

• Mr. Orszag uses plan fixed effects in his price-regression model, ignoring the reality that Medicare Advantage insurers compete in part by introducing new plans into counties.

• For example, Aetna has aggressively competed in recent years by introducing a $0 premium PPO plan.

<table>
<thead>
<tr>
<th>Aetna MAPD – Executive Summary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product and Pricing Strategy</strong></td>
<td></td>
</tr>
<tr>
<td>• Aetna &amp; Coventry overlap market</td>
<td></td>
</tr>
<tr>
<td>• Footprint expansion underway</td>
<td></td>
</tr>
<tr>
<td>• Introduce AE1 National PPO expansion H55-21 – 4.5 Star contract — Contingent upon success SAE</td>
<td></td>
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<tr>
<td>• Position as lead plan in the market for new sales with $0 premium</td>
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<tr>
<td>• Price/Benefits developed to closely mirror 2014 H9847-001 plan in order to drive migration to cell strategy</td>
<td></td>
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<tr>
<td>• Migration of %23 from 3.5 Star H9847 EV1 PPO to 4.5 Star H55-21 (AET) PPO</td>
<td></td>
</tr>
<tr>
<td>• Narrow network HVN HMOs with CVS &amp; Duke – Care 2017?</td>
<td></td>
</tr>
<tr>
<td>• Limit member losses</td>
<td></td>
</tr>
<tr>
<td>• Will introduce $29 premium on CVH H9847 PPO &amp; slight degradation to benefits YOY</td>
<td></td>
</tr>
<tr>
<td>• Careful consideration of SAR in Alamance county</td>
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<table>
<thead>
<tr>
<th>CMS Funding Headwinds</th>
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<tr>
<td>S 22</td>
<td>CMS Funding (Trend vs. BM, P2, Rebate Dynamic)</td>
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<td>S 29</td>
<td>Change in Margin Requirement</td>
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<td>SG&amp;A</td>
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<td>S 24</td>
<td>Gross Medical Trend</td>
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<tr>
<td>S 3</td>
<td>Health Insurer Fee (1% HIP + 1.1% FIT + 3.0%)</td>
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<tr>
<td>S 78</td>
<td>TOTAL</td>
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</table>

<table>
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<th>Mitigating Actions</th>
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<tr>
<td>S 5</td>
<td>Provider Recontracting</td>
<td>90%</td>
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<tr>
<td>S 4</td>
<td>Provider Collaboration / ACOs</td>
<td>90%</td>
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<tr>
<td>S 10</td>
<td>Risk Score Initiatives / CMS Changes</td>
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<tr>
<td>S 9</td>
<td>SG&amp;A Initiatives</td>
<td>80%</td>
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<tr>
<td>S 13</td>
<td>Part D</td>
<td>TBD</td>
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<tr>
<td>S 12</td>
<td>Market Exits / Reconfiguration</td>
<td>80%</td>
</tr>
<tr>
<td>S 78</td>
<td>TOTAL</td>
<td></td>
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</tbody>
</table>
Humana competed in San Antonio by offering a new plan

Q. Now, did Humana introduce a new PPO in the 2017 AEP?

A. Yes, they did.

Q. So [Humana] had their lead [plan] last year at $20, Aetna is at [$]19 and then Humana is with the new lead this year at [$]16.90?

A. Correct.

- Raul Gonzalez, President of Texas Medicare Solutions
Mr. Orszag’s Error #3: Mistaken reliance on Example 6

Medicare Advantage Plans

Prof. Nevo’s product market definition

Original Medicare combined with various MedSupp and Part D Plan Options
Mr. Orszag’s Error #3: Mistaken reliance on Example 6

What Mr. Orszag suggests
MEDICARE ADVANTAGE

Competitive Effects
The merger is presumptively unlawful in all 364 counties.

Post-Merger Change in HHI

Medicare Advantage  Market Definition  Competitive Effects  Proposed Remedy

PX0551, at Ex. 16 (Expert Report of Aviv Nevo, Ph.D.)
Aetna and Humana compete to win each other’s customers

“[W]e had a one-time bonanza this year because UHC and Humana (the largest MA plans in the State) came off $0 for their PPO’s/”

- Cynthia Follmer,
  Deep South General Manager at Aetna
Lost competition will cause prices for seniors to rise

**Simulated Changes in Rebate-Adjusted Premiums**
*Using Mr. Orszag’s Nesting Parameters*

<table>
<thead>
<tr>
<th>Observed Pre-Merger</th>
<th>Simulated Post-Merger</th>
<th>Difference - The Expected Effect of the Merger</th>
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Even using Mr/ Orszag’s nesting parameters, Prof. Nevo found that the merged company will have an incentive to increase prices, causing hundreds of millions of dollars of annual harm to consumers.
Mr. Orszag’s Entry Error #1: Ignoring unfavorable data

Mr. Orszag conveniently ignores entrants from 2012 (except when he is counting entrants) because the 2012 cohort has a relatively low rate of survival.
Mr. Orszag’s Entry Error #2: Counting Aetna and Humana

- Of the 398 entrants identified by Mr. Orszag, 191 of them (nearly 50%) are Aetna or Humana.
- Neither Aetna nor Humana will be available to enter in response to the anticompetitive effects of their own merger.
- By including Aetna and Humana, Mr. Orszag inflates his results.
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
MEDICARE ADVANTAGE

Proposed Remedy
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
Molina has failed at individual Medicare Advantage in the past.

Number of Counties in which Molina Offered Individual Medicare Advantage Plans

- 2008: 30
- 2009: 40
- 2010: 48
- 2011: 56
- 2012: 58
- 2013: 11
- 2014: 11
- 2015: 4
- 2016: 6
- 2017: 4

PX0559, at ¶ 31 and Ex. 1 (Expert Report of Dr. Lawton R. Burns)
The Defendants’ expert agrees that Molina is “not a significantly competitive market player” in Utah today.

19 years of Medicaid experience

8 years of D-SNP experience

Fewer than 400 members

Less than 1% market share

Tr. 3348:22-23 (Orszag); Tr. 2376:22-24, 2377:1-2, 2381:23-24 (Dr. Mario Molina); 2482:6-21 (Lisa Rubino)
Molina’s management recognizes its limitations in Medicare Advantage

Our name recognition is largely tied to a lower-income population and product, so it will take a good deal of time and money in order to build the same name recognition for the more affluent population. Plus we believe that AET/HUM may target these members, not sure if we will have the same relationship with all of the brokers and providers.

- John Molina, Chief Financial Officer

I might have to chase the Suburban but I would love to catch the Cooper.

- Dr. Mario Molina, Chief Executive Officer

Aetna and Humana have had many years to build up name recognition, provider and broker relationships, as well as efficient processes. While we have been in the Managed Medicare market for 10 years, we do not have the same level of administrative expertise.

- John Molina, Chief Financial Officer

I’m not sure we are ready to take on traditional MA business.

- David Pollack, President of Molina Healthcare of Florida
PUBLIC EXCHANGES

Evasion of Scrutiny
Aetna was ready to expand its exchange footprint

**June 15:** “By getting this deal done, I can make the commitment that we will expand our exchange footprint.”

**July 5:** Aetna says in a letter to DOJ that it will explore “supporting even more public exchange coverage over the next few years” if the Humana merger is approved.

**July 19:** Bertolini testifies about potential future exchange expansion

**June 27:** Fran Soistman asks to “dust off the 2017 IVL Expansion Plan and determine whether there are other new states/markets we’d consider for the future.”

**July 19:** Soistman prepares speaking notes for Aetna’s Board meeting on July 22. “For Individual, we will pursue a disciplined market participation strategy.”

**July 21:** Antitrust Complaint filed

PX0113; PX0162, at 6; PX0115, at 1; PX0117, at 2; PX0120, at 5; Tr. 1437:21-24.
The evidence contradicts Aetna’s story

### July 2016

<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
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<tr>
<td>10</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
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</tbody>
</table>

After receiving financial information on July 9, Bertolini assembled a team including Fran Soistman, Karen Lynch, Steven Kelmar, and Jonathan Mayhew

<table>
<thead>
<tr>
<th>17</th>
<th>18</th>
<th>19</th>
<th>20</th>
<th>21</th>
<th>22</th>
<th>23</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Soistman prepares Board notes – no mention of withdrawal</td>
<td>Lynch sends financial results to Bertolini</td>
<td>Complaint Filed</td>
<td>Soistman: “all bets are off”</td>
<td>Kelmar: “we have no choice”</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>24</th>
<th>25</th>
<th>26</th>
<th>27</th>
<th>28</th>
<th>29</th>
<th>30</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Lynch: “Does this include the 17 places in the DOJ complaint”</td>
<td>Guertin gets involved</td>
<td>Bertolini deposition</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Public Exchanges

Evasion of Scrutiny

Competitive Effects
July 24: Mayhew added the 17 Complaint counties at Lynch’s request

Sunday, 6:42 a.m.
Mayhew sends draft withdrawal options

Sunday, 7:35 a.m.
Lynch asks about Complaint counties

Sunday, 11:55 p.m
Mayhew responds with revisions

1 - Remain Active in the State – Optimize Product Mix; Exit Targeted Service Areas
   - Eliminate all gold metallic plans with the exception of one in the state as required to meet QHP certification requirements
   - Evaluate elimination of bronze metallic plans
   - Exit targeted service areas (17 counties in total; 3 states)

2 - Remain Active in the Market; Optimize Product Mix
   - Eliminate all gold metallic plans with the exception of one in the state as required to meet QHP certification req.
   - Evaluate elimination of bronze metallic plans

Does this include the 17 places in the DOJ complaint?
Financial results sent to Mr. Bertolini on July 20 projected on-exchange profits in Florida.

![Aetna Individual Business (Excluding Consumer) Results / Forecast As of June YTD 2016]

DX0009, at 2 (July 20, 2016)
Soistman did not testify to explain the recommendation that he authored.

Defendants’ Preliminary Fact Witness List (September 9): Fran Soistman

Defendants’ Final Fact Witness List (October 7): Fran Soistman

Defendants’ Case-in-Chief Witness List (December 9): Fran Soistman

Defendants’ Updated Case-in-Chief Witness List (December 12): ---
PUBLIC EXCHANGES

Competitive Effects
Aetna retained the ability to re-enter the exchanges because it wants “to remain in the game”

And so that was part of the mission. So just throwing it over our shoulder and running for the hills wasn't a legitimate response on my part. We needed to remain in the game. We needed to consider how we could help and we needed to find ways to make it better.

Mark Bertolini,
CEO of Aetna
EFFICIENCIES
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
Defendants’ “concurrent review” efficiencies are based on the assumption that the merged company will deny more care.

Ms. Christine Hammer, CPA

One insurance company could just decide, I'm going to increase my denial rates by X percent and save some money. So I also have a question not only about quality in this context but also about whether a merger is actually required to achieve these efficiencies.
The Defendants have made no showing to tie their claimed efficiencies to the challenged markets.

The law does not allow “anticompetitive effects in one market” to be offset by “pro-competitive consequences in another.”


Mr. Gokhale did not even attempt to quantify how much of his claimed efficiencies would remain with the merged company in the challenged markets, after all divestitures and individual commercial withdrawals.

Tr. 3435:14-24 (Christine Hammer)
U.S. & Plaintiff States
v.
Aetna Inc. & Humana Inc.
Materials for Rebuttal & Appendix

MEDICARE ADVANTAGE

Market Definition
“We have – we’ve chosen to sell each of those types of products [Medicare Advantage, Medicare Supplements, and Part D plans], because we believe, and I think the data would – would probably back us up, that there’s a market for each of those – those products/There’s seniors that prefer a Medicare Supplement plan, and there are seniors that prefer a Medicare Advantage plan/”

Todd Fincher,
President, Tidewater Management Group
Brown Shoe: Medicare Advantage is separately managed and priced

Q. Because of the nature of the two categories of products, do you agree with me that it makes sense to have a different actuarial specialization around the pricing for the two products?

A. I think -- yeah. I think it makes sense that we have two separate departments that do the work.

James Paprocki,
Head Individual Medicare Advantage actuary at Aetna
The Defendants inserted Original Medicare into their trial demonstratives.
Defendants’ actual business documents focus on other Medicare Advantage insurers.
Defendants’ actual business documents focus on other Medicare Advantage insurers.
Defendants’ actual business documents focus on other Medicare Advantage insurers

IVL Medicare AEP: Competitive Analysis
IN 2015 AEP, Aetna ranked 2nd in growth among our top competitors; Humana took market share lead away from United

- Captured 38% of newly eligibles (21% market share); availability to 85% of beneficiaries
- Vast improvement in STAR ratings; 92% of members in 4+ Star plans
- Expanded provider relationships through acquisition and exclusive relationships

- Continued network reductions and market exits
- Star ratings performance relatively flat year-over-year
  - #2 with 19% share

- Added 30k enrollees partly due to HealthSpring products
  - Improved Star performance; 5 star option in FL

- Continued poor Star rating performance
- Increased premiums in most markets

Key Trends
Slightly lower growth than last two years
- Overall MA enrollment over 16 million (30% of Medicare beneficiaries) *
- Industry growth of 4.4% below trend of 5% in 2014 and 2013
- Product exits impacted 5% of MA enrollees or 575k vs. 550k in 2014
- 11.5% of MA enrollees (~2M) in dual eligible programs

Competitors continue to move toward leaner products
- Value added benefits reduced by ~15%
- Out of pocket costs increased by 5% compared to 10% in 2014

Premiums increased and enrollment in premium products grew
- 44% of enrollees in zero premium plans, down from 56% in 2014
- Average monthly premium rising 20% to $41

*CMS Fact Sheet: Fact Sheet: Moving Medicare Advantage and Part D Forward 2/20/2015
March 2015 OC Meeting: Confidential
Defendants’ actual business documents focus on other Medicare Advantage insurers

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### Competitor by Plan Type

<table>
<thead>
<tr>
<th>Plan</th>
<th>Total Medicare Advantage (including group)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HMO Members</td>
<td>Growth</td>
</tr>
<tr>
<td>Humana</td>
<td>60,101</td>
<td>36,899</td>
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<tr>
<td>United</td>
<td>76,839</td>
<td>196</td>
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<td>BCBS</td>
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<td>66,995</td>
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<td>Aetna</td>
<td>2,523</td>
<td>713</td>
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<tr>
<td>Cigna</td>
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### Medicare Advantage Individual Plans

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<tr>
<th>Plan</th>
<th>HMO Members</th>
<th>Growth</th>
<th>LPPO Members</th>
<th>Growth</th>
<th>RPPO Members</th>
<th>Growth</th>
<th>PFFS Members</th>
<th>Growth</th>
<th>Total Members</th>
<th>Growth</th>
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<tbody>
<tr>
<td>Humana</td>
<td>60,101</td>
<td>36,899</td>
<td>24,008</td>
<td>4,652</td>
<td>28,396</td>
<td>1,973</td>
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<td>United</td>
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Based on data from the Competitive Landscape Report.

Confidential—Subject to Protective Order

11/2/2016 4:46 PM 9

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Medicare Advantage, Market Definition, Competitive Effects, Proposed Remedy

PX0295, at 48
(Apr. 28, 2015)
Defendants’ actual business documents focus on other Medicare Advantage insurers

This is Aetna’s first year marketing MA products in this region. Our largest competitor is Humana who has both of the local hospitals in network.
Defendants’ actual business documents focus on other Medicare Advantage insurers.

We probably should add Kansas City since Aetna and Humana are #1 and #2 in the market.
Few Medicare Advantage Enrollees Change Plans

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

Voluntarily switched Medicare Advantage plans, 11%
Involuntarily switched, 5%
Died, 3%
Voluntarily switched to Original Medicare, 2%

Stayed in same plan, 78%

See Medicare Advantage Plan Switching: Exception or Norm?, KFF Issue Brief, 20 September 2016.
Consumers have durable preferences for Medicare Advantage

See PX0552, at 33 (Supplemental and Rebuttal Report of Aviv Nevo, Ph.D.); Tr. 929:25-930:15 (Prof. Gary Ford)
The behavior of seniors with “guaranteed issue rights” shows these durable preferences

“Seniors with guaranteed issue rights are like age-ins in that they can enroll in Medicare Supplement plans without undergoing medical underwriting/”

Nancy Cocozza,
Head of Medicare at Aetna
Medicare Advantage consumers with guaranteed issue rights overwhelmingly stay in Medicare Advantage

Q Did -- you said you had about 70 clients with Piedmont WellStar. Did they also come to you when Piedmont WellStar left the market?

A Yes.

Q Did you explain to them that they could switch to a Medicare Supplement without underwriting?

A Yes.

Q Of your about 70 or so clients, about how many of them stayed with another Medicare Advantage plan?

A It was over 90 percent that stayed with the Medicare Advantage plan.

Robert Fitzgerald, President, Robert Fitzgerald Insurance Agency
Tr. 1080:2-14
MA insurers can change prices at the county level even within a single plan through segmentation
Materials for Rebuttal & Appendix

MEDICARE ADVANTAGE

Competitive Effects
The merger is presumptively unlawful

Post-Merger Change in HHI

Post-Merger HHI

Medicare Advantage
Market Definition
Competitive Effects

Bexar County, Texas
Mecklenburg County, North Carolina

PX0551, at Ex. 16 & Appendix I
The merger is presumptively unlawful

Mecklenburg County, NC (Charlotte)

- Humana 26%
- Aetna 22%
- United 34%
- Other 18%

See PX0378 & PX0551, at Appendix I
Aetna and Humana compete in Mecklenburg County today

Q Okay. So Humana -- if I'm a senior and I'm living in Mecklenburg County and I'm interested in that zero premium product, then if I want to go to Humana, I'm going to be looking at your HMO; right?
A That is correct.
Q Okay. And then if I'm going to look at Aetna's product, I can look at their PPO product; right?
A That is correct.
Q Okay. And that's the same in wherever they're selling that PPO product in the state; correct?

A Yes.
Q All right. And you have found over the last several years that the Humana HMO zero premium plan is actually competing against the Aetna zero premium PPO plan in the state; isn't that true?
A We were competing in particular areas with a zero HMO, which then went up to $19. And we still competed against the zero LPPO Aetna plan in many of those counties.

Patrick Farley,
North Carolina sales director for Humana

Tr. 771:16-772:8
The merger is presumptively unlawful

Bexar County, TX
(San Antonio)

Humana 29%
Aetna 10%
Other 61%

See PX0378 & PX0551, at Appendix I
Aetna and Humana “are pushing each other to be more competitive” in Bexar County today.

Let me ask you the other question, though, that wasn't asked of you. If the merger were to go through and Aetna and Humana combine, would you have any concerns about what would happen in competition in San Antonio?

A: I think, you know, the observations that I make between the two companies, between Aetna and Humana, is that they are pushing each other to be more competitive. Just my observation is that if, you know, if you look at Humana bringing down its specialist copay this year, I believe it was directly because or in response to Aetna's.

So if the competition is gone, then who is going to push Humana to be able to lower their copays.

Raul Gonzalez,
President, Texas Medicare Solutions
Aetna is a particularly aggressive competitor

“[A\n important consideration when analyzing possible anticompetitive effects” is whether the merger “would result in the elimination of a particularly aggressive competitor in a highly concentrated market/”

- FTC v. Staples, Inc.,
Aetna is a particularly aggressive competitor

Overlap between Aetna and Humana

Medicare Advantage  Market Definition  Competitive Effects  Proposed Remedy
Past experience shows that entry will not cure the competitive harm.

Over the last five years, most Complaint counties experienced no entry at all.

Most entrants from 2012, and nearly half from 2013, are no longer offering plans.

- **No Entry, 53%**
- **Any Entry, 47%**

<table>
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<th>Entry Percentage</th>
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<tr>
<td>2012</td>
<td>73%</td>
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<tr>
<td>2013</td>
<td>43%</td>
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Mr. Orszag’s entry analysis double-counts incumbents

• By defining “entry” as any time an MA insurer reaches 5% MA market share and failing to exclude incumbents, Mr. Orszag overstates the amount of entry.

• Mr. Orszag’s approach also overstates the timeliness of entry; his analysis does not identify when an insurer began offering plans and does not look at how long it took for any given insurer to reach 5% MA market share.

According to Mr. Orszag’s approach, this MA insurer “entered” twice and “exited” once
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 20%  
| 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); Tr. 574:7-18 (Wheatley)
Materials for Rebuttal & Appendix

MEDICARE ADVANTAGE

Proposed Remedy
Molina exited individual Medicare Advantage in 2012 because of “limited expertise and competitive standing.”

- **Options benefits and network are average to below average vis-à-vis competitors**
  - Plans must provide notice to members by October 1, 2012
  - Arguments for and Against Retaining Options in 2013
    - Pros (arguments for retaining)
      - Options benefits and network are average to below average vis-à-vis competitors
        - We are not aggressively marketing Options
          - We don’t have a cogent explanation on how we can and will grow Options enrollment in any state to critical mass; to grow it would require a significant infusion of capital
          - With the low enrollment we are subject to high MLR volatility on the negative side (annuities say you need 10% members to have diverse annuities mix)
          - Options detracts from our core focus, serving duals
          - Milliman changed Molina’s 5000K in 2011 to develop 10 Options plans, not counting internal time
          - Non-renewing Options would increase overall risk scores 2.5% compared to current scores
        - Pros (arguments for dropping)
          - New model needs to be trialed in various markets to really understand the impact
          - Don’t know how to set up the product strategy and that our strategy around our focus in the MAPD market.
          - We have limited expertise and competitive standing
          - We have limited expertise and competitive standing and no clear strategy around our focus in the MAPD market.
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          - We have limited expertise and competitive standing and no clear strategy around our focus in the MAPD market.
    - Cons (arguments against retaining)
      - Options generated 52.3M positive medical margin in 2019 (not counting admin costs, counting admin it was a loss), so we need to find a way to the revenue stream in other places.

---

**Medicare Advantage**

**Market Definition**

**Competitive Effects**

**Proposed Remedy**

PX0088, at 1; PX0092, at 2
Molina’s Board recognizes its limitations in Medicare Advantage

We both agree that we don’t have the internal talent to run it.

- Dick Shapiro, Molina Board member

Third, this is a very different business from what we do, including commercial marketing, pricing, contracting, etc. Unless we can acquire some talent as part of the deal, I think we are woefully under-resourced to be able to take this on.

- Dale Wolf, Molina Board member and former CEO of Coventry

I wonder how people will feel going from Aetna to a relatively unknown Molina in the medicare space. Wouldn’t they be drawn to more recognized national brands?

- Dick Shapiro, Molina Board member
Aetna plans to continue its rapid expansion; Molina may reduce its footprint

Q. And here you're conveying that Molina may reduce the county footprint of the divestiture assets if there's low membership?
A. It's always a possibility. That's the words on the paper there, yes.
Q. And that's an accurate statement?
A. Yeah, it could.
Q. Molina may reduce the footprint if there's low membership?
A. Sure.

- Aetna Board of Directors Presentation, July 2015

- Lisa Rubino, Senior Vice President for Medicare at Molina

PX0075, at 7; Tr. 2493:17-2494:1

Medicare Advantage ➜ Market Definition ➜ Competitive Effects ➜ Proposed Remedy
Before trial, Lisa Rubino raised the same concerns as Prof. Burns.

Molina Would Not Receive the Resources that are Necessary to Compete

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<tr>
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<th>Sale of an Intact Business</th>
<th>Proposed Divestiture</th>
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<tbody>
<tr>
<td>Provider Contracts</td>
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<td>Recognized Individual MA Brand</td>
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<tr>
<td>Experience with PPOs</td>
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<td>✗</td>
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</table>

I have been clear with Dr. Mario and John-key to success:

- Their Star ratings need to come over ~4.5 if not we are at risk of not being able to honor current benefits.
- Their network needs to be replicated. Lose key providers and we will lose members in droves.
- Sales and market engine 8 week selling period.
- GA and broker network.

Then the basics in ops and CM. Big fricken lift.

- Lisa Rubino, Senior Vice President for Medicare at Molina

Message
From: Craig Banks [EMAIL] TO: Lisa Rubino [EMAIL]
Sent: July 14, 2016 2:05 PM
Subject: RE: 16 aka 1G dental and vision their own or vendor

I would stick to the key points we will stick to the key points I don't know if it will work wonderful...but it is still our best option...we will have a 12-18 month TSR in place with them...to run the business under our oversight...key times.

I have been clear with Dr. Mario and John key to success:
- Their Star ratings need to come over ~4.5 if not we are at risk of not being able to honor current benefits
- Their network needs to be replicated...lose key providers and we will lose members in droves
- Sales and market engine 8 week selling period
- GA and broker network
- Then the basics in ops and CM. Big fricken lift...
Molina is unlikely to replicate Aetna and Humana’s network network.

Bruce Broussard

But yeah, it's not easy.

Lisa Rubino

It's quite easy

Tr. 1888:3-5

Tr. 2399:10-15
Molina is unlikely to maintain Aetna and Humana’s STAR scores

“The more I think about it, we should not stretch ourselves, but only pursue if we can get a clear bargain. I am most concerned about our ability to maintain the STAR ratings and the additional income that comes with those.”

- John Molina, Chief Financial Officer
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.”

The risk of the proposed divestiture falls on seniors

- Molina got “a screaming good price,” as one Board member put it.
- Molina agreed to acquire Aetna and Humana’s members for the “bargain price” of about $1,400 per member (including statutory capital), a significant discount from the typical purchase price of $3,000-$10,000 per member.
- Molina has put only $120 million at risk; the remainder of the purchase price of $400 million is statutory capital reserves that would remain with Molina if it exits MA markets.

Tr. 2249:24-2250:13 (M. Molina); PX0100; Tr. 2328:24-2329:6 (M. Molina); Tr. 9882:1-21 (J. Molina)
Materials for Rebuttal & Appendix

PUBLIC EXCHANGES
Evasion of Scrutiny
July 19: Fran Soistman prepared speaking notes for the Board meeting on July 22.

Our Individual & Public Exchange business has significant potential under the right conditions. Current projections indicate that the marketplace will grow from $68B to $99B in revenue by 2020 (10% CAGR).

- The managed Medicaid marketplace will experience substantial growth over the next few years, increasing from $282B to $425B by 2020 (11% CAGR). This unprecedented growth will be driven by ACA expansion and continued outsourcing of traditional and high-acuity Medicaid programs, which drive 40% of state budgets.

- Our Individual & Public Exchange business has significant potential under the right conditions. Current projections indicate that the marketplace will grow from $68B to $99B in revenue by 2020 (10% CAGR). This growth is highly dependent on the evolving regulatory and political environments, marketplace stability and payers’ abilities to achieve cost efficiency and profitability. In the short term, advocacy efforts will be our best option. Longer term, the industry will require legislative intervention to achieve stability.

- Not only do we expect continued growth in our Government businesses, but also continued innovation. We have made great advancements over the years by:

  - Collaborating with the government and regulators to create a level playing field.
  - Focusing on consumer-centric solutions.
  - Leveraging technology to enhance customer experience.

For Individual, we will pursue a disciplined market participation strategy, targeting deliberate growth in on-exchange silver subsidized membership – our most profitable demographic.

- For Medicare, this means expanding our county footprint to increase our coverage of Medicare eligibles from 48% today to 60% by 2016. Clearly, this is one area where the Humana transaction will enable us to make real progress.

- In existing states, this means raising our game to increase our investment in business development resources in new states and achieve excellence in RFP responses.

- And the reputation we have earned in our existing state relationships can be instrumental in paving the way for new opportunities.

- For Individual, we will pursue a disciplined market participation strategy, targeting deliberate growth in on-exchange silver subsidized membership – our most profitable demographic.

- Alignment with enterprise priority geographies will enable us to achieve scale with providers, thereby improving engagement, outcomes, and cost positioning.

- We will effectively manage our high-acuity and high-risk populations. In order to achieve this, we will:

  - Enhance our care management capabilities.
  - Invest in technology solutions.
  - Strengthen provider relationships.
July 19: Mark Bertolini testified that Aetna was still discussing expansion

“Q. And in your July – the deposition where we met in July 19th, you were still discussing the possibility that you could enter even more exchange markets. Right?

That was a potential longer term, yes.

Tr. 1437:21-24
**July 22: Soistman says that “all bets are off”**

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

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EXHIBIT PX0121, at 1 (July 22, 2016)
July 23: Kelmar says “we have no choice”

Kelmar: “Most of this is a business decision except where DOJ has been explicit about the exchange markets. There we have no choice.”

PX0125, at 1 (July 23, 2016)
July 24: Mayhew says “I was told to be careful about putting any of that in writing”

Q. Now, Mr. Mayhew, you were told to have the attorney-client privilege cc'd in order to shield the e-mail discussion about the 17 complaint counties from being produced in the Department of Justice litigation. Is that right?

A. Right.

Tr. 1508:3-7; PX0127.
Soistman wrote a recommendation on behalf of the team, and Bertololini accepted it.

Q. [To Bertololini] And you received a recommendation, I believe you even described it as an array, from staff.

A. I did.

* * *

Q. But the counties that they recommended were the counties that ultimately your decision was to withdraw?

A. Right.
Materials for Rebuttal & Appendix

PUBLIC EXCHANGES
Competitive Effects
Economic evidence confirms both market definition and the importance of competition

**Academic Literature**
- HHS and Dafny & Gruber studies show that prices rise when exchange markets become more concentrated.
- HHS, Tebaldi, and Dafny et al. show customer substitution at levels that would allow a hypothetical monopolist to increase price.

**Hypothetical Monopolist Test**
- On exchange plans pass the single product test.
- A 10 percent SSNIP would be profitable for at least one plan in all Complaint counties for a wide range of margins and measures of customer substitution.

**Regression Analysis**
- A regression of price measures on HHI finds that an increase in concentration leads to higher premiums.
- Average second lowest silver premiums in Complaint counties would increase by 2.1 percent.

Defendants’ predictions of Humana’s 2017 market share do not reflect reality

• Mr. Orszag predicted that Humana would have less than 1% market share in 2017 in the Complaint counties.

• But in 6 of the 17 counties, Humana will be one of only two insurers selling plans on-exchange.

• Basic economic theory teaches that firms compete where they expect to be profitable in the future.

PX0711; Tr. 1676:4-16 (Nevo)
Aetna and Humana are significant competitors for individual insurance

- Blue Cross Blue Shield of Kansas City – (our biggest competitor in Kansas City)

- Humana – (Biggest competitor in Joplin, and also very well priced in Kansas City)
  - 6%
  - We are neck and neck with Humana in Joplin
  - They will have a better price than us in Kansas City in 2016
  - Their network is very narrow. They only have one hospital system in network in Kansas City. Saint Luke’s Health System. We do not have Saint Luke’s but we have every other Hospital in Kansas City with the exception of Children’s Mercy.
  - They also had problems with service for billing and enrollment. No problems with commission though

Confidential disclaimer or title of presentation here, to edit go to View > Slide Master
Aetna and Humana are significant competitors for individual insurance.

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### Heads Up: Florida IVL 2016 Rate Adjustment Request

**From:** "Ciao, Christopher" <xoxo@aetna.com>
**To:** "Barth, Michael D" <balm@aetna.com>, "Mayhew, Jonathan E" <mayhewj@aetna.com>, "Kunkle, Jon (Jonathan)" <jkunkle@aetna.com>
**Cc:** "Finkelman, Robert" <finkelman@aetna.com>, "Wang, Yai" <ywang2@aetna.com>, "Bauer, Craig" <cbauer3@aetna.com>, "Keck, Kim A" <keckk@aetna.com>, "Walker, Jean H" <walkerj1@aetna.com>, "Campbell, Bruce T" <campbellb1@aetna.com>, "Weisz, Richard" <ritweisz@aetna.com>, "Ciano, Christopher" <cjano@aetna.com>

**Boo:** "Arthur & Barbara Ciano (bmciano@aol.com)" <bmciano@aol.com>

**Date:** Fri, 12 Jun 2015 03:31:52 -0400

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We are concerned that we have dropped to #2 behind Humana.

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<tr>
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<td>Centene</td>
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We are concerned that we have dropped to #2 behind Humana and strongly believe that Molina may have filed a rate decrease similar to what occurred in 2015. This would position Molina below us and we would actually drop to #3. We are trying to avoid a repeat of what happened in 2015 with Dade County where Molina cut rates and jumped to #2 resulting in a net loss of about 600 members. In order to position ourselves ahead of Humana while also creating some distance between Molina/Centene, in case they actually reduced rates, we believe that we need to lower our rates in Broward by 4%. If we do nothing with our rates and drop behind Molina/Centene, then we would expect a 600 drop (300 members) in our Broward membership. As a result, our overall profit target would drop from 6.1% to 3.6% or by 2.5%.

Unfortunately, the 4% reduction in Broward can only be achieved if applied to all counties. County specific rate changes could be made by adjusting the area factor, but the area factors are locked in and certified at this time. Since the DSR questioned our late enrollment pricing adjustment, we believe we can utilize this factor to adjust our rates. Changing this factor impacts all counties. We are proposing a 4% reduction to our rates offset by a 1% reduction in commissions and a 1% additional UIC. The net result would be a reduction in our target profit from 6.1% to 4.1% or by 2.0% while putting us in the best position to maintain #1 in Broward and preserve our 1500 members.

There is a $15M that was not used in the original pricing for non-Broward/Dade counties. This is worth 0.3% and leaves 0.7% of the 1% SA to solve for through improvements in brokerage, trend, and E0 utilization.
Materials for Rebuttal & Appendix

EFFICIENCIES
Defendants calculated pharmacy efficiencies using just a single quarter of data

- Ms. Hammer testified that any pharmacy efficiencies based on rebates would require a longitudinal study.
- Aetna’s original consultant, Deloitte, agreed that a longitudinal study was needed, so Aetna chose a different consulting firm.
U.S. & Plaintiff States
v.
Aetna Inc. & Humana Inc.