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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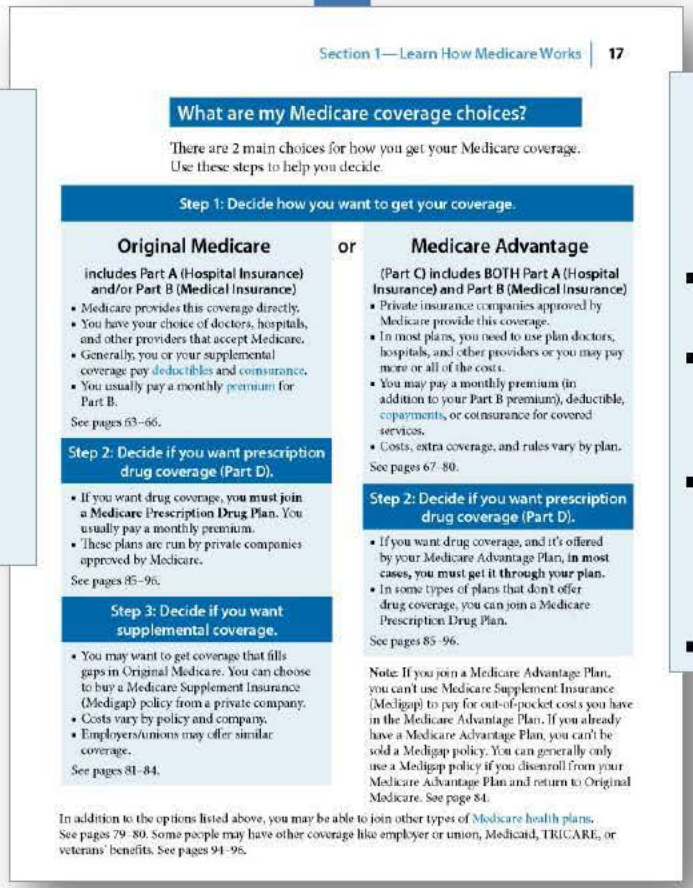
- Can Aetna avoid antitrust scrutiny by withdrawing from 17 counties?

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.



Section 1—Learn How Medicare Works | 17

What are my Medicare coverage choices?

There are 2 main choices for how you get your Medicare coverage. Use these steps to help you decide.

Step 1: Decide how you want to get your coverage.

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.

See pages 63–66.

Step 2: Decide if you want prescription drug coverage (Part D).

- If you want drug coverage, **you must join a Medicare Prescription Drug Plan.** You usually pay a monthly premium.
- These plans are run by private companies approved by Medicare.

See pages 85–96.

Step 3: Decide if you want supplemental coverage.

- You may want to get coverage that fills gaps in Original Medicare. You can choose to buy a Medicare Supplement Insurance (Medigap) policy from a private company.
- Costs vary by policy and company.
- Employers/unions may offer similar coverage.

See pages 81–84.

or

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.

See pages 67–80.

Step 2: Decide if you want prescription drug coverage (Part D).

- If you want drug coverage, and it's offered by your Medicare Advantage Plan, **in most cases, you must get it through your plan.**
- In some types of plans that don't offer drug coverage, you can join a Medicare Prescription Drug Plan.

See pages 85–96.

Note: If you join a Medicare Advantage Plan, you can't use Medicare Supplement Insurance (Medigap) to pay for out-of-pocket costs you have in the Medicare Advantage Plan. If you already have a Medicare Advantage Plan, you can't be sold a Medigap policy. You can generally only use a Medigap policy if you disenroll from your Medicare Advantage Plan and return to Original Medicare. See page 84.

In addition to the options listed above, you may be able to join other types of Medicare health plans. See pages 79–80. Some people may have other coverage like employer or union, Medicaid, TRICARE, or veterans' benefits. See pages 94–96.

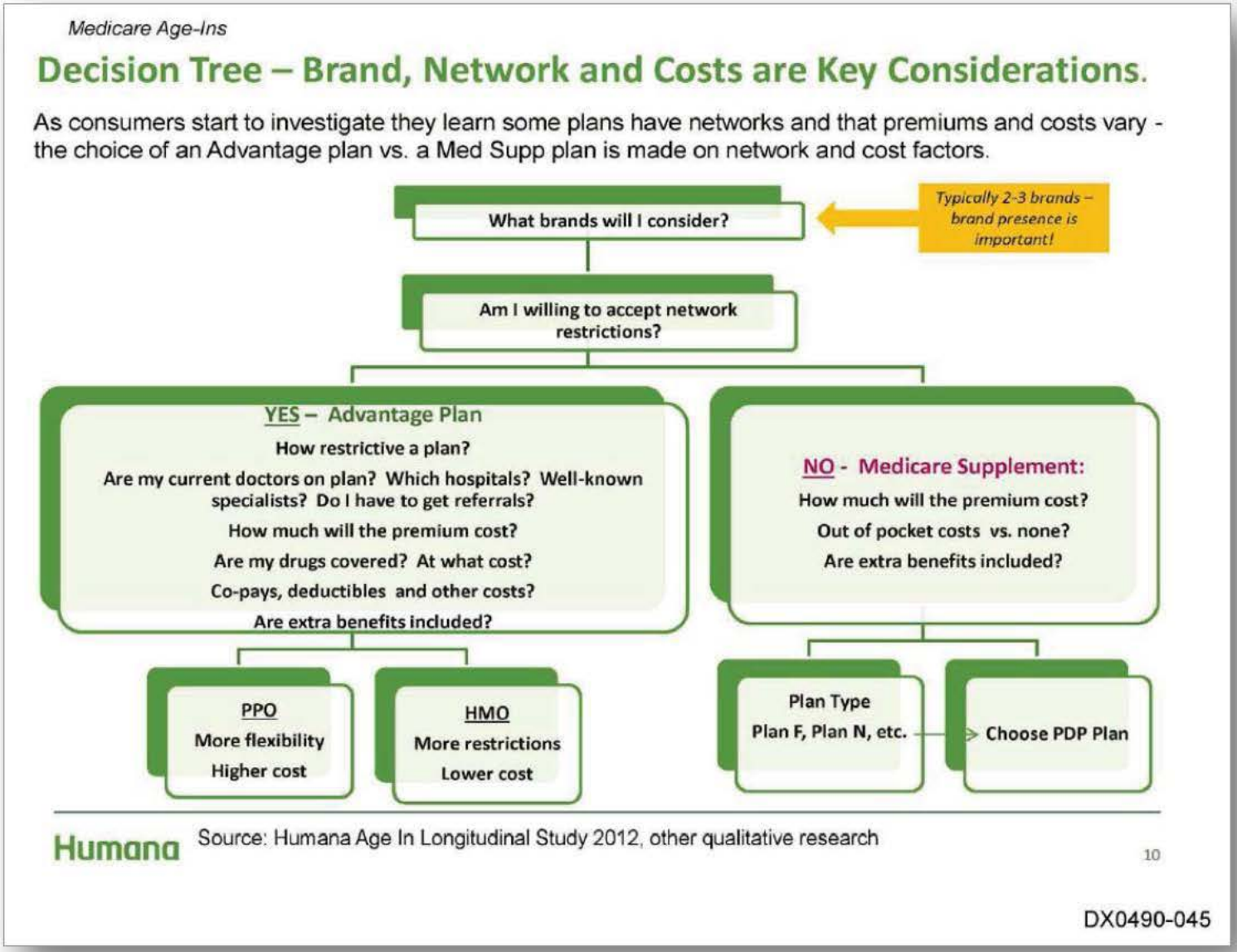
PX0519 (2017 Medicare & You Handbook)

Medicare Advantage

(Part C) includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance)

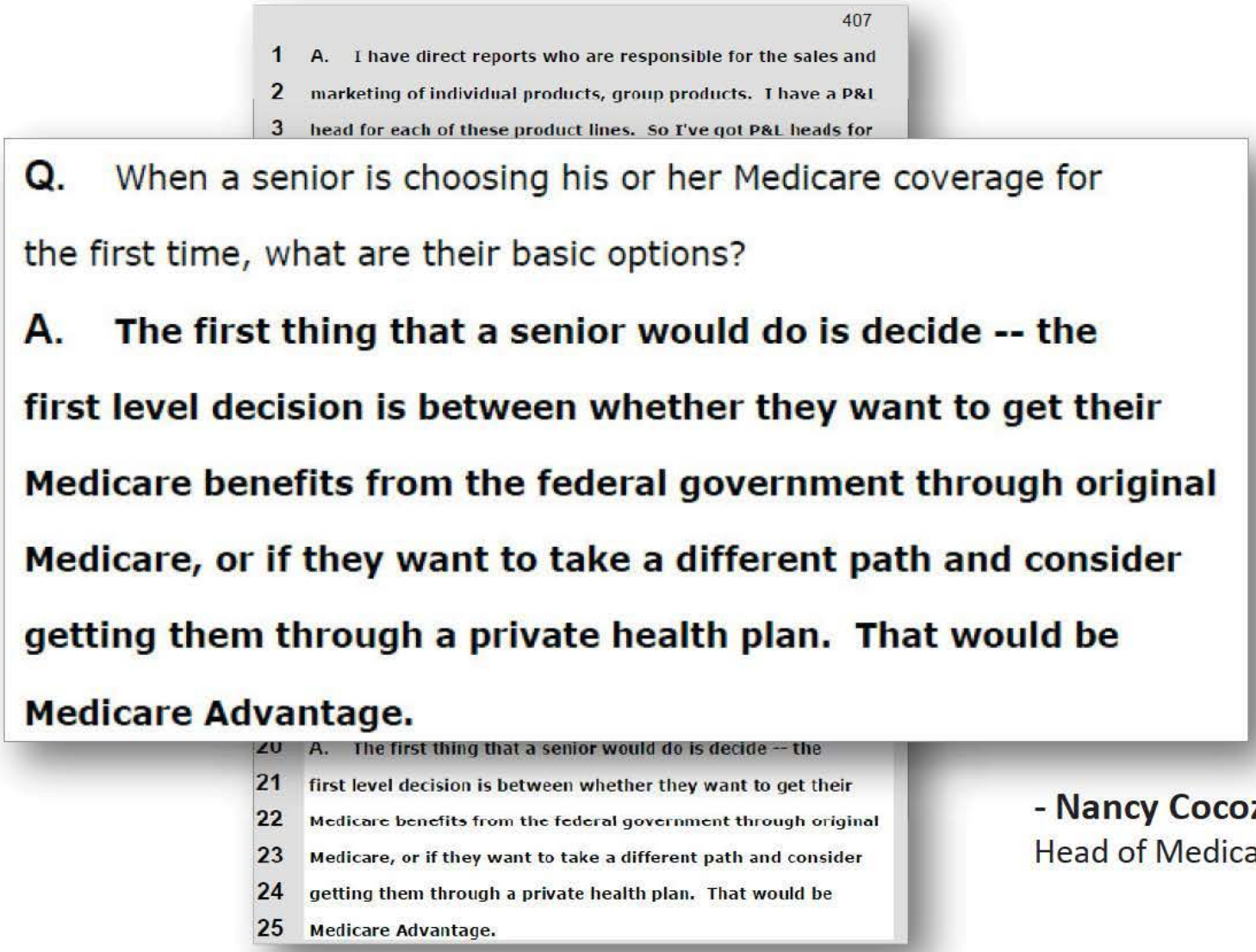
- Private insurance companies approved by Medicare provide this coverage.
- In most plans, you need to use plan doctors, hospitals, and other providers or you may pay more or all of the costs.
- You may pay a monthly premium (in addition to your Part B premium), deductible, copayments, or coinsurance for covered services.
- Costs, extra coverage, and rules vary by plan.

Seniors choose Medicare Advantage based on a durable set of preferences



DX0490, at 45 (June 26, 2015)

Nancy Cocozza agrees that some seniors choose the Original Medicare "path" and others choose the Medicare Advantage "path"



407

A. I have direct reports who are responsible for the sales and marketing of individual products, group products. I have a P&I head for each of these product lines. So I've got P&L heads for

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

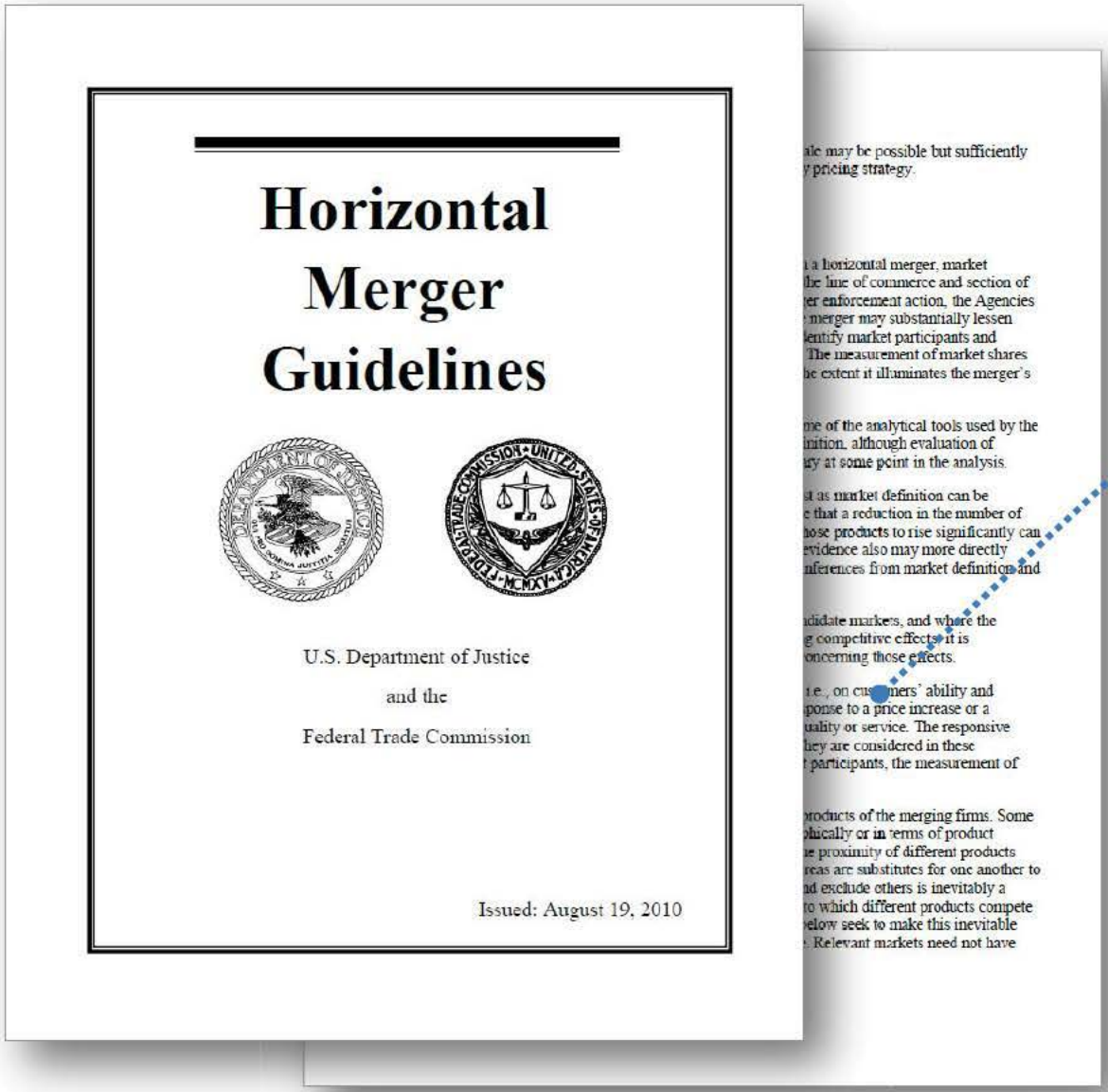
A. The first thing that a senior would do is decide -- the first level decision is between whether they want to get their Medicare benefits from the federal government through original Medicare, or if they want to take a different path and consider getting them through a private health plan. That would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

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.

Tr. 407:18-25

- Nancy Cocozza,
Head of Medicare at Aetna

Market definition focuses on consumer substitution

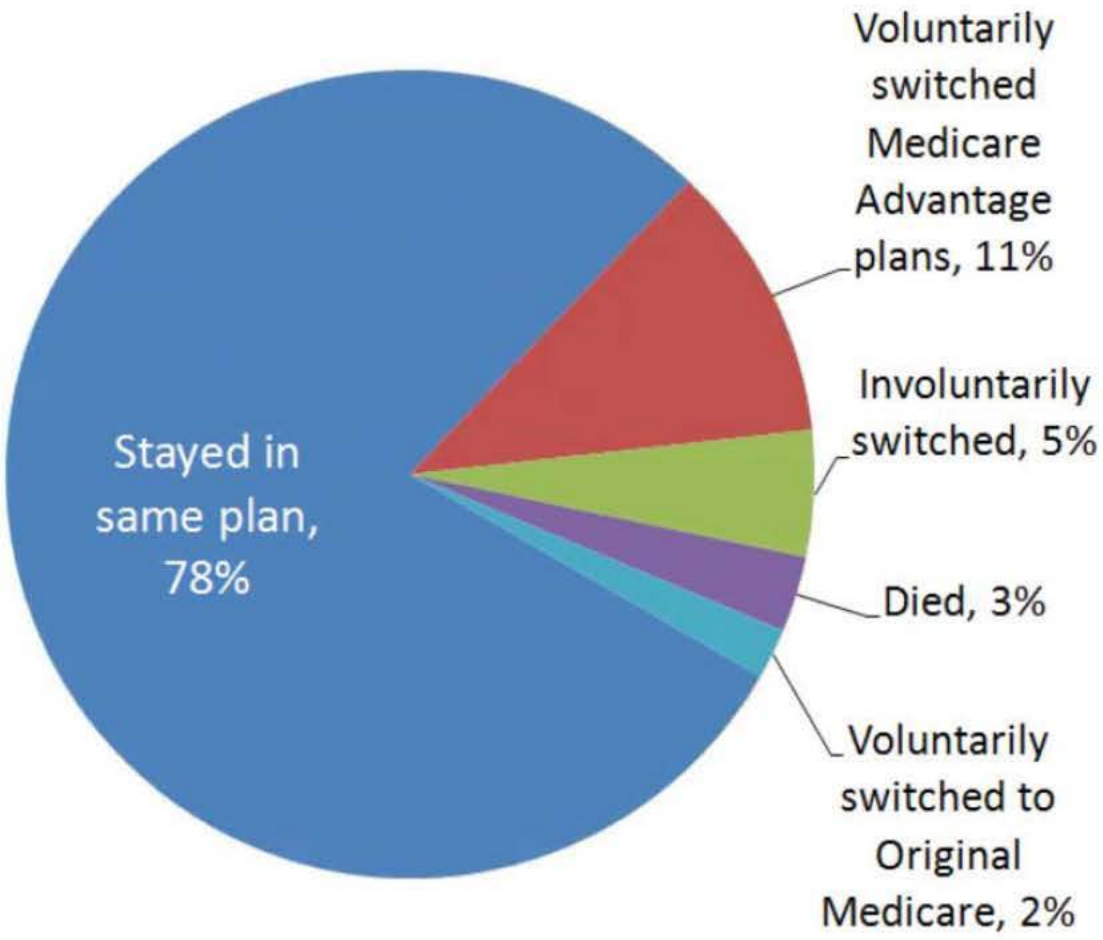


"Market definition focuses solely on demand substitution factors, i.e., on customers' ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change such as a reduction in product quality or service."

Horizontal Merger Guidelines § 4

Few Medicare Advantage Enrollees Change Plans

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

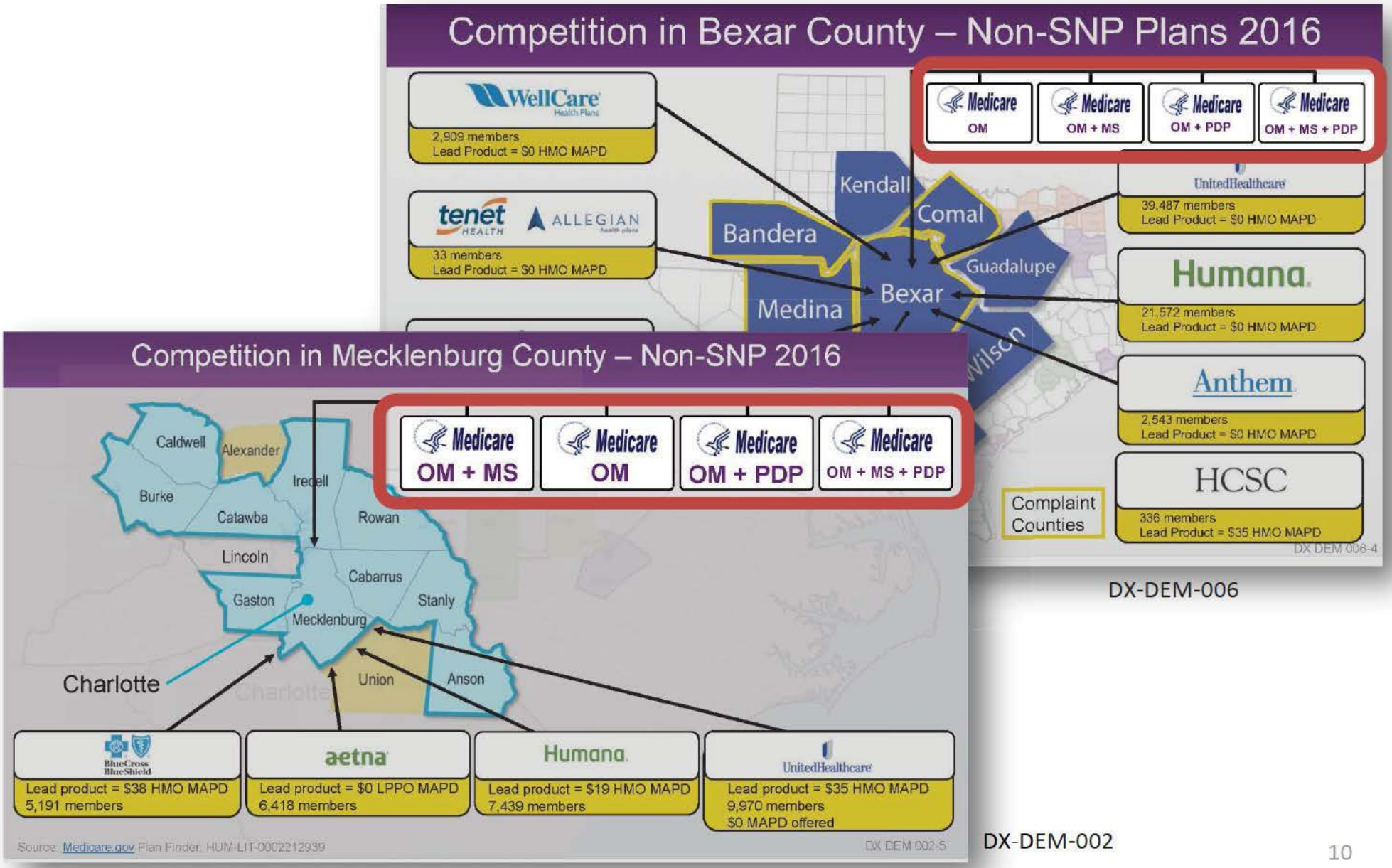


See Medicare Advantage Plan Switching: Exception or Norm?, KFF Issue Brief, 20 September 2016.

Brown Shoe "practical indicia" show that Medicare Advantage is a relevant product market

Aetna and Humana:	Regularly describe other Medicare Advantage plans as being their top competitors
	Regularly compare their Medicare Advantage plans against other companies' Medicare Advantage plans
	Regularly discuss the Medicare Advantage market and calculate their shares in the Medicare Advantage market
	Price their Medicare Advantage plans separately
	Have separate business units and profit & loss statements for their Medicare Advantage businesses
Investors:	Recognize Medicare Advantage as being separate from Medicare Supplement and Part D Prescription Drug Plans
Medicare Advantage plans:	Have different characteristics than Original Medicare with or without Medicare Supplement and Part D Plans
	Appeal to different consumers
Industry participants:	Acknowledge the differences in product characteristics and customers and recognize Medicare Advantage as a distinct market

The Defendants inserted Original Medicare into their trial demonstratives



DX-DEM-006

DX-DEM-002

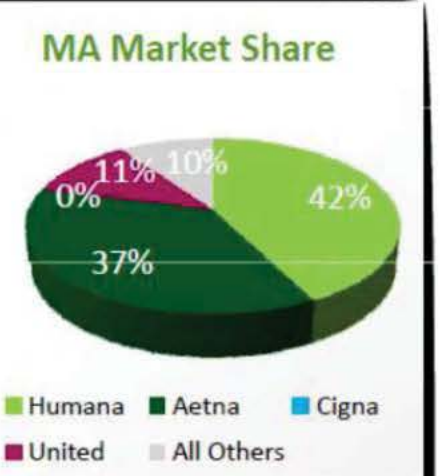
Defendants' actual business documents focus on other Medicare Advantage insurers

PX0036, at 9 (April 7, 2016)

Defendants' actual business documents focus on other Medicare Advantage insurers

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 it's 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



Carrier	Plan Type	STARS	Premium	MOOP	PCP	SPC	Inpatient	Rx
Humana	HMO	4	$0	$6,700	$25	$50	$350 Days 1-5	6/11/47/99/25%
Humana	HMO	4	$34	$6,500	$10	$45	$330 Days 1-5	6/11/47/99/29%
United	HMO	4	$39	$3900	$5	$40	$275 Days 1-6	2/8/45/95/28%
United	HMO	4	$0	$6700	$20	$50	$335 Days 1-5	2/12/47/100/26%
Aetna	HMO	3.5	$0	$5,000	$5	$40	$300 Days 1-5	4/9/47/100/33%
Aetna	PPO	4	$0	$6,700	$10	$50	$3505 Days 1-5	4/9/47/100/33%
Cigna	HMO	New	$0	$4,900	$0	$40	$250 Days 1-6	1/3/45/95/30%

PX0455, at 67 (Aug. 24, 2015)

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

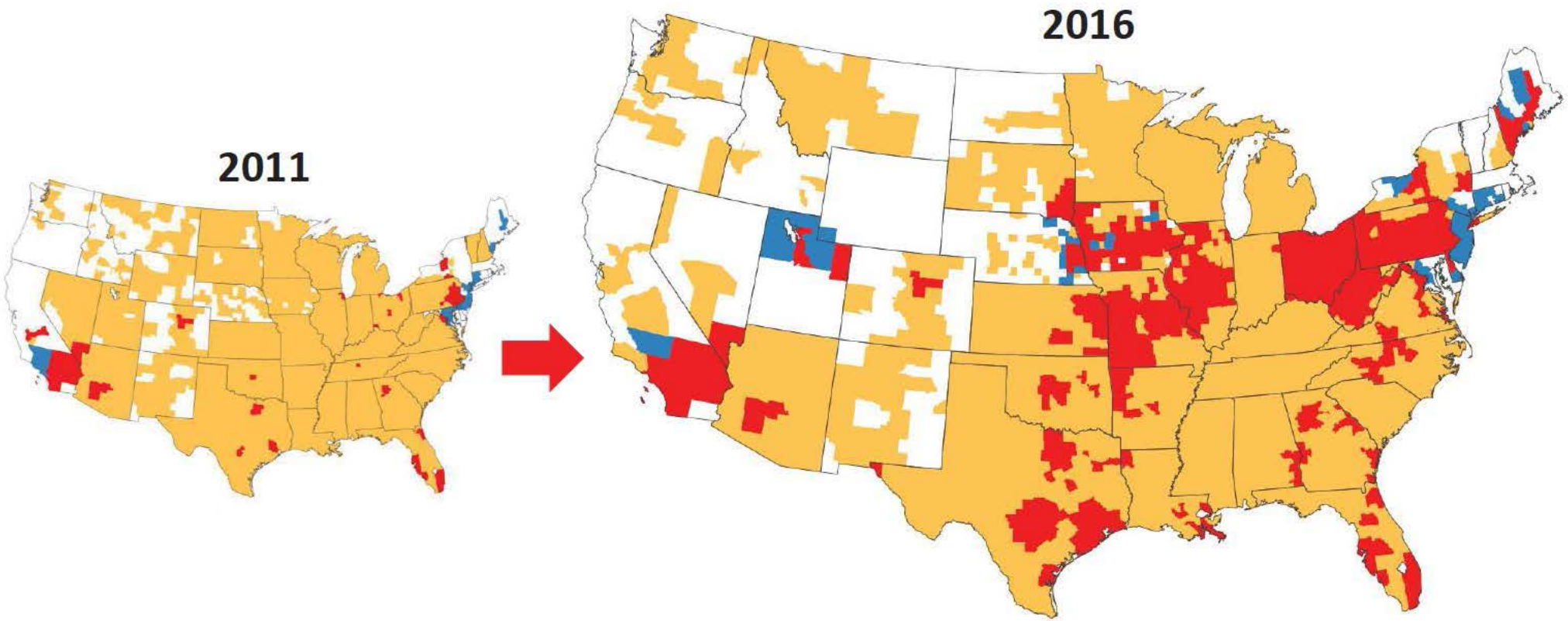
Empirical Analysis of Demand

- All estimates agree that many seniors have a distinct preference for MA

Hypothetical Monopolist Tests

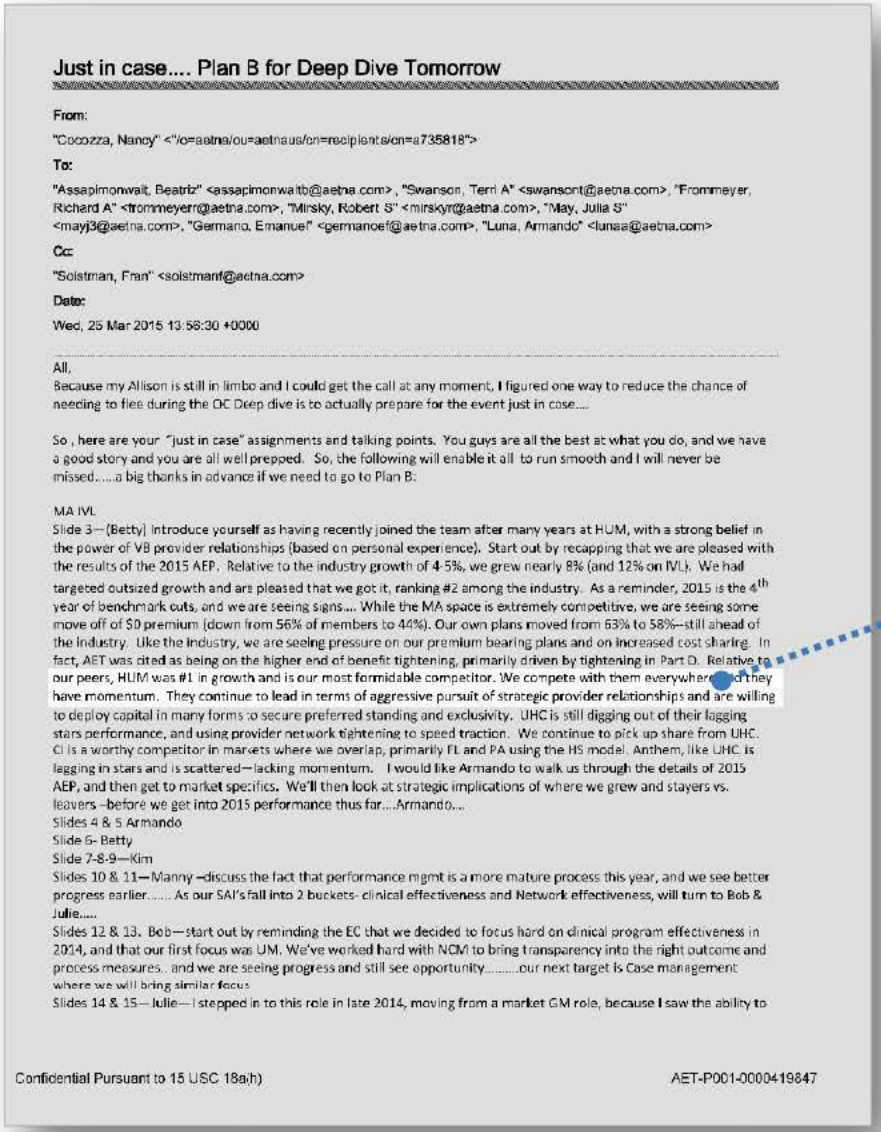
- Medicare Advantage passes the test in all or almost all counties using any formulation of the test

Aetna is a particularly aggressive competitor



PX0551, at 110 (Expert Report of Aviv Nevo, Ph.D., Oct. 21, 2016)

Aetna and Humana compete "everywhere"



Just in case.... Plan B for Deep Dive Tomorrow

From:

"Cocozza, Nancy" <"/o=aetna/ou=aetnaus/cn=recipients/cn=a735818">

To:

"Assapimonwait, Beatriz" <assapimonwaitb@aetna.com> , "Swanson, Terri A" <swansont@aetna.com>, "Frommeyer, Richard A" <frommeyerr@aetna.com>, "Mirsky, Robert S" <mirskyr@aetna.com>, "May, Julia S" <mayj3@aetna.com>, "Germano, Emanuel" <germanoef@aetna.com>, "Luna, Armando" <lunaa@aetna.com>

Cc:

"Soistman, Fran" <soistmanf@aetna.com>

Date:

Wed, 25 Mar 2015 13:58:30 +0000

All,
Because my Allison is still in limbo and I could get the call at any moment, I figured one way to reduce the chance of needing to flee during the OC Deep dive is to actually prepare for the event just in case....

So , here are your "just in case" assignments and talking points. You guys are all the best at what you do, and we have a good story and you are all well prepped. So, the following will enable it all to run smooth and I will never be missed.....a big thanks in advance if we need to go to Plan B:

MA IVL
Slide 3—(Betty) Introduce yourself as having recently joined the team after many years at HUM, with a strong belief in the power of VB provider relationships (based on personal experience). Start out by recapping that we are pleased with the results of the 2015 AEP. Relative to the industry growth of 4-5%, we grew nearly 8% (and 12% on IVL). We had targeted outsized growth and are pleased that we got it, ranking #2 among the industry. As a reminder, 2015 is the 4th year of benchmark cuts, and we are seeing signs... While the MA space is extremely competitive, we are seeing some move off of $0 premium (down from 56% of members to 44%). Our own plans moved from 63% to 58%--still ahead of the industry. Like the industry, we are seeing pressure on our premium bearing plans and on increased cost sharing. In fact, AET was cited as being on the higher end of benefit tightening, primarily driven by tightening in Part D. Relative to our peers, HUM was #1 in growth and is our most formidable competitor. We compete with them everywhere and they have momentum. They continue to lead in terms of aggressive pursuit of strategic provider relationships and are willing to deploy capital in many forms to secure preferred standing and exclusivity. UHC is still digging out of their lagging stars performance, and using provider network tightening to speed traction. We continue to pick up share from UHC. CI is a worthy competitor in markets where we overlap, primarily FL and PA using the HS model. Anthem, like UHC is lagging in stars and is scattered—lacking momentum. I would like Armando to walk us through the details of 2015 AEP, and then get to market specifics. We'll then look at strategic implications of where we grew and stayers vs. leavers --before we get into 2015 performance thus far....Armando...
Slides 4 & 5 Armando
Slide 6- Betty
Slide 7-8-9—Kim
Slides 10 & 11—Manny --discuss the fact that performance mgmt is a more mature process this year, and we see better progress earlier..... As our SAI's fall into 2 buckets- clinical effectiveness and Network effectiveness, will turn to Bob & Julie.....
Slides 12 & 13. Bob—start out by reminding the EC that we decided to focus hard on clinical program effectiveness in 2014, and that our first focus was UM. We've worked hard with NCM to bring transparency into the right outcome and process measures.. and we are seeing progress and still see opportunity.....our next target is Case management where we will bring similar focus
Slides 14 & 15—Julie—I stepped in to this role in late 2014, moving from a market GM role, because I saw the ability to

Confidential Pursuant to 15 USC 18a(h) AET-P001-0000419847

PX007 (Mar. 25, 2015)

"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

Five Key Questions

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CMS sets the "contours" and "framework" for competition

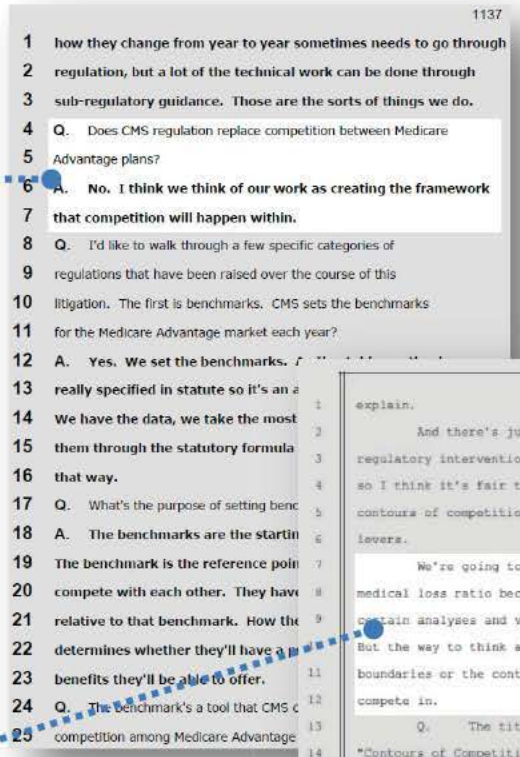
Q. Does CMS regulation replace competition between Medicare Advantage plans?

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



1137

how they change from year to year sometimes needs to go through regulation, but a lot of the technical work can be done through sub-regulatory guidance. Those are the sorts of things we do.

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.

Q. I'd like to walk through a few specific categories of regulations that have been raised over the course of this litigation. The first is benchmarks. CMS sets the benchmarks for the Medicare Advantage market each year?

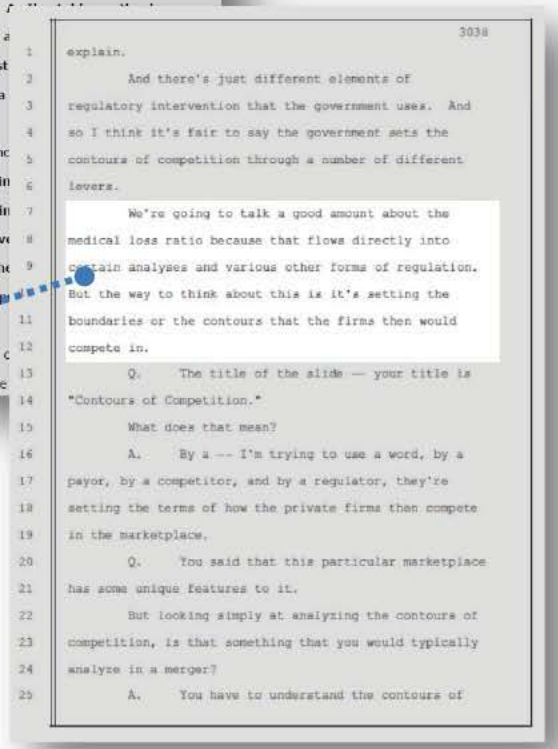
A. Yes. We set the benchmarks. [illegible] really specified in statute so it's an a[illegible] We have the data, we take the most[illegible] them through the statutory formula[illegible] that way.

Q. What's the purpose of setting benc[illegible]

A. The benchmarks are the startin[illegible] The benchmark is the reference poin[illegible] compete with each other. They have[illegible] relative to that benchmark. How the[illegible] determines whether they'll have a[illegible] benefits they'll be able to offer.

Q. The benchmark's a tool that CMS c[illegible] competition among Medicare Advantage[illegible]

Tr. 1137:4-7



3038

explain.

And there's just different elements of regulatory intervention that the government uses. And so I think it's fair to say the government sets the contours of competition through a number of different levers.

We're going to talk a good amount about the medical loss ratio because that flows directly into certain analyses and various other forms of regulation. But the way to think about this is it's setting the boundaries or the contours that the firms then would compete in.

Q. The title of the slide -- your title is "Contours of Competition."

What does that mean?

A. By a -- I'm trying to use a word, by a payor, by a competitor, and by a regulator, they're setting the terms of how the private firms than compete in the marketplace.

Q. You said that this particular marketplace has some unique features to it.

But looking simply at analyzing the contours of competition, is that something that you would typically analyze in a merger?

A. You have to understand the contours of

Tr. 3038:2-12

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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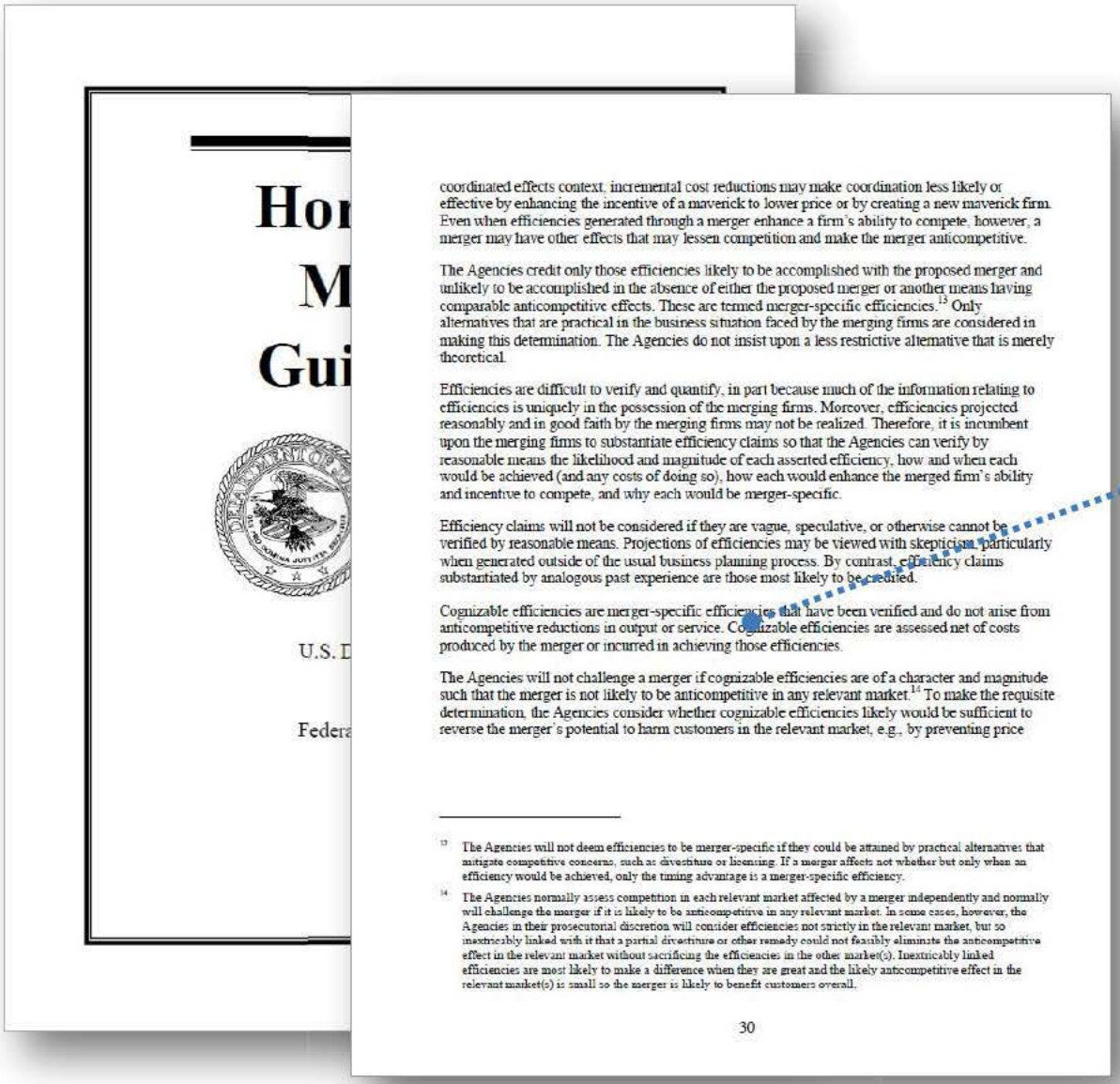
The claimed efficiencies do not outweigh the competitive harm



coordinated effects context, incremental cost reductions may make coordination less likely or effective by enhancing the incentive of a maverick to lower price or by creating a new maverick firm. Even when efficiencies generated through a merger enhance a firm's ability to compete, however, a merger may have other effects that may lessen competition and make the merger anticompetitive.

The Agencies credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. These are termed merger-specific efficiencies.[13] Only alternatives that are practical in the business situation faced by the merging firms are considered in making this determination. The Agencies do not insist upon a less restrictive alternative that is merely theoretical.

Efficiencies are difficult to verify and quantify, in part because much of the information relating to efficiencies is uniquely in the possession of the merging firms. Moreover, efficiencies projected reasonably and in good faith by the merging firms may not be realized. Therefore, it is incumbent upon the merging firms to substantiate efficiency claims so that the Agencies can verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific.

Efficiency claims will not be considered if they are vague, speculative, or otherwise cannot be verified by reasonable means. Projections of efficiencies may be viewed with skepticism, particularly when generated outside of the usual business planning process. By contrast, efficiency claims substantiated by analogous past experience are those most likely to be credited.

Cognizable efficiencies are merger-specific efficiencies that have been verified and do not arise from anticompetitive reductions in output or service. Cognizable efficiencies are assessed net of costs produced by the merger or incurred in achieving those efficiencies.

The Agencies will not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market.[14] To make the requisite determination, the Agencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger's potential to harm customers in the relevant market, e.g., by preventing price

[13] The Agencies will not deem efficiencies to be merger-specific if they could be attained by practical alternatives that mitigate competitive concerns, such as divestiture or licensing. If a merger affects not whether but only when an efficiency would be achieved, only the timing advantage is a merger-specific efficiency.

[14] The Agencies normally assess competition in each relevant market affected by a merger independently and normally will challenge the merger if it is likely to be anticompetitive in any relevant market. In some cases, however, the Agencies in their prosecutorial discretion will consider efficiencies not strictly in the relevant market, but so inextricably linked with it that a partial divestiture or other remedy could not feasibly eliminate the anticompetitive effect in the relevant market without sacrificing the efficiencies in the other market(s). Inextricably linked efficiencies are most likely to make a difference when they are great and the likely anticompetitive effect in the relevant market(s) is small so the merger is likely to benefit customers overall.

30

"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

Five Key Questions

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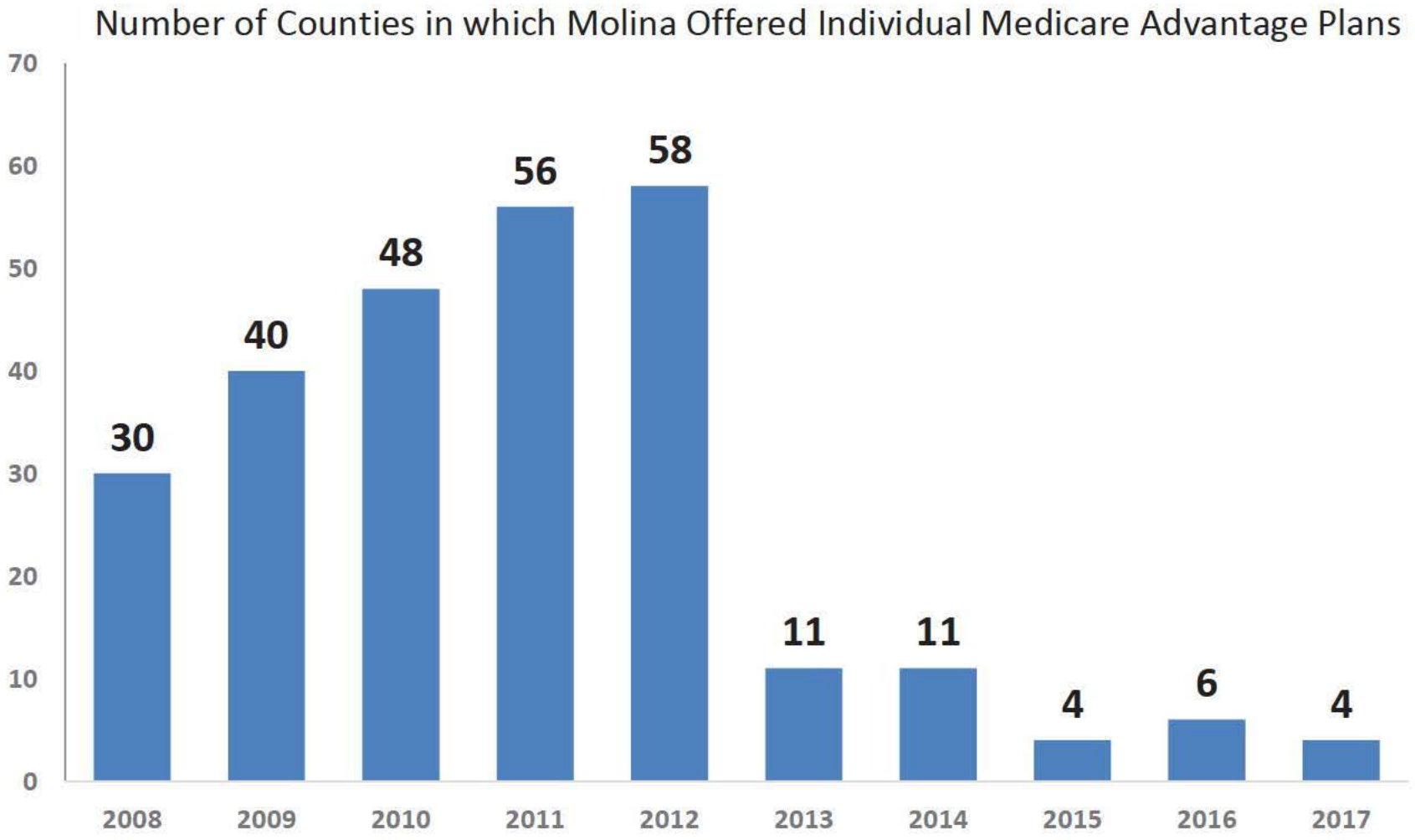
The proposed divestiture is unprecedented and risky

"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."

U.S. Department of Justice, Policy Guide to Merger Remedies 1 (2011)

Molina has failed at individual Medicare Advantage in the past

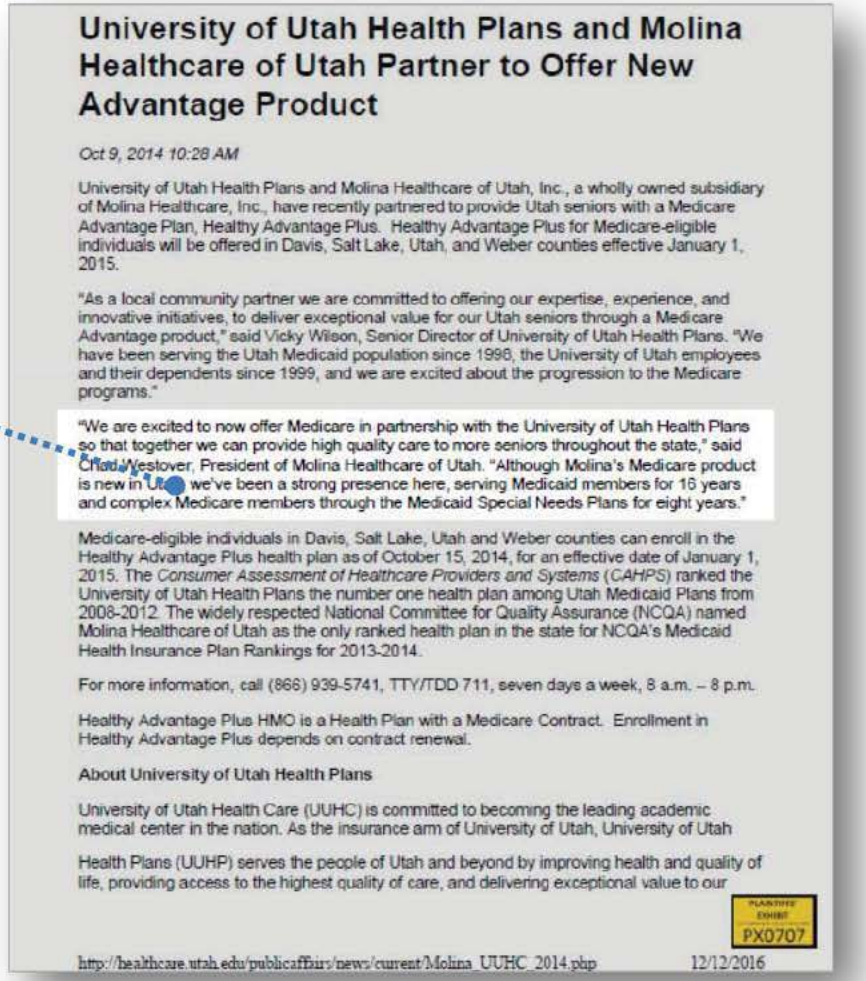


PX0559, at ¶ 31 and Ex. 1 (Expert Report of Dr. Lawton R. Burns, Oct. 21, 2016)

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



University of Utah Health Plans and Molina Healthcare of Utah Partner to Offer New Advantage Product

Oct 9, 2014 10:28 AM

University of Utah Health Plans and Molina Healthcare of Utah, Inc., a wholly owned subsidiary of Molina Healthcare, Inc., have recently partnered to provide Utah seniors with a Medicare Advantage Plan, Healthy Advantage Plus. Healthy Advantage Plus for Medicare-eligible individuals will be offered in Davis, Salt Lake, Utah, and Weber counties effective January 1, 2015.

"As a local community partner we are committed to offering our expertise, experience, and innovative initiatives, to deliver exceptional value for our Utah seniors through a Medicare Advantage product," said Vicky Wilson, Senior Director of University of Utah Health Plans. "We have been serving the Utah Medicaid population since 1998, the University of Utah employees and their dependents since 1999, and we are excited about the progression to the Medicare programs."

"We are excited to now offer Medicare in partnership with the University of Utah Health Plans so that together we can provide high quality care to more seniors throughout the state," said Chad Westover, President of Molina Healthcare of Utah. "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."

Medicare-eligible individuals in Davis, Salt Lake, Utah and Weber counties can enroll in the Healthy Advantage Plus health plan as of October 15, 2014, for an effective date of January 1, 2015. The *Consumer Assessment of Healthcare Providers and Systems* (*CAHPS*) ranked the University of Utah Health Plans the number one health plan among Utah Medicaid Plans from 2008-2012. The widely respected National Committee for Quality Assurance (NCQA) named Molina Healthcare of Utah as the only ranked health plan in the state for NCQA's Medicaid Health Insurance Plan Rankings for 2013-2014.

For more information, call (866) 939-5741, TTY/TDD 711, seven days a week, 8 a.m. – 8 p.m.

Healthy Advantage Plus HMO is a Health Plan with a Medicare Contract. Enrollment in Healthy Advantage Plus depends on contract renewal.

About University of Utah Health Plans

University of Utah Health Care (UUHC) is committed to becoming the leading academic medical center in the nation. As the insurance arm of University of Utah, University of Utah

Health Plans (UUHP) serves the people of Utah and beyond by improving health and quality of life, providing access to the highest quality of care, and delivering exceptional value to our

PLAINTIFF'S EXHIBIT PX0707

http://healthcare.utah.edu/publicaffairs/news/current/Molina_UUHC_2014.php 12/12/2016

PX0707 (Oct. 9, 2014)

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

Tr. 2381:23-24 (Dr. Mario Molina); 2482:6-21 (Lisa Rubino).

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

Tr. 2382:15-22.

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."

U.S. Department of Justice, Policy Guide to Merger Remedies 1 (2011)

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?

The probative value of post-acquisition conduct is "extremely limited"

The probative value of merging parties' 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."
United States v. General Dynamics Corp., 415 U.S. 486, 504-05 (1974)	**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

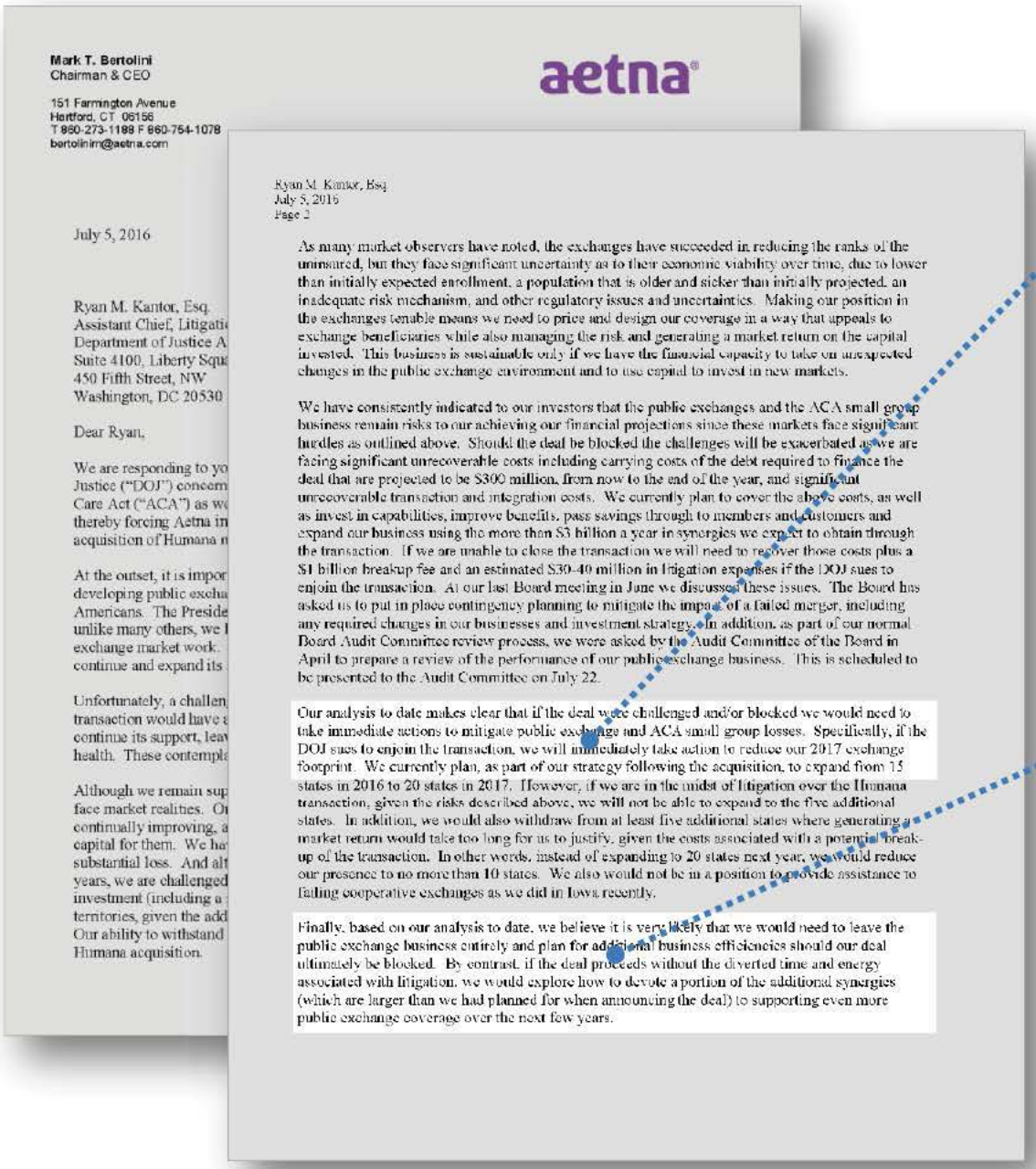
July 24: "Does this include the 17 places in the DOJ complaint[?]"

- **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

Public Exchanges: Getting the Deal Done



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Chairman & CEO

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aetna

July 5, 2016

Ryan M. Kantor, Esq.
Assistant Chief, Litigati
Department of Justice A
Suite 4100, Liberty Squ
450 Fifth Street, NW
Washington, DC 20530

Dear Ryan,

We are responding to yo
Justice ("DOJ") concern
Care Act ("ACA") as we
thereby forcing Aetna in
acquisition of Humana n

At the outset, it is impor
developing public excha
Americans. The Preside
unlike many others, we
exchange market work.
continue and expand its

Unfortunately, a challen
transaction would have
continue its support, lea
health. These contempl

Although we remain sup
face market realities. O
continually improving, a
capital for them. We ha
substantial loss. And alt
years, we are challenged
investment (including a
territories, given the add
Our ability to withstand
Humana acquisition.

Ryan M. Kantor, Esq.
July 5, 2016
Page 2

As many market observers have noted, the exchanges have succeeded in reducing the ranks of the uninsured, but they face significant uncertainty as to their economic viability over time, due to lower than initially expected enrollment, a population that is older and sicker than initially projected, an inadequate risk mechanism, and other regulatory issues and uncertainties. Making our position in the exchanges tenable means we need to price and design our coverage in a way that appeals to exchange beneficiaries while also managing the risk and generating a market return on the capital invested. This business is sustainable only if we have the financial capacity to take on unexpected changes in the public exchange environment and to use capital to invest in new markets.

We have consistently indicated to our investors that the public exchanges and the ACA small group business remain risks to our achieving our financial projections since these markets face significant hurdles as outlined above. Should the deal be blocked the challenges will be exacerbated as we are facing significant unrecoverable costs including carrying costs of the debt required to finance the deal that are projected to be $300 million, from now to the end of the year, and significant unrecoverable transaction and integration costs. We currently plan to cover the above costs, as well as invest in capabilities, improve benefits, pass savings through to members and customers and expand our business using the more than $3 billion a year in synergies we expect to obtain through the transaction. If we are unable to close the transaction we will need to recover those costs plus a $1 billion breakup fee and an estimated $30-40 million in litigation expenses if the DOJ sues to enjoin the transaction. At our last Board meeting in June we discussed these issues. The Board has asked us to put in place contingency planning to mitigate the impact of a failed merger, including any required changes in our businesses and investment strategy. In addition, as part of our normal Board Audit Committee review process, we were asked by the Audit Committee of the Board in April to prepare a review of the performance of our public exchange business. This is scheduled to be presented to the Audit Committee on July 22.

Our analysis to date makes clear that if the deal were challenged and/or blocked we would need to take immediate actions to mitigate public exchange and ACA small group losses. Specifically, if the DOJ sues to enjoin the transaction, we will immediately take action to reduce our 2017 exchange footprint. We currently plan, as part of our strategy following the acquisition, to expand from 15 states in 2016 to 20 states in 2017. However, if we are in the midst of litigation over the Humana transaction, given the risks described above, we will not be able to expand to the five additional states. In addition, we would also withdraw from at least five additional states where generating a market return would take too long for us to justify, given the costs associated with a potential break-up of the transaction. In other words, instead of expanding to 20 states next year, we would reduce our presence to no more than 10 states. We also would not be in a position to provide assistance to failing cooperative exchanges as we did in Iowa recently.

Finally, based on our analysis to date, we believe it is very likely that we would need to leave the public exchange business entirely and plan for additional business efficiencies should our deal ultimately be blocked. 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.

PX0117 (July 5, 2016)

"[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

U.S. & Plaintiff States

v.

Aetna Inc. & Humana Inc.