EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, *et al.*, *Plaintiffs*, v. AETNA INC., and HUMANA INC., *Defendants*.	Civil Action No. 1:16-cv-1494 (JDB) **PUBLIC VERSION (REDACTED)**

PLAINTIFFS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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INTRODUCTION

Aetna's proposed merger with Humana would eliminate competition between the largest individual Medicare Advantage (MA) insurer, Humana, and the rapidly growing fourth-largest, Aetna. Defendants struck their deal in the midst of a "merger frenzy," and recognized from its inception that it raised serious antitrust concerns. To get Humana to a deal, Aetna agreed to a $1 billion break-up fee. And indeed, the concerns were correct. The merger of Aetna and Humana would greatly increase concentration in markets for the sale of individual MA plans across the country to the detriment of 1.7 million senior citizens. It also would eliminate competition between Aetna and Humana for the sale of individual health insurance on the Affordable Care Act (ACA) public exchanges and likely harm hundreds of thousands of consumers in counties in three states. Because it would substantially lessen competition in many markets across the United States for both of these products, the merger violates Section 7 of the Clayton Act and should be permanently enjoined.

The government is entitled to a presumption of illegality if it shows that the merger would lead to a high degree of concentration in a well-defined market. There is no real dispute that if the relevant markets are defined as individual MA plans sold in the Complaint counties—as the record shows that they should be—the proposed merger is presumptively unlawful. Indeed, this is an easy case for applying the presumption: the merger would lead to a monopoly in 70 counties and high levels of concentration in many others.

The principal issue for the Court on Plaintiffs' first claim is whether the product market is limited to individual MA plans, or should be expanded to include all Original Medicare options as Defendants contend. Plaintiffs proved that MA is a distinct market through evidence from Defendants' own documents and witnesses describing how MA insurers compete and how consumers choose among Medicare options—the "practical indicia" of *Brown Shoe Co. v.*

United States, 370 U.S. 294 (1962)—and through economic evidence from Professor Aviv Nevo and Professor Richard Frank.

Defendants' ordinary course planning documents overwhelmingly show that the competitive focus of MA insurers is on other MA plans, not on Original Medicare options. For example, Defendants did not present at trial business documents calculating their shares of a market that included Original Medicare. Defendants make much of the fact that, when individuals first become eligible for Medicare ("age in"), they must choose between MA and Original Medicare options. But the fact that two products compete to some extent—even that they are functionally interchangeable—does not mean that they are "reasonably interchangeable" and thus belong in the same relevant product market, which is the question under antitrust law. Here, the record establishes that competition among MA insurers—not with Original Medicare—is what keeps the prices and benefits of MA plans competitive.

Professor Nevo's economic analysis confirmed this fact using data from the Centers for Medicare and Medicaid Services (CMS) on the real-life enrollment decisions made by seniors. Those decisions showed first that 85% of those who choose to leave an existing MA plan switch to another MA plan. He next used the millions of Medicare choices made by both "age-ins" and ongoing enrollees to estimate an econometric model of demand. While most seniors would not switch if faced with a price increase, Professor Nevo's results predict that 70% of those seniors who leave an MA plan in response to a price increase would move to another MA plan. Most importantly, he performed several variations of the hypothetical monopolist test prescribed by the Merger Guidelines and used by courts—including performing the test using Defendants' expert's demand estimates. Professor Nevo found that a hypothetical monopolist of individual MA plans would impose at least a small price increase—a SSNIP—establishing that individual

MA plans constitute a relevant product market.

These facts establish Plaintiffs' prima facie case. But Plaintiffs offered much more evidence showing that the proposed merger would harm consumers by eliminating all direct competition between Defendants. The record shows that seniors have benefited from competition between Aetna and Humana—both "formidable competitors." And Professor Nevo's merger simulation predicts that if the merger is allowed to proceed, seniors in the Complaint counties would face up to $360 million each year in higher premiums and reduced benefits, while taxpayers would pay an additional $140 million to fund the MA program.

Turning to rebuttal issues—on which Defendants bear the burden of showing that Plaintiffs' prima facie case overstates the likely effects of the merger—Defendants argue that regulation by CMS would prevent any potential anticompetitive effects from the merger. But the record shows that vigorous competition among MA insurers is needed to bring high quality, affordable MA plans to seniors and that CMS's oversight is no substitute for competition. Defendants also failed to support their contention that recent changes in MA benchmark levels and the introduction of accountable care organizations (ACOs) make Original Medicare a closer substitute for MA.

Defendants similarly failed to meet their burden of showing that the proposed divestiture of selected MA enrollees to Molina Healthcare would prevent the merger from harming consumers. They could not show that the divestiture is certain to take place, much less that it would replace the competition lost as a result of the merger. Molina is not comparable to either Aetna or Humana today, and it would face many hurdles. It would have difficulty replicating Defendants' provider networks, star ratings, and brand strength, and it lacks the experienced employees and infrastructure needed to run a successful individual MA business. Molina's own

board members and executives—in candid remarks made when not under the microscope of this trial—acknowledged the enormous challenges Molina would face in making this divestiture a success. The fact that Molina's limited experience with individual MA was a dismal failure underscores those risks. And Molina itself anticipates losing customers and potentially shrinking its footprint post-divestiture—in stark contrast to the growth that Aetna planned for its MA program. It is the millions of seniors in the Complaint counties—who today rely on competition between Aetna and Humana to bring them attractive MA plans—who would bear the risk of Molina's inability to replace the lost competition. Molina itself would be protected by the fire-sale price it would pay for the divested lives. In addition, for many of the same reasons that Molina is unlikely to succeed, Defendants were unable to show that new entry in the relevant markets would be likely, timely, or sufficient to replace the lost competition.

Finally, no court has ever found that merging parties successfully rebutted the government's prima facie case through evidence of proven efficiencies, and this case is no exception. Defendants not only failed to produce a witness who could adequately explain the basis for the claimed efficiencies, they also failed to show that any of the claimed efficiencies would be realized in the relevant markets at issue or that they would benefit consumers. Defendants also could not show that the efficiencies are merger-specific—Aetna's own CEO conceded that Aetna would not gain any capabilities from Humana that it could not build on its own.

Professor Nevo's analysis showed that after a prior merger, Humana-Arcadian, there were increases in quality-adjusted prices in affected counties, and that these price increases were not forestalled by competition from Original Medicare options, by competition for "age-ins," by entry, by efficiencies, by CMS regulation, or even by divestitures.

The proposed merger between Aetna and Humana also violates Section 7 because it likely would substantially lessen competition for the sale of individual insurance on the public exchanges in counties in Florida, Georgia, and Missouri. Defendants do not seriously contest that their combination is presumptively unlawful based on 2016 market conditions. Nor do they make a meaningful attempt to rebut this presumption. Instead, the principal issue is whether Aetna's withdrawal from the Complaint counties for 2017—which the record showed was done to advance Aetna's litigating position—puts an end to Plaintiffs' claim. When a party to a merger manipulates the facts to avoid antitrust scrutiny, the Court should assess the legality of the merger without crediting those facts. Under both the law and public policy, Aetna's temporary withdrawal from the exchanges in 2017—where it remains able to compete in 2018 and beyond—does not absolve it of antitrust liability.

This Court should permanently enjoin the merger of Aetna and Humana because it likely would substantially lessen competition in the relevant markets and it thus violates Section 7 of the Clayton Act.

PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. THE PARTIES, JURISDICTION, AND VENUE

1. Defendant Aetna Inc. is a Pennsylvania corporation headquartered in Hartford, Connecticut. PX0503 at 7 and 162.[1] Aetna is the nation's third-largest health insurance company. Aetna Answer ¶ 15. It has a broad national footprint and competes in every state and the District

[1] Specific pages within trial exhibits are cited as follows. For Plaintiffs' exhibits, we provide the last three digits of the bates-numbered page (e.g., PX0566 at -110); and for exhibits without bates numbers, we provide a page reference counting from the first page of the exhibit (i.e., the pdf page number) (e.g., PX0303 at 11). For Defendants' exhibits, we use the unique exhibit-page reference found on the page (e.g., DX0021-013). "Tr." refers to pages within the trial transcript. Deposition excerpts admitted in evidence are cited as "Dep."

of Columbia. Aetna Answer ¶ 15. In 2015, approximately 23.5 million Americans obtained health insurance through Aetna, and the company earned revenue of $60 billion. Aetna Answer ¶ 15.

2. Defendant Humana Inc. is a Delaware corporation headquartered in Louisville, Kentucky. PX0303 at 11. Humana is the nation's fifth-largest health insurance company. Humana Answer ¶ 16. Like Aetna, it has a broad national footprint and competes in every state and the District of Columbia. Humana Answer ¶ 16. In 2015, more than 14 million Americans obtained health insurance through Humana, and the company earned revenue of $54.3 billion. Humana Answer ¶ 16; PX0303 at 11.

3. This Court has personal jurisdiction over each Defendant under Section 12 of the Clayton Act, 15 U.S.C. § 22. Aetna and Humana both transact business in this district. Aetna Answer ¶ 65; Humana Answer ¶ 65.

4. Venue is proper in this district under Section 12 of the Clayton Act, 15 U.S.C. § 22, and under 28 U.S.C. § 1391(b)-(c). Aetna Answer ¶ 66; Humana Answer ¶ 66.

5. Defendants are engaged in, and their activities substantially affect, interstate commerce. Aetna and Humana sell health insurance to numerous customers located throughout the United States, and that insurance covers enrollees when they travel across state lines. Aetna Answer ¶ 64; Humana Answer ¶ 64.

II. THE PROPOSED TRANSACTION

6. Aetna and Humana are two of the "Big Five" companies that dominate health insurance in the United States. Aetna Answer ¶ 4; Humana Answer ¶ 4. The "Big Five," or the "G-5," as Defendants sometimes call them, also includes Anthem, Cigna, and United Healthcare. Tr. 1883:5-14 (Broussard); Humana Answer ¶ 4; Aetna Answer ¶ 4; *see also* PX0384 at -793.

7. Humana is the largest individual Medicare Advantage (MA) insurer in the country,

with over 2.5 million enrollees in 2016.[2] PX0551 (Nevo Report) ¶ 40. Humana is "viewed as a leader in Medicare Advantage." Tr. 1837:21-23 (Broussard). Over the past three years, Humana has added more MA customers than any other insurer. PX0551 (Nevo Report) ¶ 40; PX0566 at -110 (noting that Humana was "[f]astest growing Individual MA plan in 2015 open enrollment). Humana also has been one of the most active insurers on the public exchanges. Humana began selling insurance on the public exchanges in 2014, and in 2016 sold individual insurance on exchanges in 15 states. Humana Answer ¶ 42.

8. Aetna is a major, and growing, MA competitor. It is the fourth-largest individual MA insurer in the country. Aetna Answer ¶ 8. Aetna expanded into 640 new counties in the past four years alone—more than twice as many as any other insurer and almost doubling its geographic footprint. PX0551 (Nevo Report) ¶ 218, Ex. 18. Aetna also has been an active participant on the public exchanges. Aetna began selling insurance on the public exchanges in 2014, and in 2016, it sold individual insurance on exchanges in 15 states. Aetna Answer ¶ 42.

9. Aetna first began to talk to Humana about a potential merger in March 2015. Aetna Answer ¶ 17. The discussions formed part of an industry-wide rush to consolidate—what Aetna's CEO Mark Bertolini described as a "merger frenzy." Tr. 1319:20-1320:3 (Bertolini). United Healthcare first approached Aetna about a possible combination in August 2014 and eventually made Aetna an offer in June 2015. Tr. 1321:8-13, 1322:10-13 (Bertolini). In addition, on a number of occasions, Aetna "made approaches through bankers" to Cigna. Tr. 1321:24-1322:3 (Bertolini). Mindful that Anthem and Cigna were seeking to merge, Aetna warned its

[2] Plaintiffs' claims focus on MA sold to individuals, as distinguished from MA sold to employers, and non-Medicare Advantage options, including Original Medicare (with or without MedSupp or Part D plans), and eligibility-restricted Medicare options. *See also infra* ¶ 56 n. 5.

board of directors that other "transactions could leave Aetna playing catch-up" "depending on who did what to whom." Tr. 1323:8-11, 1325:14-24 (Bertolini); PX0566 at -112.

10. Aetna's desire to merge was not motivated by any need to combine with Humana to bring benefits to consumers that Aetna could not achieve independently. Rather, Aetna was pursuing "potential opportunities of mergers in the market as an alternative to building out [its] own strategy." Tr. 1323:22-1324:5 (Bertolini). In September 2015, Mr. Bertolini testified before the Senate that Aetna could accomplish the benefits of the acquisition on its own within three to four years. PX0005 at 21; *see also* Tr. 1426:7-11 (Bertolini) (agreeing that Aetna would not gain any capabilities from Humana that it could not invest in and build itself over time).

11. On July 2, 2015, Aetna agreed to pay $37 billion for Humana. Aetna Answer ¶ 17.

12. Defendants realized at the outset that their combination would raise significant antitrust concerns. Tr. 1328:20-23 (Bertolini); PX0003 at -713("[S]ounds like we are going to get REALLY BIG in MA, which is not helpful in alleviating antitrust concerns."). Aetna hired Jonathan Orszag, Defendants' economic expert in this case, around the time that the deal was signed. Tr. 1328:24-1329:11 (Bertolini).

13. To convince Humana to proceed in the face of the risk that the merger might not close due to antitrust concerns, Aetna agreed to pay Humana a $1 billion breakup fee (after Humana had demanded more) if the deal was not consummated by June 30, 2016. Tr. 1329:12-1330:1 (Bertolini); Aetna Answer ¶ 18. This date was later extended to December 31, 2016, Aetna Answer ¶ 18, and then again to February 15, 2017, as Aetna recently announced.

14. Aetna sought to mask the antitrust implications of the merger by scrubbing internal documents of such terms as "markets," "[s]cale," "dominate/dominance," "consolidate," "market power," "pricing power," and others that could be antitrust red flags. PX0001 (internal quotation

marks omitted); PX0002 at 6 (listing "WORDS TO AVOID"). Aetna's counsel even instructed employees to destroy certain documents related to Aetna's business strategy on the day before the deal was announced. PX0001. Employees also were encouraged by counsel to use certain phrases in internal documents to attempt to minimize the antitrust issues. PX0001. One of these recommendations—that "we say small competitors are effective competitors," PX0001—found its way two days later into a shareholder presentation providing an overview of the merger. Tr. 1443:24-1448:4 (Bertolini); DX0021-013 (stating "managed care industry continues to be highly competitive with even small operators acting as viable competitors").

15. These efforts to manipulate the record could not mask the serious antitrust implications of the proposed merger. As detailed below, the transaction violates Section 7 of the Clayton Act in the markets for the sale of individual MA plans in 364 counties and in the markets for the sale of individual insurance on the public exchanges in 17 counties.

III. THE LEGAL FRAMEWORK FOR MERGER REVIEW

A. The Presumption of Illegality and Burden-Shifting Framework

16. Under Section 7 of the Clayton Act, a merger is illegal "where in any line of commerce . . . in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. As the statutory text indicates, merger review is concerned with "probabilities, not certainties." *Brown Shoe*, 370 U.S. at 323. Because merger review is necessarily a forward-looking analysis, the government's burden is not to show that the proposed merger *will cause* competitive harm, but rather that it "create[s] an appreciable danger of [anticompetitive consequences] in the future." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 719 (D.C. Cir. 2001) (quoting *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1389 (7th Cir. 1986)).

17. Merger analysis often begins with market definition. *See, e.g., FTC v. Sysco Corp.*,

113 F. Supp. 3d 1, 24 (D.D.C. 2015). Market definition consists of defining both geographic and product markets. *United States v. Marine Bancorp.*, 418 U.S. 602, 618 (1974). "The merger must be viewed functionally in the context of the particular market involved, its structure, history and probable future." *United States v. Cont'l Can Co.*, 378 U.S. 441, 458 (1964). Examining the structure, history, and likely future of relevant markets is necessary to "provide the appropriate setting for judging the probable anticompetitive effects of the merger." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116 (D.D.C. 2004) (quoting *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974) (quoting *Brown Shoe*, 370 U.S. at 316 n.28)).

18. Courts next analyze whether substantial anticompetitive effects are likely within one or more defined markets. If the government proves that the transaction would "produce 'a firm controlling an undue percentage share of the relevant market, and [would] result[] in a significant increase in the concentration of firms in that market,'" that creates "a 'presumption' that the merger will substantially lessen competition." *Heinz*, 246 F.3d at 715 (alterations in original) (quoting *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 363 (1963)). Proof that the merger would lead to a high level of concentration in a well-defined market "establishe[s] a prima facie case of anticompetitive effect." *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982-83 (D.C. Cir. 1990).

19. Under the burden-shifting framework used in this circuit, once the government shows the merger is presumptively unlawful, the burden shifts to the defendant to rebut the presumption by offering proof that "the market-share statistics [give] an inaccurate account of the [merger's] probable effects on competition in the relevant market." *Heinz*, 246 F.3d at 715 (quotation omitted, alterations in original); *see also Baker Hughes*, 908 F.2d at 991 ("[A] defendant seeking to rebut a presumption of anticompetitive effect must show that the prima facie case inaccurately

predicts the relevant transaction's probable effect on future competition."). "The more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully." *Id.*

20. "If the defendant successfully rebuts the presumption [of illegality], the burden of producing additional evidence of anticompetitive effect shifts to the government, and merges with the ultimate burden of persuasion, which remains with the government at all times." *Heinz*, 246 F.3d at 715 (alterations in original) (quoting *Baker Hughes*, 908 F.2d at 983).

B. Harm in a Single Market Is Sufficient to Enjoin the Entire Transaction

21. A merger is unlawful under Section 7 if its effect may be substantially to lessen competition in "*any* line of commerce" in "*any* section of the country." 15 U.S.C. § 18 (emphasis added). A finding that the merger may substantially lessen competition in any relevant market is therefore sufficient to enjoin the merger. As the Supreme Court has explained, "[b]ecause § 7 of the Clayton Act prohibits any merger which may substantially lessen competition 'in *any* line of commerce,' it is necessary to examine the effects of a merger in each such economically significant submarket to determine if there is a reasonable probability that the merger will substantially lessen competition. If such a probability is found to exist, the merger is proscribed." *Brown Shoe*, 370 U.S. at 325 (emphasis in original).

22. The legality of a proposed merger under Section 7 does not turn on the relative size of the market or markets in which the transaction is likely to lessen competition. Courts have found markets with relatively few consumers to be "economically significant." *See, e.g.*, *Brown Shoe*, 370 U.S. at 337-39 (holding that district court appropriately found relevant geographic markets included cities with 10,000 people or more); *United States v. Phillipsburg Nat'l Bank & Trust Co.*, 399 U.S. 350, 362-65 (1970) (district court erred in defining relevant market in bank merger case to be larger than immediate Phillipsburg-Easton area).

23. Legality also does not depend on the size of the market where harm is likely relative to the size of the overall transaction. As explained in the legislative history to the 1950 amendments to the Clayton Act: "It is intended that acquisitions which substantially lessen competition, as well as those which tend to create a monopoly, will be unlawful if they have the specified effect in any line of commerce, whether or not that line of commerce is a large part of the business of any of the corporations involved in the acquisition." S. REP. 81-1775 at 5 (1950); *see also* 4A PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 972a (4th ed. 2016) (The Clayton Act "plainly contemplates that mergers may involve more than one market, yet it bases legality on a separate market-by-market appraisal. This is corroborated by the legislative history, and the courts have consistently so held.") (citations omitted).

IV. THE PROPOSED MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF INDIVIDUAL MEDICARE ADVANTAGE PLANS IN THE COMPLAINT COUNTIES

A. Factual Background

1. Original Medicare, Medical Supplemental Plans, and Prescription Drug Plans

24. Congress created the Medicare program in 1965 "[t]o provide a hospital insurance program for the aged . . . with a supplementary medical benefits program and an expanded program of medical assistance." Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 286 (1965). Medicare is administered by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS). Tr. 1114:16-25, 1115:10-23 (Cavanaugh); PX0551 (Nevo Report) ¶ 29.

25. Medicare Part A generally covers inpatient hospital care, and Part B generally covers physician and outpatient care. Tr. 101:20-102:11, 103:14-104:3 (Frank). Parts A and B together are called Original (or Traditional) Medicare. Tr. 103:2-8 (Frank); PX0551 (Nevo Report) ¶ 29;

PX0006 at -980 to -982.

26. Original Medicare operates on a fee-for-service basis. Tr. 103:2-8 (Frank). Providers are paid for their services according to fee schedules established by CMS. *See* Tr. 1115:15-23 (Cavanaugh); DX0131-012, -016. Original Medicare enrollees can obtain medical care, without a referral, from any doctor or hospital in the United States that accepts Medicare. Tr. 1118:12-21, 1133:17-25 (Cavanaugh); Tr. 104:20-105:25 (Frank); PX0553 (Frank Report) ¶ 19.

27. Almost all physicians and hospitals accept Medicare. PX0551 (Nevo Report) ¶ 44 (2013 survey found that less than 1% of physicians providing patient care had formally opted out of Medicare; 2015 survey found that 93% of non-pediatric primary care physicians accept Medicare). Seniors with Original Medicare therefore do not need to be concerned about having access to a particular provider, geographic restrictions on where they can obtain care within the United States, or whether their access to their current physicians will change from year to year. PX0551 (Nevo Report) ¶ 44.

28. Original Medicare can impose high cost-sharing burdens on enrollees. Tr. 1117:19-21 (Cavanaugh); DX0543-010. While there is no monthly premium for Part A coverage, seniors must pay a $1,288 deductible for each benefit period under Medicare Part A. PX0551 (Nevo Report) ¶ 45. Seniors pay a Part B premium, which in 2016 is set at $104.90 per month for most seniors. PX0551 (Nevo Report) ¶ 43; Tr. 1066:10-19 (Fitzgerald) (amount varies by income and is different for newly entering seniors). In addition, Part B has a 20% coinsurance rate for most physician services and physician-administered drugs like chemotherapy. Tr. 102:5-11, 103:21-104:3 (Frank); PX0553 (Frank Report) ¶ 18; PX0551 (Nevo Report) ¶ 45; PX0006 at -990. Original Medicare does not cover outpatient prescription drug costs. Tr. 110:4-9 (Frank); PX0551 (Nevo Report) ¶ 45.

29. Original Medicare also does not cap total out-of-pocket expenses for seniors. Tr. 104:4-10 (Frank) ("so it is not catastrophic insurance"); Tr. 492:19-493:2 (Wheatley). Research has shown that out-of-pocket medical expenses for seniors covered only under Original Medicare can be significant. Tr. 105:8-13 (Frank). Expensive treatments, such as cancer therapies, can be "a serious burden" for Original Medicare enrollees, especially if they are on a fixed income. Tr. 105:3-16 (Frank); Tr. 493:20-494:5 (Wheatley).

30. To reduce the cost sharing obligations of Original Medicare, seniors can buy supplemental plans known as MedSupp (or Medigap) from private insurers. Tr. 1193:21-1194:3 (Cavanaugh). MedSupp plans are regulated products sold in standardized forms set by statute. Tr. 1194:1-3 (Cavanaugh); Tr. 106:2-10 (Frank); PX0551 (Nevo Report) ¶ 47. MedSupp plans help cover the deductibles, copayments, and other cost-sharing requirements of Parts A and B coverage, and provide catastrophic coverage, but they do not cover fitness, dental, vision, or hearing benefits. Tr. 105:17-106:1 (Frank); Tr. 668:15-18 (Wooldridge). They also cannot provide prescription drug coverage, as that is available under Medicare Part D. Tr. 105:23-106:1 (Frank); Tr. 428:17-23 (Cocozza); PX0519 at 83, 95.

31. When an individual turns 65, he or she "ages in" or becomes eligible for Medicare. 42 U.S.C. § 1395c; Tr. 408:1-7 (Frank). During the six months after aging-in to Medicare, an individual is eligible for guaranteed MedSupp coverage. Tr. 106:11-17 (Frank); Tr. 688:23-689:2 (Wooldridge); PX0551 (Nevo Report) ¶ 49.

32. Seniors enrolled in Original Medicare can purchase prescription drug coverage through a Part D plan. Like MedSupp plans, Part D plans are provided by private insurers and the benefits they offer are subject to regulation. PX0551 (Nevo Report) ¶¶ 50-51. Standalone Part D plans must provide, at a minimum, actuarially equivalent benefits to a CMS-mandated

standard plan, which, in 2016, required seniors to pay an annual deductible of $360 and a share of prescription drug costs above the deductible. PX0551 (Nevo Report) ¶ 51. Monthly premiums for Part D plans vary greatly by geography, ranging in 2016 from $11.40 for a plan in Arkansas to $174.70 for a plan in Florida. PX0551 (Nevo Report) ¶ 52; PX0553 (Frank) ¶ 22 (2016 average premium for a part D plan is $39 per month).

2. Medicare Advantage Was Created to Bring the Benefits of Competition among Private Companies to Medicare Enrollees

33. In 1997, Congress created Medicare Part C, which permits seniors to opt out of Original Medicare and obtain government-subsidized health insurance through private insurers. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275 (1997). In 2003, Congress revised Part C and renamed it Medicare Advantage. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, §§ 201-223, 117 Stat. 2066, 2176 (2003). The MMA also established Part D, the prescription drug coverage program discussed above. MMA §§ 101-111.

34. Competition among MA insurers is integral to the MA program's success. Congress intended MA to be a "competitive program" that "encourage[s] beneficiaries to enroll in the most efficient plan, producing savings both for beneficiaries, through reduced premiums, and for taxpayers, through relatively lower Medicare costs." H.R. REP. NO. 108-391, 525 (2003) (Conf. Rep.). The MA program was designed to "[u]se open season competition among MA plans to improve service, improve benefits, invest in preventive care, and hold costs down in ways that attract enrollees." Establishment of the Medicare Advantage Program (Final Rule), 70 Fed. Reg. 4588, 4589 (Jan. 28, 2005) (Establishment of MA Program). "Over time, participating plans will

be under continued competitive pressure to improve their benefits, reduce their premiums and cost sharing, and improve their networks and services, in order to gain or retain enrollees."[3] *Id.*

35. In a recent report to Congress, CMS continued to highlight the importance of competition among MA insurers to the legislative and regulatory scheme, observing that "Congress and other policymakers have attempted to . . . promote competition among MAOs [Medicare Advantage Organizations]." Ctrs. for Medicare & Medicaid Servs., *Report to Congress: Alternative Payment Models & Medicare Advantage* 8 (2016) (MA Report), *available at* https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/Report-to-Congress-APMs-and-Medicare-Advantage.pdf. As CMS explained, "competition among participating insurers," along with capitated payments and emphasis on care coordination, "intrinsically incentivizes MAOs to create cost efficiencies without compromising the quality of care furnished to their beneficiaries." *Id.* at 43.[4]

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[3] *See also* Establishment of Medicare Program, 70 Fed. Reg. at 4671 ("the MMA contemplated competition between [MA] plans so that beneficiaries will have greater choice of high-quality, low-cost regional and local plans"); Tr. 98:5-14 (Frank) ("Medicare Advantage relies on competition among private insurers to promote efficient coverage for [beneficiaries]"); Tr. 1126:18-1127:12 (Cavanaugh) (under the MA program, competition among private insurers is "the primary mechanism to drive value").

[4] The MA Report demonstrates that CMS has expressed a consistent view on legislative and regulatory intent. Such "legislative facts" do not require judicial notice. *See* Fed. R. Evid. 201(a) advisory committee's note to 1972 proposed rules ("Legislative facts . . . are those which have relevance to legal reasoning and the lawmaking process, whether in the formulation of a legal principle or ruling by a judge or court or in the enactment of a legislative body."). Alternatively, the Court should take judicial notice of the MA Report. As a report produced for Congress, *see* Medicare Access and Chip Reauthorization Act of 2015, Pub. L. No. 114-10, § 101(z)(6), 129 Stat. 87, 123 (2015), the MA Report "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned," *see* Fed. R. Evid. 201(b)(2); *see also, e.g.*, *Pharm. Research & Mfrs. of Am. v. U.S. Dep't of Health & Human Servs.*, 43 F. Supp. 3d 28, 33 (D.D.C. 2014) ("Courts in this jurisdiction have frequently taken judicial notice of information posted on official public websites of government agencies.").

3. Key Attributes of MA Plans

36. MA plans differ from other Medicare options for seniors in many important respects, both as a result of the MA program parameters established by Congress and CMS and because competition among MA insurers drives further differentiation. Within the regulatory bounds of the MA program, MA insurers decide what plans they want to bring to market in terms of benefits and prices. Humana's CEO, Mr. Broussard, succinctly described some of the differences between MA and Original Medicare options in a slide in a 2014 presentation entitled, "Medicare Advantage, Better benefits, lower costs." DX0480-006; *see also* PX0551 (Nevo Report) ¶ 106, Ex. 7.

37. All MA plans must include Parts A and B coverage. Tr. 107:12-13 (Frank); 42 U.S.C. § 1395w-22(d)(4)(A), *as amended by* 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016). Unlike Original Medicare, most MA plans (89%) also include prescription drug plans; 96% of seniors enrolled in an MA plan receive prescription drug coverage through their plan. PX0551 (Nevo Report) ¶ 55; Tr. 2062:8-11 (Kauffmann). Although not required, most MA plans include other additional benefits such as gym memberships, dental, vision, and hearing coverage. Tr. 107:21-25 (Frank); PX0551 (Nevo Report) ¶¶ 55-56; DX0480-007.

38. Another important distinction between MA plans and Original Medicare is that all MA plans must cap annual out-of-pocket spending for enrollees at $6,700 or less. Tr. 107:13-17 (Frank); 42 C.F.R. § 422.100(f)(4), § 422.101(d)(2). In practice, competition drives most MA plans to offer a cap below the $6,700 statutory maximum. Tr. 107:15-17 (Frank); PX0551 (Nevo Report) ¶ 54. In addition, compared to Original Medicare, MA plans typically offer more limited deductibles, with fixed copays or lower coinsurance. PX0553 (Frank Report) ¶ 35.

39. MA plan premiums are set by the insurer. 42 C.F.R. § 422.252 (defining MA monthly basic beneficiary premium). MA plans that charge no premium in addition to the Part B premium

are known as $0 premium plans. In 2016, nearly half of individual MA plan members were enrolled in $0 premium plans, up slightly from 2015. PX0348 at 7. As Mr. Bertolini testified, "the competitive benchmark is zero premium." Tr. 1336:5-20 (Bertolini).

40. A senior usually cannot "replicate" MA coverage by purchasing Original Medicare, even with a MedSupp and Part D plan. Tr. 110:19-111:4 (Frank); Tr. 284:7-21 (Cocozza). Seniors cannot obtain fitness, dental, vision, hearing, or other supplemental coverage through Original Medicare, MedSupp, or Part D plans. Tr. 110:24-111:4 (Frank); PX0519 at 16, 81.

41. While seniors can obtain Parts A and B coverage through Original Medicare, prescription drug coverage with a Part D plan, and limit their out-of-pocket costs by purchasing a MedSupp plan, to obtain coverage with an out-of-pocket limit and comparable actuarial value to a typical MA plan they would have to spend, on average, twice as much on premiums. PX0554 (Frank Reply Report) ¶ 26, Ex. 4 (estimating a $284 average monthly premium for coverage from Original Medicare, MedSupp, and a Part D plan, and $142 for comparable MA plan coverage). Much of the cost difference between MA and the other options comes from the premium on the MedSupp plan that would be needed to fill in Original Medicare's cost-sharing gaps. Tr. 111:12-112:7 (Frank); *see also* Tr. 670:20-671:10 (Wooldridge) (average premium for most common MedSupp plans is about $150 per month); PX0348 at 1 (MA enrollees pay an average premium of $37 per month).

42. MA also can simplify management of health care expenses for seniors because all coverage is provided by a single plan. Tr. 499:22-25 (Wheatley); DX0111-015 ("All you need with Medicare Advantage is one card."); Tr. 2060:21-25 (Kauffmann).

43. MA plans are sold by private insurance companies such as Aetna and Humana, whereas Original Medicare is provided directly by the government. PX0551 (Nevo Report) ¶ 31;

DX0131-023; PX0519 at 17. For MA enrollees, this allows them to choose plans offered by insurers with which they are familiar and whose brands they trust. Tr. 290:2-7 (Cocozza); PX0523 at -561 ("Brand is overarching consideration. Brands get into the consideration set based on familiarity and reputation (past experience, friends & family)."); DX0490-012 (depicting "Decision Tree" for "Medicare Age-Ins" starting with question "What brands will I consider?"); *see also* Tr. 1057:6-21 (Gonzalez).

44. MA also differs from Original Medicare in that it does not rely on a fee-for-service model. Instead, CMS pays the MA insurer a fixed per-member, per-month fee (known as the capitation payment) for each MA enrollee, regardless of the enrollee's actual medical costs. Tr. 121:18-21 (Frank). As Congress intended, this creates an incentive for the insurer to reduce medical expenses because the MA insurer is "not paid more for doing more." Tr. 121:22-122:8 (Frank); DX0097-003 ("Because Medicare pays private plans a per-person capitation rate, rather than a per-service rate, MA plans have a greater incentive to innovate and use care-management techniques."); *see also* Tr. 1117:11-1118:2 (Cavanaugh).

45. MA plans are almost always managed care programs, either health maintenance organizations (HMO) or preferred provider organizations (PPO). PX0551 (Nevo Report) ¶ 57; Tr. 108:4-21 (Frank); PX0006 at -998 to -000. MA plans typically limit an enrollee's ability to be reimbursed for medical care received from outside a specific network of providers with which the MA plan has negotiated contracts. PX0551 (Nevo Report) ¶¶ 57-58. HMOs generally require that the primary care physician act as a gatekeeper to manage a patient's care and refer the patient to specialists as needed. Tr. 273:4-14 (Cocozza); PX0303 at 13; DX0506-041; PX0551 (Nevo Report) ¶ 58. Seniors in HMOs are not reimbursed for non-emergency, out-of-network care. Tr. 272:23-273:3 (Cocozza). PPOs often do not require a referral for specialists, and they

reimburse enrollees for out-of-network care, but at a lower rate or for fewer services relative to in-network care. Tr. 272:12-22 (Cocozza); PX0303 at 13.

46. Because MA plans are managed care plans, they help insurers control medical expenses and manage quality better than Original Medicare. PX0551 (Nevo Report) ¶ 57; Tr. 108:1-15 (Frank). Managed care plans also are better than Original Medicare at managing long-term health care needs and coordinating care among providers. Tr. 1870:24-1871:19 (Broussard); Tr. 432:20-24 (Cocozza); DX0506-013 (Humana's "clinical programs have demonstrated a strong ability to manage costs and improve health outcomes relative to Original Medicare programs.").

47. While Original Medicare and MedSupp enrollees can obtain medical care from almost any provider in the United States, MA enrollees have limited choices of providers if they want to maximize reimbursement for their medical expenses. For seniors, the difference in provider networks between Original Medicare and MA plans is an important distinction. Tr. 421:6-17 (Cocozza); Tr. 1072:1-1073:1 (Fitzgerald); DX0490-012.

4. MA Competition Provides Seniors with High Quality Plans at Reasonable Prices and Maintains Sustainable Program Costs

48. The benefits and costs associated with any particular MA plan depend in large part on the plan's capitation payment from CMS. The capitation payment is determined by the relationship between the "benchmark" for the county where the plan is offered and the "bid" that the insurer submits to CMS for the plan. Tr. 122:9-123:10 (Frank). Each year, CMS announces the benchmark for every county in the United States based on the average cost for Original Medicare to provide Part A and B benefits to enrollees in that county in the prior year. Tr. 446:15-22 (Cocozza); PX0553 (Frank Report) ¶ 27; PX0551 (Nevo Report) ¶ 64; DX0360-002. The benchmark is the maximum that CMS will pay an insurer for an MA enrollee in the county

(not counting the potential stars bonus discussed *infra* at ¶ 52). PX0553 (Frank Report) ¶ 27.

49. After CMS publishes the county benchmarks, insurers submit bids to CMS for each of their MA plans. Tr. 1910:25-1911:12 (Paprocki); PX0551 (Nevo Report) ¶ 64. If the insurer's bid for the plan is above the benchmark, CMS pays the insurer the benchmark, and the insurer must charge enrollees a Part C premium for the entire difference; however, if the bid is below the benchmark, CMS pays the insurer the bid plus a "rebate" that is a portion of the difference between the bid and the benchmark. Tr. 122:9-123:8 (Frank); PX0553 (Frank Report) ¶¶ 28, 29; PX0551 (Nevo Report) ¶ 64; DX0131-023 to -024.

50. Since 2012, the amount of the capitation payment has depended on the MA plan's "star rating." PX0551 (Nevo Report) ¶ 68. CMS assigns star ratings to MA insurer contracts based on quality measures such as clinical outcomes and customer satisfaction. Tr. 125:6-16 (Frank); PX0551 (Nevo Report) ¶ 68. The contracts cover groups of the same type of MA plan (e.g., HMO or PPO) offered by the same MA insurer, and all plans within the same contract receive the same star rating. PX0551 (Nevo Report) ¶ 68. Ratings vary in half point increments from 1 (the lowest) to 5 (the highest). PX0553 (Frank Report) ¶ 31; Tr. 299:18-22 (Cocozza); DX0360-003 to -005. Plans rated 4 stars or higher receive a bonus that effectively raises the benchmark 5% for those plans. Tr. 125:17-22 (Frank); Tr. 299:23-300:9 (Cocozza); PX0553 (Frank Report) ¶ 32.

51. Rebates also vary according to star ratings, with plans rated 3 stars or less receiving a 50% rebate (i.e., half of the difference between the bid and the benchmark). The rebate is 65% for 3.5 or 4 stars, and 70% for 4.5 or 5 stars. PX0553 (Frank Report) ¶ 32. MA insurers must use the rebates to pay down the standard Part B premium, reduce the MA plan's cost sharing requirements, or provide additional benefits such as vision or hearing coverage. Tr. 122:19-123:3

(Frank); Tr. 300:15-24 (Cocozza); PX0553 (Frank Report) ¶ 30.

52. Star ratings are important to the competitiveness of MA plans. Because CMS pays more per enrollee to higher rated plans, plans with higher star ratings can offer seniors better benefits at a lower premium. Tr. 539:11-20 (Wheatley); Tr. 125:17-126:3 (Frank); PX0008 at -329 ("Aetna's star ratings are helping us to maintain our $0 premium" and "valuable supplemental benefits"). The quality bonus associated with receiving a 4-plus star rating can equate to a $35 per member per month difference in what a plan offers. Tr. 540:13-541:7 (Wheatley) ("If I lose star ratings on a plan where I had high star ratings before, that will absolutely impact my ability to keep premiums and benefits stable."). Star ratings also can be meaningful to seniors when selecting a plan. Tr. 1342:7-19 (Bertolini) ("[a]ll other things being equal," seniors will choose a plan with higher star ratings); PX0531 at -046 (noting that "[c]ontinued Star Ratings excellence" is "believed to drive purchasing behavior and retention").

53. MA plans also need to make the most of the payments they receive from CMS to compete effectively. One way they do this is through value-based contracts with providers. Tr. 345:25-347:1, 422:7-15 (Cocozza) (value-based contracts "drive more efficiency and better outcomes, and we take those savings and we make a better value proposition for beneficiaries"); DX0506-055 ("As MA reimbursement rates fall, [value-based] programs will be one of the primary drivers of our ability to profitably serve members."). Value-based contracts typically incentivize providers to coordinate care and reduce costs by tying a portion of their compensation to quality-of-care and patient-outcome measures. Tr. 549:6-15 (Wheatley); Tr. 1838:16-1839:10 (Broussard); Tr. 342:25-343:17 (Cocozza); Tr. 1252:20-1253:7 (Burns); PX0303 at 21 ("Some physicians may have arrangements [with Humana] under which they can earn bonuses when certain target goals relating to the provision of quality patient care are met.").

54. Competition drives insurers to offer a variety of plans—with different combinations of benefits and prices—to appeal to different seniors' preferences. "Competition and beneficiary choice is supposed to be the primary mechanism to drive value." Tr. 1127:4-9 (Cavanaugh).

55. Bidding below the benchmark allows insurers to make their plans more attractive without increasing premiums. PX0551 (Nevo Report) ¶¶ 64, 65. In 2016, 94% of MA enrollees were in plans that bid below the benchmark and received a rebate. PX0551 (Nevo Report) ¶ 67. Most insurers use the rebate to pay for additional benefits such as fitness, dental, vision, and hearing coverage. Tr. 122:19-123:3 (Frank); PX0059 at -162 (listing common benefits insurer may add with rebate revenue); *see also* PX0551 (Nevo Report) ¶¶ 65, 66.

56. This competition is important to a large number of seniors. Today, there are approximately 57 million people in the United States eligible for Medicare. PX0348 at 2. According to Professor Nevo's analysis, the portion of seniors with individual Medicare coverage enrolled in MA plans has increased from 37.8% in 2011 to 44.4% in 2016. PX0551 (Nevo Report) ¶ 38, Ex. 2. In 2015, 11.5 million seniors were enrolled in individual MA plans; 8.9 million were enrolled in Original Medicare with MedSupp; and 6 million were enrolled in Original Medicare only.[5] PX0551 (Nevo Report) ¶¶ 35-36, Ex. 1; Tr. 1578:23-1579:17 (Nevo).

57. When competition drives insurers to bid below the benchmark, it also lowers overall costs to taxpayers. The portion of the difference between the benchmark and the bid that is not paid to the insurer as a rebate reduces MA program costs and represents taxpayer savings. Tr.

[5] These figures exclude eligibility-restricted Medicare options such as Special Needs Plans (SNP), Original Medicare with Medicaid (also referred to as MMP or "dual-eligible" plans), Dual-eligible Special Needs Plans (D-SNP), Group MA, and Original Medicare supplemented by employer-sponsored coverage, which together represented slightly more than half of all Medicare enrollees in 2015. Tr. 1575:18-1578:20 (Nevo); PX0551 (Nevo Report) ¶¶ 35-36, Ex. 1. *See also infra* ¶ 112.

122:19-123:3, 124:4-12 (Frank); Tr. 1967:12-23 (Paprocki); PX0553 (Frank Report) ¶ 29.

B. The Sale of Medicare Advantage Plans in Each of the Complaint Counties Constitutes a Relevant Antitrust Market

58. The sale of individual MA plans in each of the 364 Complaint counties constitutes a relevant antitrust market. Defendants do not dispute that counties are relevant geographic markets, but they contend that the relevant product market should include not only MA but also Original Medicare and other Medicare options. The record establishes, however, that Original Medicare, with or without MedSupp or Part D plans, is not reasonably interchangeable with MA plans and, therefore, that the markets for the sale of individual MA plans in the 364 Complaint counties are the proper focus for analyzing the likely effects of the proposed merger.

1. Applicable Legal Standards

59. Relevant markets are defined by "reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it." *Brown Shoe*, 370 U.S. at 325. Market definition is an inquiry into "'whether two products can be used for the same purpose, and if so, whether and to what extent purchasers are willing to substitute one for the other.'" *Arch Coal*, 329 F. Supp. 2d at 119 (citation omitted). Relevant markets have two dimensions: product and geographic area. *Id.*; U.S. Dep't of Justice and FTC, Horizontal Merger Guidelines § 4 (2010) (Merger Guidelines).[6]

60. Market definition thus "focuses solely on demand substitution factors, i.e., on customers' ability and willingness to substitute away from one product to another in response to

[6] Courts frequently rely on the Merger Guidelines when determining the legality of mergers under Section 7. The Merger Guidelines are not binding on the Court, but "courts in antitrust cases often look to them as persuasive authority." *H&R Block*, 833 F. Supp. 2d 36, 52 n.10 (D.D.C. 2011); *see also Heinz*, 246 F.3d at 718 (relying on Merger Guidelines); *FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1036-38 (D.C. Cir. 2008) (Brown, J.) (same).

a price increase or a corresponding non-price change such as a reduction in product quality or service." Merger Guidelines § 4; *see also United States v. H&R Block, Inc.*, 833 F. Supp. 2d 36, 51 (D.D.C. 2011) (in defining the relevant product market "courts look at 'whether two products can be used for the same purpose, and, if so, whether and to what extent purchasers are willing to substitute one for the other'") (quoting *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1074 (D.D.C. 1997) (*Staples I*)); *Arch Coal*, 329 F. Supp. 2d at 119 (same).

61. Courts look to two types of evidence in defining the product market: "the 'practical indicia' set forth by the Supreme Court in *Brown Shoe* and testimony from experts in the field of economics." *Sysco*, 113 F. Supp. 3d at 27.

62. In *Brown Shoe*, the Supreme Court explained that the contours of a product market can be determined by examining such factors as "industry or public recognition of the [relevant market] as a separate economic entity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors." 370 U.S. at 325. Courts in this circuit "routinely rely" on these factors as a "useful analytical tool" in defining the product market. *FTC v. Staples, Inc.*, No. 15-2115 (EGS), 2016 WL 2899222, at *9 n.11 (D.D.C. May 17, 2016) (*Staples II*); *see also, e.g.*, *Sysco*, 113 F. Supp. 3d at 27-33; *H&R Block*, 833 F. Supp. 2d at 51-60. But the *Brown Shoe* factors are not "criteria to be rigidly applied," and courts "have found that submarkets can exist even if only some of these factors are present." *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 159 (D.D.C. 2000).

63. Courts also give substantial weight to economic analysis in defining markets. *See, e.g., Arch Coal*, 329 F. Supp. 2d at 120-23. Expert economists normally apply the "hypothetical monopolist test" set out in the Merger Guidelines. The hypothetical monopolist test asks whether

a profit-maximizing monopolist of all products within a proposed market likely would apply a "small but significant and non-transitory increase in price" (known as a SSNIP) on at least one product sold by the merging firms. Merger Guidelines § 4.1. If a hypothetical monopolist would impose a SSNIP, the proposed market is a relevant antitrust market. If a hypothetical monopolist would not impose a SSNIP because the price increase or quality decrease would cause too many buyers to substitute to products outside the proposed market such that the price increase would not be profit-maximizing, the proposed relevant market is too narrowly defined. *See generally* Merger Guidelines § 4.1; *Sysco*, 113 F. Supp. 3d at 33-34; *H&R Block*, 833 F. Supp. 2d at 51-52.

64. Professor Nevo explained that the hypothetical monopolist will lose some sales as it increases price and demand falls, but it will "make higher profits on . . . the sales" it retains, and "the hypothetical monopolist tries to balance these two effects, and you can compute those, which one is greater, to decide whether it would like to increase the price or not." Tr. 1608:8-1609:6 (Nevo); *see also* PX0551 (Nevo Report) ¶ 77 (hypothetical monopolist test, "when properly applied, ensures that the defined market is neither too broad nor too narrow").

65. Both the *Brown Shoe* factors and economic analysis are tools to answer the same question: whether a product outside the proposed relevant market is "reasonably interchangeable" with the products within the proposed market. Reasonable interchangeability turns on whether a price increase in the proposed market likely would "drive consumers to an alternative product" such that "that product must be reasonably substitutable for those in the proposed market and must therefore be part of the market, properly defined." *FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1038 (D.C. Cir. 2008) (Brown, J.); *see also H&R Block*, 833 F. Supp. 2d at 55 ("key question" for court is whether products outside the proposed market "are sufficiently close substitutes to constrain any anticompetitive [] pricing" on products within

the proposed market).

66. "[P]roperly defined antitrust markets often exclude some substitutes to which some customers might turn in the face of a price increase even if such substitutes provide alternatives for those customers." Merger Guidelines § 4.0. As the Supreme Court has explained, "[f]or every product, substitutes exist. But a relevant market cannot meaningfully encompass [an] infinite range [of products]. The circle must be drawn narrowly to exclude any other product to which, within reasonable variations in price, only a limited number of buyers will turn." *Times-Picayune Publ'g Co. v. United States*, 345 U.S. 594, 612 n.31 (1953).

67. Applying these principles, courts draw an important distinction between functional interchangeability and reasonable interchangeability. "Finding two products to be functionally interchangeable . . . does not end the analysis." *Swedish Match*, 131 F. Supp. 2d at 158; *see also, e.g.*, *Staples I*, 970 F. Supp. at 1074 (two products that are "similar in character or use" may be deemed functionally interchangeable, but "functional interchangeability should not end the Court's analysis"). The Court also must determine whether the products are "reasonably interchangeable," which "depends not only on the ease and speed with which customers can substitute it and the desirability of doing so, but also on the cost of substitution." *Whole Foods*, 548 F.3d at 1037 (Brown, J.) (internal citations omitted).

68. Courts define relevant markets to exclude functionally interchangeable products when the record shows that those products are not close enough substitutes to the products in the proposed relevant market to prevent a hypothetical monopolist of the products in the proposed market from imposing a price increase. In *H&R Block*, for example, the court found that the relevant market was limited to digital do-it-yourself tax preparation even though it was "beyond debate" that "[a]ll tax preparation methods provide taxpayers with a means to perform the task of

completing a tax return" and "are, to some degree, in competition." 833 F. Supp. 2d at 54; *see also Swedish Match*, 131 F. Supp. 2d at 157-165 (finding loose leaf tobacco and moist snuff to be functionally interchangeable but not in same relevant market); *Sysco*, 113 F. Supp. 3d at 26 ("the fact that buyers may cross-shop between modes of food distribution does not necessarily make them part of the same market for the purpose of merger analysis."); *FTC v. Coca-Cola Co.*, 641 F. Supp. 1128, 1133 (D.D.C. 1986) (holding relevant market for purposes of analyzing a merger between Coca-Cola and Dr. Pepper was limited to carbonated soft drinks "even though it is true that other beverages quench thirst"), *vacated as moot*, 829 F.2d 191 (D.C. Cir. 1987); *United States. v. Visa U.S.A. Inc.*, 163 F. Supp. 2d 322, 338 (S.D.N.Y. 2001) (holding that cash and checks should not be included in same relevant market as general purpose credit cards because, even though cash and checks "compete with general purpose cards as an option for payment by consumers and that growth in payments via cards takes share from cash and checks in some instances, cash and checks do not drive many of the means of competition in the general purpose card market"), *aff'd*, 344 F.3d 229 (2d Cir. 2003).

69. Market definition is, at core, a "matter of business reality." *Coca-Cola*, 641 F. Supp. at 1132; *see also Sysco*, 113 F. Supp. 3d at 48; *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, *342 (3d Cir. 2016) (relevant market must reflect "commercial realities of the specific industry involved"). Because of this focus on the business realities of the products and industry involved, "[w]hen determining the relevant product market, courts often pay close attention to the defendants' ordinary course of business documents." *H&R Block*, 833 F. Supp. 2d at 52. "[E]vidence of "'industry or public recognition of the submarket as a separate economic' unit matters because we assume that economic actors usually have accurate perceptions of economic realities.'" *Whole Foods*, 548 F.3d at 1045 (Tatel, J.) (citation omitted).

70. Other than the observation in *Omni Healthcare Inc. v. Health First, Inc.*, No. 6:13-cv-1509-Orl-37DAB, 2016 WL 4272164, at *19 (M.D. Fla. Aug. 13, 2016), that "Medicare Advantage is a product independent of Medicare," Plaintiffs are not aware of any court decision addressing whether MA is in a separate product market from Original Medicare. In particular, none of the cases cited by Defendants for the proposition that courts "have recognized that Medicare Advantage is simply a species of Medicare" address relevant antitrust markets or otherwise support Defendants' market definition contentions here. Defs. Pretrial Br. at 11 n.9.[7] Indeed, in one of Defendants' cases, the court distinguished Medicare Parts A and B from MA in holding that an MA insurer was not an agency or instrumentality of the government within the meaning of the Federal Tort Claims Act. *See Zanecki v. Health All. Plan of Detroit*, No. 12-13234, 2013 WL 2626717, at *12-14, *17 (E.D. Mich. June 11, 2013) (noting MA insurer "bears the risk of making a mistake" regarding a benefit decision), *aff'd*, 577 F. App'x 394 (6th Cir. 2014).

2. Individual Complaint Counties Are Relevant Geographic Markets

71. Individual counties are separate geographic markets for purposes of analyzing the effect of the proposed merger on the sale of individual MA plans. Seniors may enroll only in individual MA plans offered in their county of residence. PX0551 (Nevo Report) ¶ 88; Tr. 393:25-394:10 (Cocozza); 42 C.F.R. § 422.50(a)(3). Competition among MA insurers is focused

[7] *See also Exley v. Burwell*, No. 3:14-cv-1230, 2015 WL 3649632, at *1 (D. Conn. June 10, 2015) (addressing procedures for administrative review of benefit denials); *Walkwell Int'l Labs. v. Nordian Admin. Servs., LLC*, No. 1:13-cv-0199, 2014 WL 174948, at * 1 (D. Idaho Jan. 13, 2014) (addressing whether plaintiff stated valid Administrative Procedure Act and tort claims relating to coverage denials); *United HealthCare Ins. Co. v. Sebelius*, 774 F. Supp. 2d 1014, 1019 (D. Minn. 2011) (addressing whether MA insurer should have compensated a beneficiary for a certain procedure).

at the county level. Tr. 2075:17-18 (Follmer) ("This is a very county-specific business."); Tr. 443:7-25 (Cocozza); PX0045 at -196 ("the competitiveness of our value propositions vary by the counties we are offered in"). Insurers monitor their competitors' activities on a county-by-county basis and set pricing and other plan attributes accordingly. PX0219; *see generally* PX0551 (Nevo Report) ¶¶ 93-94 & n.133.

72. Defendants agree that individual counties are relevant geographic markets. DX0419 (Orszag Report) ¶ 112; Defs. Pretrial Br. at 10 n.6.

3. Medicare Advantage Is a Separate Product Market

73. MA is a distinct product from Original Medicare, or Original Medicare supplemented with MedSupp and Part D plans. MA offers seniors, in a single plan, health insurance, prescription drug coverage, and supplemental benefits, all for a lower average premium. In return, seniors give up some flexibility in their choice of medical providers. Highlighting these differences, Defendants organize, manage, and operate their MA businesses separately from their MedSupp and Part D businesses. MA also attracts different customers than other Medicare products, and the evidence shows that those customers rarely switch to other Medicare options, even when faced with a price increase. This factual record, along with economic analysis conducted by Plaintiffs' expert, Professor Aviv Nevo of the Wharton School of Business and Department of Economics at the University of Pennsylvania, together show that MA constitutes a separate product market under the applicable Section 7 standards.

a. Medicare Advantage Is Not Reasonably Interchangeable with Original Medicare under *Brown Shoe*

74. The conclusion that the sale of individual MA plans is a relevant product market is supported by the *Brown Shoe* factors, which show that MA is not reasonably interchangeable with Original Medicare or other forms of health insurance available to seniors.

i. Industry Recognition of MA as a Distinct Product

75. Defendants' documents and business practices show that MA is distinct from Original Medicare options. Aetna and Humana both report MA results separately in their annual reports. PX0303 at 13, 60; PX0503 at 13. Alan Wheatley, Humana's President of Medicare, explained that investors want the company to report its MA business performance separately from its other Medicare products "[b]ecause that's how they think about it[,] . . . comparing organizations that they evaluate . . . across and against each other." Tr. 482:8-15 (Wheatley). Nancy Cocozza, Aetna's president of Medicare, testified that MedSupp is "a different product than Medicare Advantage," and one that Aetna regards as a "separate line of business" from MA. Tr. 260:6-9, 257:14-18 (Cocozza).

76. Other major health insurers also view MA as distinct from Original Medicare options. [redacted] PX0070 at -626. [redacted] PX0494. [redacted] PX0369 at -610, -615, -619 to -625, -684 to -695.

ii. MA's Characteristics and Uses

77. MA plans are structured differently than Original Medicare, MedSupp, and Part D plans. In the words of one Aetna MedSupp executive, MA and MedSupp are "apples and oranges." PX0021 at -017. Most MA plans allow seniors to obtain Medicare Parts A and B, a cap on out-of-pocket costs, and prescription drug coverage all within a single plan. PX0303 at 14. MA plans also often offer supplemental benefits such as dental insurance, vision insurance, hearing aids, and gym memberships to "differentiate [their MA plans] and to provide members

additional value." PX0046 at -283; Tr. 1124:20-25 (Cavanaugh); Tr. 1026:9-13 (Gonzalez).

78. Original Medicare and MedSupp plans allow seniors to obtain care from any provider willing to accept Medicare rates, whereas MA enrollees have less flexibility in their choice of provider. *See supra* ¶¶ 27, 45, 47. Seniors who have a strong preference for Original Medicare because they want to be able to choose their own providers would not view Original Medicare and MA as reasonable substitutes. *See* Tr. 104:20-105:2 (Frank); PX0523 at -561 ("Monthly premium and choice of doctors usually top the list" of criteria consumers use to select an MA plan.).

iii. Defendants Manage Their MA Businesses Separately

79. Defendants operate their MA and MedSupp businesses separately because of the inherent differences in the two types of plans. MA plans are local in nature because they are constructed around networks of health care providers. Tr. 1859:9-15 (Broussard); Tr. 254:3-23 (Cocozza); Tr. 542:13-543:10 (Wheatley). MA plans also typically offer a variety of supplemental benefits to be determined by the insurer. *See supra* ¶ 77. In contrast, MedSupp plans offer standardized benefits set by statute and are typically priced and sold at the state level. Tr. 427:19-428:4 (Cocozza).

80. Aetna's MA business has its own dedicated team of over 3,000 employees, unique market assessment models, and separate business platforms. Tr. 261:9-18, 266:1-7, 267:18-24, 255:7-22 (Cocozza). Aetna has a separate team of 400 people that run its MedSupp business at the national level, and it uses a different, and simpler, IT platform for MedSupp than for its MA business. Tr. 255:23-256:6, 254:3-257:8 (Cocozza); Tr. 682:3-13 (Wooldridge). Ms. Cocozza testified that MedSupp is a "different business" from MA, one that "doesn't have all the care coordination or network features [that MA has] associated with it." Tr. 255:3-6 (Cocozza).

81. Humana also has "separate business units" for MA and MedSupp, Tr. 475:19-21,

477:6-8 (Wheatley), and has always kept the management of its MA business separate from its MedSupp and Part D businesses, Tr. 478:1-16 (Wheatley).

82. Aetna has separate groups of actuaries (who construct plan prices) for its MA and MedSupp businesses. Tr. 680:13-16 (Wooldridge); Tr. 1995:6-18 (Paprocki). In pricing its MedSupp products, Aetna does not consider the price of MA plans in the same area. Tr. 257:23-258:2 (Cocozza). Tyree Wooldridge, the head of Aetna's MedSupp product group, testified that he does not (i) participate in setting the prices of Aetna's MA plans, (ii) know how MA prices are set, or (iii) review data on average MA plan prices. Tr. 678:10-679:3 (Wooldridge). Humana sets different target profit margins for MA and MedSupp. Tr. 571:11-14 (Wheatley).

83. The differences between MA and Original Medicare are also reflected in their administration at CMS. One team at CMS administers Original Medicare while a different team is responsible for overseeing private health plans, including MA under Part C and prescription drug coverage under Part D. Tr. 1115:14-23 (Cavanaugh). Each component has "really distinct responsibilities," and "[t]heir duties really don't overlap." Tr. 1116:4-12 (Cavanaugh).

iv. MA Appeals to Different Customers

84. When seniors turn 65, they are asked to choose between different government-subsidized health coverage options. 42 U.S.C. § 1395w-21, *as amended by* 21st Century Cures Act; PX0519 at 16. While this is an individual choice, seniors who choose MA over other options tend to exhibit different characteristics than those who select Original Medicare alone or Original Medicare supplemented with MedSupp and Part D plans. *See, e.g.*, Tr. 112:8-25 (Frank) (research shows MA appeals to people "with different characteristics and different proclivities"); DX0297-009 (Aetna document noting that, "[f]or the most part, the typical Med Supp customer is different than an MA customer"). As Aetna's Mr. Wooldridge explained, "Medicare Supplement and Medicare Advantage [] appeal to different kinds of things. And so any given

senior is going to choose one way or the other because of their individual circumstances." Tr. 716:11-14 (Wooldridge); *see also* Tr. 2064:18-23 (Kauffmann).

85. MA enrollees generally are more focused on lowering their health care expenditures than are MedSupp enrollees. PX0011 at -895 [redacted]; Tr. 1341:9-12 (Bertolini) (seniors who buy MA tend on average to be lower income than the population as a whole); Tr. 112:14-18 (Frank) (seniors with lower income and education levels disproportionately enroll in MA plans); Tr. 1024:19-1025:8 (Gonzalez) (in San Antonio, where 65% of seniors are considered low-income, 90% of his clients choose MA); PX0553 (Frank Report) ¶ 43. Residents of urban areas, where provider networks tend to be better developed, also disproportionately enroll in MA plans. Tr. 112:19-20 (Frank).

86. While MA plans tend to attract seniors concerned about health care costs, Original Medicare enrollees are more likely to value provider choice. *See* Tr. 716:2-9 (Wooldridge). And, given the higher costs associated with Original Medicare and supplemental plans, seniors enrolling in MedSupp typically have higher income levels than MA enrollees. PX0045 at -196 (low MA penetration indicates "higher income eligibles in the area who are more inclined to have Med Supp policies versus MA plans"). Sales of MedSupp plans also tend to be "more skewed toward smaller towns and rural areas." Tr. 714:22-23 (Wooldridge); PX0025 at -920.

87. Defendants strive to have a portfolio of health insurance products—including MA plans, MedSupp plans, and Part D plans—because different products appeal to different seniors. *See* Tr. 406:13-21 (Cocozza) (Aetna maintains multiple Medicare-related business lines to create a portfolio from which seniors can choose); Tr. 2077:5-11 (Follmer) (Aetna agents sell both MedSupp and MA plans so that "they're offering a portfolio of products and they want to make

sure they are selling one that meets the senior's needs"); Tr. 2077:17-2078:8 (Follmer) (describing the benefit, at sales meetings, of understanding the seniors' circumstances so as to tailor the presentation to their needs). Defendants recognize that choosing between Original Medicare and MA is a "very personal choice . . . [a]nd so our job is to make available again a whole range, a whole portfolio of product options for these beneficiaries because their choice will depend on their circumstances and their preferences." Tr. 431:7-15 (Cocozza). Ms. Cocozza explained that if Aetna tries "to force-fit a product that's not what [the senior is] looking for, they're not going to stay and they're not going to have a good experience." Tr. 436:2-437:2 (Cocozza). A 2013 Humana strategy document discussing whether Humana should expand its MedSupp business states that "by limiting our MedSupp presence we effectively remove ourselves from competition for relationships [with] a significant share of the senior population for whom MedSupp offers a superior value proposition." DX0506-044.

88. Brokers also consider MA and MedSupp to be separate products, and they offer both types of plans to meet the needs of customers who prefer one over the other. *See* Tr. 1023:24-1024:8 (Gonzalez) (for many seniors, affordability of monthly premium quickly determines which of the two they will choose); Tr. 1071:11-20 (Fitzgerald) (Atlanta Medicare broker shows clients a page with both options and they gravitate to one or the other); *see also* Tr. 1092:6-19 (Fitzgerald) (broker's book of business is split evenly between MA and MedSupp depending on the beneficiary's individual situation). As one broker explained, "[t]here's seniors that prefer a Medicare Supplement plan, and there are seniors that prefer a Medicare Advantage plan. We want to offer them either product that they like." Fincher Dep. 73:10-74:3; *see also* Tr. 1073:18-1074:1 (Fitzgerald) (broker has never compared a particular MA plan against a particular MedSupp plan for a client).

v. MA Provides Better Benefits at Lower Prices Than Other Options

89. MA plans use a different pricing structure than Original Medicare. As discussed above, Original Medicare requires that seniors pay a significant portion of their health care costs and does not cap out-of-pocket costs. Tr. 1064:21-1065:11, 1066:22-1067:2 (Fitzgerald); *supra* ¶¶ 28-29. The risk of financial exposure is significant to seniors. Tr. 1019:24-1020:9 (Gonzalez) ("So if they've got a million [dollars] in bills, they are going to pay 20 percent of that."); Tr. 1067:4-10 (Fitzgerald). MA plans typically provide more comprehensive coverage than Original Medicare at little or no additional premium and with a cap on out-of-pocket expenses. DX0480-006; Tr. 1070:11-1071:10 (Fitzgerald); PX0072 at -796 to -797; *supra* ¶¶ 38-39.

90. MA plans are also priced differently than Original Medicare supplemented with MedSupp and Part D plans. Seniors usually need to pay substantially more for MedSupp and Part D plans to match the benefits provided by a typical MA plan (in terms of both coverage and out-of-pocket costs). Tr. 503:17-19 (Wheatley); Tr. 2061:6-9 (Kauffmann) (Humana tells seniors that MA plans have lower out-of-pocket costs); *supra* ¶ 41.

91. The monthly premium is usually one of the most important criteria seniors use to select an MA plan. PX0523 at -561. For many seniors on fixed incomes, MedSupp and Part D plans are unaffordable and not "an option." Tr. 1023:24-1024:15 (Gonzalez); *see also* Tr. 2045:15-17 (Kauffmann). Mr. Gonzalez, a San Antonio broker, explained that one of the first topics he discusses with seniors shopping for Medicare coverage is the monthly premium, because he needs "to determine if a Medicare supplement is an option for them or if it's just Medicare Advantage." Tr.1022:17-1023:11 (Gonzalez).

vi. MA Enrollees Are Unlikely to Switch to Other Options When Faced with a Price Increase

92. Seniors who choose MA over other Medicare options tend to exhibit durable

preferences for MA. PX0554 (Frank Report) ¶¶ 16-17; Tr. 1094:24-1095:1 (Fitzgerald) (once a senior selects MA or Original Medicare with supplements, "they are kind of there for the rest of the trip"); Tr. 1076:1-6 (Fitzgerald) (it is "not really common" for broker's customers to switch from MA to MedSupp); DX0506-014 (Humana's MA retention rate in 2013 was approximately 90%). MA plans have certain attributes that seniors value, such as supplemental benefits and low premiums, and when seniors disenroll from an MA plan, they tend to switch to another MA plan because that plan has the same valuable attributes. Tr. 338:19-339:8 (Cocozza).

93. Seniors' preferences for MA can have different sources. *See* Tr. 491:5-499:25 (Wheatley) (discussing various reasons why seniors choose MA plans). Some seniors might prefer having a single health plan for all of their coverage. Tr. 497:11-499:25 (Wheatley) (simplicity of dealing with one insurance company for all coverage is a benefit of MA plans). Other seniors want to have low or zero monthly premiums and reasonable caps on out-of-pocket costs. *See* Tr. 279:19-280:13 (Cocozza); 2080:4-2081:15 (Follmer) (maximum out of pocket protection is one of the "big value propositions" of MA and is "very important" for seniors). Still other seniors might be "drawn to plans that are more familiar to them based on their history" of being enrolled in managed care plans. Tr. 164:9-12 (Frank); *see also* Tr. 433:15-19 (Cocozza) (seniors accustomed "in their working life" to receiving health care "through an HMO or a PPO" are likely to "be more comfortable choosing a private [MA] plan"); PX0062 at 4 (Mr. Broussard commenting that MA will continue to grow because "demographic changes will continue to favor a more plan-centric approach as opposed to fee-for-service, because that's what they're coming out of, they're coming out of a planned approach"); DX0095 (noting "growing familiarity of managed care among younger beneficiaries").

94. Some seniors may be unable to switch to a MedSupp plan after the initial enrollment

period even if they wanted to, because they would be denied coverage or face higher premiums due to preexisting medical conditions. Tr. 1075:22-25 (Fitzgerald); Tr. 116:25-117:3 (Frank).

95. These durable preferences are reflected in MA switching data. Most MA enrollees do not switch plans from year-to-year. Tr. 113:16-114:10 (Frank) (78% stay in the same plan); DX0123-009 (only 21% of MA enrollees switch out of their MA plan annually). When MA enrollees do switch plans, the vast majority choose another MA plan. Tr. 115:2-16 (Frank) (consistently between 80% and 85% of switchers choose another MA plan); *see also* Tr. 1076:1-6 (Fitzgerald); PX0515 at -334. Each year, only 2% of MA enrollees switch to Original Medicare with or without supplementation. Tr. 114:6-7 (Frank). Mr. Wheatley testified that "historically we've seen on average the majority [of members that leave a Humana MA plan] move to another Medicare Advantage plan versus back to original Medicare." Tr. 526:11-17 (Wheatley).

96. Similarly, when MedSupp and Part D plan enrollees switch plans, they also tend to choose another MedSupp or Part D plan. Tr. 529:1-7 (Wheatley); PX0033 at -299 (less than 1% of Humana prescription drug plan members converted to MA during 2012 enrollment period); PX0062 at 3.

97. Even when MA enrollees were required to change plans (e.g., when their MA plan was canceled), and they therefore could enroll in a MedSupp plan without undergoing medical underwriting, they still "overwhelmingly returned to Medicare Advantage." Tr. 116:2-6 (Frank); PX0554 (Frank Rebuttal Report) ¶ 31 (between 83% and 95% of MA enrollees whose plans were terminated switched to another MA plan). Mr. Gonzalez testified that when Humana discontinued an MA plan in Guadalupe County, Texas, of the 200 members in the canceled plan that he placed into new plans, 186 to 188 of them selected another MA plan. Tr. 1033:9-1035:10 (Gonzalez); *see also* Tr. 1077:17-1080:14 (Fitzgerald) (90% of broker's clients remained in MA

despite gaining guaranteed issue rights following plan exits). Both Aetna and Humana have picked up members in their MA plans from competitors when the competitors either increased the premium on their MA plan or discontinued ("plexed") that plan in a county. Tr. 793:16-21 (Farley); Tr. 317:3-17 (Cocozza); PX0461 at -118, -119 (listing competitors' increased premiums or decreased benefits as advantages).

98. The same switching behavior holds true when seniors change plans in response to an increase in the price of their MA plan. Industry studies have found that seniors switching plans in the face of a significant premium increase "almost universally" switch to another MA plan. Tr. 114:19-115:1 (Frank) (about 97% of switchers go to another MA plan in response to a $20 or more a month price increase in their MA premium); *see also* PX0554 (Frank Rebuttal Report) ¶ 32. Aetna, for example, has gained customers when other MA insurers increased prices or reduced benefits. Tr. 317:18-318:2, 321:18-322:21 (Cocozza).

99. In 2014, Humana commissioned a study by Burke, a leading survey research firm, to learn more about what drives disenrollment from Humana's MA plans. PX0015. The results of this study indicate that most seniors who leave their current MA plan because of a price increase switch to another MA plan. Specifically, the study found that 85% of seniors leaving a Humana MA plan switched to another MA plan. PX0015 at -879. Only 13% of departing members switched to some form of Original Medicare (with or without a MedSupp or Part D plan). PX0015 at -879. Cost-related issues were the most common reasons seniors gave for switching. PX0015 at -856 to -857. The study concluded that "[c]osts play a huge role in MAPD members defecting." PX0015 at -853, -877.

100. Plaintiffs' expert, Dr. Gary Ford, a professor of marketing and an expert on the subject of survey research, methodology, and analysis, reviewed the disenrollment study and

found that it was reliable and supported the conclusions that (1) 85% of Humana MA plan disenrollees switched to another MA plan rather than some form of Original Medicare and (2) the top reasons given for switching all related to cost. Tr. 929:25-930:12 (Ford). He also found, based on his review of Humana documents and third party information, that "low and medium risk" members (the subject of the disenrollment study) constitute about 80% of Humana's MA plan membership. Tr. 917:23-918:3 (Ford). Among the survey respondents who said that a change in their 2014 Humana plan caused them to switch to another MA plan, 83.6% mentioned cost as a reason for switching. PX0556 (Ford Rebuttal Report) ¶ 24.

101. Plaintiffs' expert economist, Professor Aviv Nevo, also analyzed MA switching data. As discussed below, the switching data support his conclusion that individual MA is a relevant antitrust product market.

b. Defendants' MA Businesses Focus Almost Exclusively on Competition with Other MA Insurers

102. Consistent with the *Brown Shoe* factors discussed above, the record shows that the competitive focus of Defendants' MA businesses is almost entirely on other MA plans, not on Original Medicare options.

103. For example, Aetna creates annual strategic planning documents that it uses in formulating its MA bids, including its Individual Medicare Advantage Prescription Drug Plans "Bid Pricing Review." *See, e.g.*, PX0046 (Apr. 2016 Bid Pricing Review); PX0039 (Apr. 2015 Bid Pricing Review). These documents incorporate input from Aetna's local operations and are used by senior management in strategic decision-making relating to the MA plans. Tr. 371:8-372:3 (Cocozza). These strategic planning documents overwhelmingly refer to competition with other MA plans and not Original Medicare or MedSupp. *See, e.g.*, PX0046 at -300 to -320; Tr. 374:18-375:5, 375:16-376:8 (Cocozza) (Aetna "[a]bsolutely" uses the "competitive

intelligence" in PX0046 "coming up from the general managers" in "putting together [its] bid for [its] Medicare Advantage plans"); *see also* PX0066 (2017 Bid Pricing Review); PX0036 (Apr. 2016 Medicare Deep Dive); PX0154 (Mar. 2015 Medicare Deep Dive); PX0602 (Feb. 2014 Medicare Deep Dive); PX0381 (May 2014 Bid Pricing Review); Tr. 241:12-243:19, 307:7-308:8, 312:9-313:10 (Cocozza).

104. In March 2015, when Ms. Cocozza thought she might miss a strategic planning meeting with Aetna's executive committee, she drafted talking points for her staff to convey at the meeting. PX0007. These talking points exclusively discuss competition with other MA plans, including Humana ("#1 in growth and is our most formidable competitor"), United ("[w]e continue to pick up share from UHC"), Cigna ("a worthy competitor in markets where we overlap"), and Anthem ("lagging in stars and is scattered-lacking momentum"). PX0007 at -847. MedSupp is not mentioned and Part D plans (PDP) have a standalone section that does not discuss competition with MA. PX0007.

105. In general, the great weight of Defendants' ordinary course planning documents reflects that the competitive focus of their individual MA businesses is almost exclusively on other MA insurers and not on Original Medicare options.[8] Defendants' executives' testimony

[8] *See, e.g.*, PX0027 at -229 (Aetna describing Humana as "our primary MA competitor"); PX0026 at -418 (Aetna planning document describing Miami as "extremely competitive MA market where Aetna and Humana have >50% market share" and describing Atlanta as a "large MA market" where Aetna is "#2 in market (after Humana)"); PX0012 (Humana focusing on Aetna and Cigna); PX0022 at -602 (Humana describing Kansas City as "mature market dominated by Aetna & Humana"); PX0035 at -802 (Humana calling "Aetna main competitor followed by United" in Kansas City); PX0039 at -692 (Aetna referring to Humana and United Healthcare as first and second in market shares in Florida); PX0047 at -274 to -277 (Aetna reviewing the "Medicare Individual Competitive landscape" in Ohio and Kentucky including Anthem, Humana, UHC, HealthSpan, and MMO); PX0058 (Aetna reviewing its HMO and PPO plans against competitors and focusing exclusively on MA insurers such as United, Humana,

(continued on next page)

confirms that competition with other MA insurers is their principal focus. *See, e.g.*, Tr. 763:18-764:15; 803:22-804:3, 812:18-813:1 (Farley); Tr. 239:3-7, 246:2-247:13, 257:23-260:2, 265:16-19 (Cocozza).

106. Aetna and Humana routinely calculate market shares in the MA markets. *See, e.g.*, Tr. 238:22-239:7, 263:10-16 (Cocozza); Tr. 475:2-5 (Wheatley); PX0009 at -938; PX0036 at - 429; PX0583 at -210. Defendants did not present at trial any ordinary course market share calculations in which Aetna or Humana looked at their share of a market including Original Medicare options. At most, Defendants reference an "MA penetration rate," which represents the overall percentage of Medicare-eligible seniors enrolled in MA plans, including eligibility-restricted plans. This "penetration rate" does not break out the shares of the many different, separate products it compasses (i.e., shares of individual MA, Original Medicare-only, MedSupp, Part D plans) or individual insurers' shares.

107. Mirroring the MA-only focus of their MA businesses, Defendants monitor their MedSupp plans by comparing them to other MedSupp plans, not MA. Tr. 672:1-6 (Wooldridge)

Cigna, and BCBS); PX0155 at -454, -460 (Humana, BCBSNC, United, Aetna, and Cigna "major competitors"); PX0023 (comparing Humana, Aetna, and United Healthcare MA plans); PX0479 at -682 (comparing premium changes for Humana, United, and Aetna); PX0449 at -435 (same); DX0283-003 (competitive analysis showing only Humana, United, Cigna, and Anthem); PX0053 at -964 ("Our largest competitor is Humana"); PX0057 at -718 (email asking Aetna general managers to fill in key benefit plan designs for competing Humana, Cigna, and United MA plans); PX0063 at -446 (email to Humana CEO discussing performance of Aetna, United, Cigna, and Anthem MA plans); PX0071 at -10 ("Aetna and Humana are #1 and #2 in the market"); PX0073 at-765 ("Our MA HMO growth has been flat for the past three years. This is primarily due to Aetna (Coventry) offering a $0 premium LPPO and HMO with rich benefits, against our $25 premium."); PX0074 at -001 ("Aetna is expanding their HMO footprint . . . [and] we are at risk of losing 1,500 members to Aetna"); PX0397 at -647 ("Humana will be our most serious threat in the near future"); PX0446 at -723 (Humana document noting that "Aetna is expanding and will be offering a $0 premium PPO" in a number of Ohio counties), at -725 ("Most concerned about Aetna" in Virginia).

(MedSupp prices are set to compete with other MedSupp plans), Tr. 675:15-22 ("it's very important" for Aetna to know how its MedSupp plans "compare with other MedSupp plans"). They also track their market share by including only MedSupp plans. Tr. 663:1-5 (Wooldridge); PX0423 at -813; PX0605 at -562 to -649.

108. To facilitate comparisons across competitors' MA plans, Humana worked with a data consulting firm, Milliman, to develop the Medicare Advantage Competitive Value Added Tool (MACVAT). Tr. 515:18-23 (Wheatley). Many MA insurers now use MACVAT to compare the actuarial or benefits value of their MA plans relative "to all the other Medicare Advantage organizations to [get] a sense for competition and benefit values across the landscape of whatever market you have." Tr. 516:2-9 (Wheatley); PX0064 (Ms. Cocozza directing her staff to use MACVAT to compare Coventry's plan to Humana's in San Antonio to determine what "cost concession it will take to compete"). Defendants argue that, while one purpose of the MACVAT tool is to compare MA plans to each other, its other key purpose is to compare MA plans to Original Medicare. However, the MACVAT tool incorporates Original Medicare only as a benchmark or "comparator." Tr. 1865:5-17 (Broussard). It does not allow any comparisons to be made between MA plans and any of Original Medicare's supplemental products. Tr. 1866:23-1867:3 (Broussard); *see also* Tr. 669:11-17 (Wooldridge) (Aetna's head of MedSupp does not know what MACVAT is). If Defendants are right that combinations of those supplemental products—rather than Original Medicare by itself—are competitive alternatives to MA, the MACVAT tool cannot be used to draw the comparison.

109. One of the few—and perhaps the only—examples in the record of Aetna or Humana designing one of their MA plans to compete against MedSupp products is when Aetna created an MA plan in Georgia with very low cost-sharing. Tr. 2094:9-2095:3 (Follmer). Aetna called this

their "Med Supp killer" plan. Tr. 2094:17-19 (Follmer); DX0035-002. Despite being designed to target seniors with Original Medicare options, Aetna's "Med Supp killer" plan has not been successful. It has low membership and a medical loss ratio of 99.4%. Tr. 2095:6-2097:8 (Follmer). Although the plan is still available, Aetna has stopped paying broker commissions and is no longer actively selling the plan in any way. Tr. 2097:9-2098:1 (Follmer). The fact that Aetna designed this plan expressly to compete with MedSupp products implies that Aetna's other MA plans are *not* designed that way. Furthermore, the failure of the "Med Supp killer" plan is evidence that there are very few customers on the margin between MA and MedSupp. Seniors who are attracted to MedSupp plans will enroll in those plans; seniors attracted to MA plans will enroll in MA plans. Aetna's experience in Georgia shows that few consumers are interested in an MA plan that tries to look like a MedSupp plan.

110. Mr. Orszag suggested at trial that there are a comparable number of ordinary course documents referring to MA competing with Original Medicare options as there are documents showing that MA insurers focus almost solely on competition with other MA insurers. *See* Tr. 3048:10-24 (Orszag). Yet he referred only to two specific documents (and cited just a handful more in his report). Isolated statements pulled from a small number of documents cannot change the fact that the evidence taken as a whole establishes that Original Medicare options are not significant drivers of competition for MA insurers.

c. Economic Evidence Establishes that MA is a Relevant Product Market

i. Professor Nevo's Analyses Show that Individual MA Plans Are in a Separate Product Market from Original Medicare Options

111. Professor Nevo concluded that MA plans sold to individuals constitute a relevant product market in which to analyze the effects of the proposed merger in the Complaint counties.

112. Professor Nevo began his product market analysis by identifying the products that are available to all seniors: Original Medicare, with and without supplements, and individual MA plans. Tr. 1575:18-1576:20, 1579:8-17 (Nevo). He excluded eligibility-restricted Medicare options because they are not available to seniors in the event of a small price increase. Tr. 1576:10-17 (Nevo); *see also supra* ¶ 56 n.5. Mr. Orszag agrees that excluding eligibility-restricted Medicare options is appropriate. Tr. 3041:15-21 (Orszag).

113. Next, Professor Nevo considered four complementary sources of evidence to identify a candidate product market. *First*, his review of industry evidence, including party documents and testimony, showed that "Medicare Advantage is very different . . . in some of its attributes" than Original Medicare options. Tr. 1580:7-9 (Nevo). As a result of its unique mix of attributes, "MA appeals to a different set of seniors. . . . Some are willing to accept the tradeoffs, and some not." Tr. 1583:3-8 (Nevo). He further found that these differences in preferences among seniors are reflected in the behavior of insurers: Defendants "price their MA plans separately from the Medigap and the . . . various supplemental insurance options." Tr. 1586:19-1587:1 (Nevo). This is significant because "a firm tends to price products that are close substitutes . . . jointly when they compete with each other." Tr. 1587:2-5 (Nevo).

114. *Second*, Professor Nevo analyzed CMS data to study "actual switching by actual consumers." Tr. 1587:20-22 (Nevo). His analysis of these data led him to two conclusions: (1) seniors who leave an MA plan "are mostly going to switch to another MA plan," and (2) "MA appeals to a different set of consumers" than Original Medicare options. Tr. 1588:1-11 (Nevo).

115. Professor Nevo considered three types of CMS data on consumer switching. Each of these data sets showed that "at least 85 percent of consumers switch to another MA plan when

they leave their current MA plan." Tr. 1592:16-18 (Nevo); PX0551 (Nevo Report) ¶ 136, Ex. 8; PX0552 (Nevo Rebuttal Report) ¶ 58, Ex. 7. One of the three data sets concerned seniors whose plans were canceled in 2015. Tr. 1590:19-22 (Nevo). These seniors are of particular interest because their circumstances closely approximate the circumstances confronted by seniors when they first become eligible for Medicare coverage (i.e., when they age in) in that enrollees in a canceled MA plan (1) can switch to MedSupp without having to go through underwriting and (2) are automatically enrolled in Original Medicare and have to affirmatively switch back to MA if they wish to choose another MA plan. Tr. 1590:19-1591:12 (Nevo). Thus, seniors whose plans are canceled face decisions and constraints that are closer to those faced by age-ins than is true for switchers in general. Tr. 1591:9-12 (Nevo). Professor Nevo found that seniors choose another MA plan when their plan is canceled as frequently as do other switchers. Tr. 1591:13-16 (Nevo).

116. Professor Nevo's review of evidence drawn from party documents, survey data, and a Kaiser Family Foundation study led him to conclude that the principal reason seniors switch is price. Tr. 1593:18-1594:9 (Nevo); PX0551 (Nevo Report) ¶ 142. This is important because "for the purpose of market definition, what we want is . . . to see switching in response to price changes because . . . we really want to study" how consumers substitute in response to price increases. Tr. 1593:20-1594:1 (Nevo).

117. *Third*, Professor Nevo reviewed empirical studies examining how millions of actual seniors make choices for Medicare coverage. Tr. 1594:16-1595:24 (Nevo). All of the studies tested whether MA products form a distinct "nest," and all found that seniors do indeed see MA plans as better substitutes for each other than are other Medicare options. PX0551 (Nevo Report) ¶ 150.

118. *Fourth*, Professor Nevo conducted an independent empirical analysis of demand for

MA plans using a "nested logit model." Tr. 1602:12-19 (Nevo). Economists use nested logit models to estimate demand in situations in which consumers may have a distinct preference for a group, or "nest," of choices. PX0551 (Nevo Report) ¶ 148 & n.214. Professor Nevo's model evaluates the choices of both existing and new (i.e., age-in) Medicare enrollees. Tr. 1603:16-21, 1604:9-15 (Nevo). His nested logit model includes all MA plans in one "nest," while Original Medicare, including all of its supplemental options, forms the outside-the-nest option. Tr. 1595:25-1596:23 (Nevo). The model then estimates demand for plans within one group (MA), versus all Original Medicare options outside the nest, in response to a price increase on an MA plan. PX0551 (Nevo Report) ¶ 149.

119. Professor Nevo's demand estimation results from his nested logit model showed that "many seniors have a distinct preference for MA plans as a group." Tr. 1602:4-9 (Nevo). Using his model's demand estimates, Professor Nevo then calculated aggregate diversion ratios (i.e., the percentage of seniors who respond to a price increase on a particular MA plan by staying in the candidate product market). PX0551 (Nevo Report) ¶ 164. Professor Nevo's results predict that 70% of those seniors who leave an MA plan in response to a price increase would move to another MA plan. Tr.1605:1-3 (Nevo). This is close to, but lower than, the roughly 85% observed in the CMS switching data discussed above, which indicates that Professor Nevo's estimates are conservative. Tr. 1605:9-12 (Nevo). This diversion rate also is consistent with market realities and the relevant academic literature, which all show that seniors have a distinct preference for MA plans as a group. Tr. 1601:24-1602:19 (Nevo); PX0551 (Nevo Report) ¶ 151.

120. Mr. Orszag's demand estimates, on the other hand, imply that only 50% of seniors leaving an MA plan because of a price increase will choose another MA plan, which is significantly lower substitution than the 85% seen in the CMS switching data.

See Tr. 1605:13-19 (Nevo); PX0552 (Nevo Rebuttal Report) ¶ 58, Ex. 7. But even Mr. Orszag's demand estimates—like those of Professor Nevo—show that a significant group of seniors have a distinct preference for MA plans. Tr. 1602:4-9 (Nevo); Tr. 3313:3-17 (Orszag).

121. Following the Merger Guidelines, Professor Nevo used the foregoing analyses to identify individual MA plans as a candidate market. Tr. 1609:9-16 (Nevo). He then applied several formulations of the hypothetical monopolist test—including using both a 5% and a 10% SSNIP—to determine whether individual MA plans constitute a separate product market. Tr. 1609:17-23, 1612:10-15 (Nevo). All of his formulations of the test showed that a hypothetical profit-maximizing monopolist would impose a SSNIP in each of the Complaint counties. Tr. 1609:24-1612:15, 1613:20-1614:18, 1617:22-1618:8 (Nevo).

122. Professor Nevo's results support the conclusion "that MA plans constitute a relevant antitrust product market." Tr. 1610:16-21 (Nevo). These results are consistent with the documentary evidence, the switching data, the results found by academics who have researched senior preferences, and the predictions made by Professor Nevo's nested logit model. Tr. 1618:13-1619:9 (Nevo).

123. Having performed the Merger Guidelines' prescribed hypothetical monopolist test in multiple ways (including using the demand estimates of Dr. Curto, an academic whose work was favored by Mr. Orszag)—all of which passed the hypothetical monopolist test—Professor Nevo also performed the test using Mr. Orszag's demand estimates. Tr. 1612:16-20 (Nevo). He found that his candidate market of individual MA plans passed the hypothetical monopolist test in almost all of the Complaint counties. Tr. 1612:21-1613:13, 1618:9-12 (Nevo).

124. Based on these various analyses, Professor Nevo correctly concluded that individual MA plans constitute a relevant antitrust product market.

ii. Defendants' Criticisms of Professor Nevo's Analysis and Conclusions Are Misplaced

125. Defendants make five direct or indirect criticisms of Professor Nevo's application of the hypothetical monopolist test.

126. *First*, Mr. Orszag purports to perform a hypothetical monopolist test of his own that leads to a different conclusion. Tr. 3062:16-23 (Orszag). His test is based upon an analysis that finds that an increase in MA concentration has no effect on MA premiums. Tr. 3060:23-3061:24 (Orszag). This leads him to conclude that MA plans are too narrow a relevant product market because concentration within a county could increase all the way to monopoly without premiums increasing. Tr. 3229:24-3230:9 (Orszag).

127. The analysis that Mr. Orszag uses as the basis of his purported hypothetical monopolist test is flawed. Tr. 3508:25-3511:5 (Nevo). Mr. Orszag's regression is not a proper hypothetical monopolist test because it is not focused on consumer behavior, but is instead an indirect firm-focused test that purports to measure competitor responses to concentration, despite clear guidance from the Merger Guidelines that "[m]arket definition focuses solely on demand substitution factors." Merger Guidelines § 4; *see also* Tr. 3046:11-12 ("Because market definition is inherently a demand-side question"), 3247:22-3248:10 (Orszag). The Guidelines also provide that the hypothetical monopolist is the "only present and future seller" (i.e., it is not threatened by actual or potential entry) of the relevant product, Merger Guidelines § 4.1.1, and yet Mr. Orszag's test includes supply-side factors such as potential entry, *see* Tr. 3230:1-9 (Orszag). Furthermore, Mr. Orszag's citation to the Guidelines as support for his price-concentration test is misplaced. While the Merger Guidelines may state that "evidence that a reduction in the number of significant rivals offering a group of products causes prices for those products to rise significantly can itself establish that those products form a relevant market,"

Merger Guidelines § 4, there is no logical corollary that markets can be defined by evidence that prices fail to rise in response to a decrease in rivals, Tr. 3597:14-3598:15 (Nevo).

128. Mr. Orszag's regression itself is also flawed. His price-concentration regression analysis focuses entirely on the "price of actual individual plans," Tr. 3192:17-21 (Orszag), and how those prices change over time in response to competition, but ignores the possibility that an insurer may respond to competition from its rivals by introducing new plans or segmenting existing plans, Tr. 3513:5-23 (Nevo). Through the use of plan fixed effects, Mr. Orszag's regression does not allow for the makeup of plans in the county to change. He therefore misses changes in effective prices that occur when insurers introduce new plans in response to competition. So, for example, if competition causes the introduction of a new $0 premium plan (or plan segment) in a county, *see, e.g.*, PX0035 at -806 to -808; PX0379 at -689; PX0497 at -606; DX0313-005 to -007, -021, Mr. Orszag's model will show that the prices of plans in that county remain the same even though a new lower price option causes overall prices to drop, Tr. 3513:16-23 (Nevo); PX0552 (Nevo Rebuttal Report) ¶¶ 63-70. When Professor Nevo adjusts Mr. Orszag's analysis to account for this weakness and others, he finds that MA premiums in fact do increase with MA concentration. Tr. 3512:10-12 (Nevo).

129. Mr. Orszag therefore failed to conduct a proper hypothetical monopolist test. His results do not call into question the results of Professor Nevo's hypothetical monopolist tests.

130. *Second*, Mr. Orszag argues that the relevant product market must include some "flavors of Original Medicare" through the application of his "circle principle," purportedly derived from Example 6 in the Merger Guidelines. *See* Tr. 3253:6-3254:12 (Orszag); Merger Guidelines § 4.1.1. Mr. Orszag's appeal to Example 6 relies on his factual assumption that "there must be a number of examples where diversions to some flavors of Original Medicare

exceed diversion ratios between certain Medicare Advantage products," because of the existence of small MA plans. DX0418 (Orszag Rebuttal Report) ¶ 83. Mr. Orszag, however, does not provide any actual evidence of diversion to any such Original Medicare "flavor." Nor does he explain how Example 6—which speaks in terms of diversion to a "Product C"—requires that *all* Original Medicare products be included in the relevant product market because there "must be" higher diversion to *some* Original Medicare options "than some MA option." Tr. 3254:5-6 (Orszag); *see H&R Block*, 833 F. Supp 2d at 65-66 (rejecting defendants' expert's misapplication of Example 6).

131. Courts must define antitrust markets "in a common-sense way." Tr. 3498:20-23, 3627:16-20 (Nevo). As Professor Nevo illustrated, some beer consumers may opt for wine before they opt for certain craft beers, but that does not mean that all wine must be in the same relevant antitrust market as beer. Tr. 3497:9-3498:8 (Nevo). Here, small MA plans play the role of craft beer and Original Medicare is the wine. Tr. 3567:21-3569:19 (Nevo). As Professor Nevo explained, it is possible that small MA plans could have been excluded from a relevant product market, but their inclusion does not undercut the conclusion that MA plans pass the hypothetical monopolist test. Tr. 3569:1-19 (Nevo).

132. Mr. Orszag's misapplication of Example 6 in the Merger Guidelines fails to take into account the guidance that immediately follows it in the Guidelines:

> The hypothetical monopolist test ensures that markets are not defined too narrowly, but it does not lead to a single relevant market. The Agencies may evaluate a merger ***in any relevant market satisfying the test***, guided by the overarching principle that the purpose of defining the market and measuring market shares is to illuminate the evaluation of competitive effects. Because the relative competitive significance of more distant substitutes is apt to be overstated by their share of sales, when the Agencies rely on market shares and concentration, they usually do so in the smallest relevant market satisfying the hypothetical monopolist test.

Merger Guidelines § 4.1.1 (emphasis added). Mr. Orszag also ignores Example 5. Tr. 3499:24-

3500:9 (Nevo). Two products can satisfy the hypothetical monopolist test even if diversion to other products outside the relevant market rises to two-thirds of lost sales. Merger Guidelines § 4.1.1. Here, Professor Nevo found that diversion to Original Medicare from Aetna was about 30% and from Humana about 35%, Tr. 3501:10-14 (Nevo)—far below the two-thirds threshold in Example 5.

133. Mr. Orszag's misplaced reliance on Example 6 also is inconsistent with the case law. The Supreme Court explained in *Times-Picayune* that the relevant market "must be drawn narrowly to exclude any other product to which, within reasonable variations in price, only a limited number of buyers will turn." 345 U.S. at 612 n.31; *see also Arch Coal*, 329 F. Supp. 2d at 120 (discussing "narrowest market" principle). If the relevant market is too broadly defined, "consumers will be harmed because the likely anticompetitive effects of [the merger] will be understated." *FTC v. Advocate Health Care Network*, 841 F.3d 460, 472 (7th Cir. 2016). Professor Nevo followed sensible and appropriate market definition principles: he identified a logical candidate market (MA plans) and then he tested that candidate market with multiple versions of the hypothetical monopolist test, all leading to the conclusion that MA plans constitute a relevant product market.

134. *Third*, Defendants assert that the "mark-up" or margins that Professor Nevo's merger simulations and demand estimates imply are too high and neither track financial margins earned in the industry nor comport with CMS regulations relating to MA insurer margins and medical loss ratios. Tr. 3176:17-24 (Orszag).

135. Professor Nevo's conclusion that individual MA plans pass the hypothetical monopolist test in all Complaint counties does not depend, however, on the margins implied by the demand estimates. As discussed above, he ran his merger simulation using Mr. Orszag's

eight preferred demand estimates, and his merger simulation predicted significant price increases for each of these estimates as well. PX0552 (Nevo Rebuttal Report) ¶ 84, Ex. 12. The hypothetical monopolist test is passed in the vast majority of counties under all of Mr. Orszag's demand estimates, including two sets of estimates from Mr. Orszag with implied margins that are very close (10.8% and 12.4%) to the 11% average variable profit Mr. Orszag claims the parties observe. PX0552 (Nevo Rebuttal Report) ¶ 39, Ex. 2, ¶ 41, Ex. 3; Tr. 3177:8-10 (Orszag).

136. Moreover, Defendants' critique of Professor Nevo's implied economic margins as inconsistent with actual margins and CMS requirements ignores the well-established principle that accounting margins do not necessarily reflect economic margins. *See* 2B PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 516f1 (4th ed. 2016); Franklin M. Fisher & John J. McGowan, *On the Misuse of Accounting Rates of Return to Infer Monopoly Profits*, 73 Am. Econ. Rev. 82 (1983). Mr. Orszag agrees that accounting margins are different from the economic margins that are relevant to economists. Tr. 3180:8-22, 3320:19-3321:2 (Orszag). Accounting data cannot be used to calculate economic margins without many assumptions. Tr. 1750:2-5 (Nevo). Furthermore, Professor Nevo's analysis addressed the economic margins that firms can earn on average across the Complaint counties, not in specific counties or across their entire MA business. Tr. 1727:5-14 (Nevo). In addition, the medical loss ratio is calculated at the contract level, not at the plan level where margins can be as high as 20%. Wheatley Apr. 22, 2016 Dep. 138:11-23, admitted into evidence at Tr. 579:1-580:6 (Wheatley); Tr. 1784:19-1785:23 (Nevo).

137. *Fourth*, Defendants argue that Professor Nevo's analysis fails to account for the fact that the ACA has moved MA and Original Medicare closer together, pointing to the growth of ACOs since the enactment of the ACA, the reduction of MA reimbursement benchmarks, and the

claim that MA's share of Medicare enrollees is purportedly "about flat" over time, Tr. 3042:10-23 (Orszag).

138. These incorrect arguments do not undermine Professor Nevo's conclusions. With respect to ACOs,[9] the CMS data Professor Nevo used in his merger-simulation application of the hypothetical monopolist test covered the time period after the introduction of ACOs. This means that his analysis reflects any impact of ACOs on seniors' preferences for different Medicare options. Tr. 1627:24-1628:16 (Nevo). He also estimated specifications of his model that explicitly controlled for the expansion of ACOs. Tr. 3488:2-19 (Nevo).

139. Regarding MA's penetration rate, Professor Frank, Professor Nevo, and the Kaiser Family Foundation all agree that it is increasing over time. Tr. 116:10-17 (Frank); Tr. 1581:21-1582:4, 3486:21-3487:18 (Nevo); PX0348 at 2.

140. Mr. Orszag previously presented an analysis that supposedly showed that MA and Original Medicare are moving closer together, DX0419 (Orszag Report) ¶¶ 95-96. Mr. Orszag has since withdrawn that analysis, and he now concedes that it shows no statistically significant trend over time. Tr. 3156:10-24 (Orszag).

141. *Fifth*, Defendants argue that Professor Nevo's hypothetical monopolist test and merger simulation fail to take into account the multiple-county service area of some of the plans offered by Aetna and Humana. As a result, Defendants contend, Professor Nevo's models and tests likely misstate the incentive of the merged firm to raise prices post-merger because he assumes that prices are set at the county level rather than by an MA plans' service area. They note that CMS regulations require that an insurer offer the same prices and benefits in all

[9] ACOs are discussed in more detail *infra* in Section IV.E.2.b.

counties covered by the plan,[10] which may include counties with a different competitive dynamic than the Complaint counties covered by the plan.

142. These criticisms are also misguided. Mr. Orszag agrees that the relevant geographic market is the county and that, from a demand perspective, it is appropriate to focus on counties as the geographic area of competition. Tr. 3173:25-3174:3 (Orszag). Defendants' multiple-county service area critique therefore cannot be relevant to market definition considerations. Defendants' argument also ignores the fact that MA insurers can control which counties they choose to include in a plan's service area and that they select the counties served by a particular plan with an awareness of CMS's regulation. Tr.1755:23-1756:16 (Nevo) ("there's a conscious choice made by the insurers where to offer" their plans). Approximately 15-20% of Aetna and Humana's offerings are single county plans. PX0551 (Nevo Report) ¶ 94 & n.133. In other words, if an insurer feels the plan's service area constrains pricing (e.g., after the merger), the insurer can change the service area.

143. Professor Nevo's applications of the hypothetical monopolist test are reliable and support the conclusion that individual MA is an appropriate product market in which to analyze the effects of the proposed merger in the Complaint counties. Mr. Orszag's own purported application of the hypothetical monopolist test is unreliable, and none of Defendants' criticisms of Professor Nevo's analysis undermine his conclusions.

144. Finally, even if some of Defendants' criticism of his analysis were well-grounded, Professor Nevo's application of the hypothetical monopolist test "relied on many different variations." Tr. 1711:15-21 (Nevo). He did not rely on any one estimate, but considered a variety

[10] CMS regulations are discussed in more detail *infra* in Section IV.E.1.

of inputs to conduct the test. Tr. 1712:1-11 (Nevo). As he explained, "even if there were a problem with one of those legs of that stool, that stool still has many legs to lean on." Tr. 1711:15-21 (Nevo).

d. That Seniors "Age In" to Medicare Does Not Mean That Original Medicare Is in the Same Product Market as MA

145. Defendants argue that, because seniors turning 65 choose between Original Medicare (with or without a MedSupp and Part D plan) and MA as two alternative forms of government-subsidized health insurance, Original Medicare options and MA must be in the same product market. In the first variation of this argument, Defendants state that MA cannot be in a separate market from Original Medicare because of a purported "congressional determination . . . that Original Medicare is an appropriate and adequate substitute for Medicare Advantage for *every* Medicare-eligible consumer," which, according to Defendants, "resolves the question of the interchangeability of OM and MA and is binding on the Court." Defs. Pretrial Br. at 11. This argument is overreaching and unsupportable.

146. The statutory regime and regulatory history of MA directly contradict the notion that Congress was not concerned about competition among MA plans. Defendants fail to cite the 2005 final rule establishing the MA program, which explains that it was designed to "[u]se open season *competition among MA plans* to improve service, improve benefits, invest in preventive care, and hold costs down in ways that attract enrollees." Establishment of MA Program, 70 Fed. Reg. at 4589 (emphasis added); *see also supra* ¶¶ 34-35.

147. Moreover, there is no support for Defendants' assertion that Congress intended to foreclose the possibility that a court could find MA to be in a separate antitrust market from Original Medicare. As a "fact-intensive inquiry," *Todd v. Exxon Corp.*, 275 F.3d 191, 199-200 (2d Cir. 2001), market definition must be "based on evidence that describes real markets, not

hypothetical ones," *Community Publishers, Inc. v. DR Partners*, 139 F.3d 1180, 1184 (8th Cir. 1998). The statutory language that Defendants cite (Defs. Pretrial Br. at 10-11) does not speak directly to antitrust market definition; nor does it address whether MA and Original Medicare options are "reasonably interchangeable," which is the relevant question under antitrust law. On the contrary, under the antitrust laws, Congress "turn[ed] over exceptional law-shaping authority to the courts" and courts' "rulings necessarily turn[] on [their] understanding of economics." *Kimble v. Marvel Entm't, LLC*, 135 S. Ct. 2401, 2413 (2015) (contrasting antitrust with the patent laws, which are rooted more in statutory interpretation).

148. Absent clear Congressional intent to reach the issue of defining relevant markets involving MA for purposes of the Clayton Act, these statutes should not be interpreted to do so. *See, e.g., United States v. Texas*, 507 U.S. 529, 534 (1993) ("[s]tatutes which invade the common law . . . are to be read with a presumption favoring the retention of long-established and familiar principles, except when a statutory purpose to the contrary is evident") (citation omitted).

149. In the second variation of their argument, Defendants contend that MA cannot be in a separate market from Original Medicare because at age 65 seniors have the choice of enrolling in Original Medicare (with or without MedSupp and Part D plans) or MA, and Defendants focus on winning business away from Original Medicare options when seniors age in. This argument fundamentally misconceives the relevant market analysis by improperly conflating "functional interchangeability" with "reasonable interchangeability"—the proper focus of market definition.

150. The fact that two products compete to some extent, or even that they are functionally interchangeable, does not answer the question of whether they are reasonably interchangeable, i.e., whether they are in the same relevant market for purposes of analyzing a proposed merger. *See supra* ¶¶ 65-68. In *H&R Block*, for example, the merging parties argued that assisted tax

preparation should be in the same market as digital do-it-yourself tax preparation (DDIY) because all methods of tax preparation compete to be the method of choice for individual taxpayers. The court disagreed and explained:

> While the evidence does show that companies in the DDIY and assisted markets all generally compete with each other for the same overall pool of potential customers—U.S. taxpayers—that fact does not necessarily mean that DDIY and assisted must be viewed as part of the same relevant product market. DDIY provides customers with tax preparation services through an entirely different method, technology, and user experience than assisted preparation.

833 F. Supp. 2d at 54-55.

151. Just as seniors turning 65 face an initial choice between whether to enroll in Original Medicare options or MA, U.S. taxpayers must decide whether to complete their own tax returns manually using the instructions supplied by the government, complete their own tax returns with software such as TurboTax, or hire someone to complete their tax returns for them. In *H&R Block*, "[t]he key question for the Court" was not whether there is competition between different forms of tax preparation, but "whether DDIY and assisted products are sufficiently close substitutes to constrain any anticompetitive DDIY pricing after the proposed merger." 833 F. Supp. 2d at 55 (holding that "[e]vidence of the absence of close price competition between DDIY and assisted products makes clear that the answer to that question is no—and that DDIY is the relevant product market here").

152. Nor does the fact that MA was created after Original Medicare to provide an alternative for seniors seeking government-subsidized health care coverage answer the question of whether MA and Original Medicare options are in the same relevant market. As Judge Tatel explained in *Whole Foods*:

> [W]hen the automobile was first invented, competing auto manufacturers obviously took customers primarily from companies selling horses and buggies, not from other auto manufacturers, but that hardly shows that cars and horse-drawn carriages should be treated as the same product market. That Whole Foods

> and Wild Oats have attracted many customers away from conventional grocery stores by offering extensive selections of natural and organic products thus tells us nothing about whether Whole Foods and Wild Oats should be treated as operating in the same market as conventional grocery stores.

548 F.3d at 1048.

153. These principles apply here and lead to the conclusion that MA is a separate product market. The relevant market analysis for seniors aging in is the same as for seniors who already made the initial choice to enroll in MA. Regardless of when seniors choose to enroll, their choice of MA over its alternatives is an expression of their preexisting preferences. Many seniors—whether they are aging in or not—have significant and durable preferences for MA such that a hypothetical monopolist of MA plans in each of the Complaint counties profitably to impose a SSNIP. These preferences could be based on, for example, a history of membership in managed care plans or a need to limit out-of-pocket costs and pay little or no premium. *See, e.g.*, Tr. 116:10-17 (Frank); *supra* ¶ 93.

154. Defendants imagine a world in which age-ins have no preexisting preferences at all. That world is contrary to reality and intuition. Like everyone else, seniors aging into Medicare have distinct needs and preferences, and many of them prefer MA, as demonstrated by the behavior of seniors with guaranteed-issue rights. Under certain circumstances, including when their MA plan is terminated, seniors can enroll in Original Medicare with a MedSupp plan without going through medical underwriting. Tr. 430:5-22 (Cocozza). Because they are free to choose any Medicare product without being underwritten, these seniors and age-ins are similarly situated. Tr. 1077:17-24 (Fitzgerald); *see also* Tr. 430:23-431:3 (Cocozza) (age-ins and people who lose their MA plans are similar). Even when they can choose any product, these seniors overwhelmingly choose another MA plan. Tr. 1590:19-1591:16 (Nevo) (finding 86.5% of involuntary switchers stay in MA). These seniors demonstrate that for many consumers,

including a portion of age-ins, MA is sufficiently attractive that a hypothetical monopolist of MA plans in a given geographic market could profitably impose a SSNIP.

155. Lastly, Defendants contend that Original Medicare constrains MA prices and, therefore, must be included in the product market. Defendants have identified no support in the record for this contention apart from a handful of isolated statements taken out of context. For example, Defendants point to stray comments by one Dr. McGuire, an independent advisor to HHS, but Professor Frank testified that these comments were made in the context of a much larger policy discussion. Tr. 205:15-206:6 (Frank). And, when taken out of context as Defendants do, they are contrary not only to Dr. McGuire's own published work, which supports his view that insurers exercise market power within MA, *see, e.g.*, PX0701 at 37-38, but also to the views and practices of CMS, *see supra* ¶¶ 34-35; *infra* ¶ 244; Tr. 98:15-20 (Frank) ("[T]he design of the Medicare Advantage program is particularly susceptible to the exercise of market power . . . because the competition is really focused inside of the Medicare Advantage program, and it occurs primarily between Medicare Advantage participating insurers."); Tr. 1122:22-25 (Cavanaugh) (Original Medicare does not try to compete with MA plans).

156. Plaintiffs do not dispute that MA competes with Original Medicare and MedSupp options to some degree, and for some seniors. But this proposition does not answer the question ofwhether MA is reasonably interchangeable with those other products. Professor Nevo's economic analysis and the evidence discussed above prove that it is not. While a hypothetical monopolist of MA theoretically could raise prices to such a degree that enough MA enrollees would switch to Original Medicare to make further MA price increases unprofitable, the evidence shows that this theoretical threshold is well above current prices. *See* Tr. 1612:10-15, 1683:7-21 (Nevo); PX0551 (Nevo Report) ¶ 178, Ex. 12 (hypothetical monopolist in all

Complaint counties would impose a 10% price increase).

157. The court discussed a similar issue in *H&R Block*:

> The possibility of preparing one's own tax return necessarily constrains the prices of other methods of preparation at some level. For example, if the price of DDIY and assisted products were raised to $1 million per tax return, surely all but the most well-heeled taxpayers would switch to pen-and-paper. Yet, at the more practical price increase levels that trigger antitrust concern—the typical five to ten percent price increase of the SSNIP test—pen-and-paper preparation is unlikely to provide a meaningful restraint for DDIY products . . . .

833 F. Supp. 2d at 57.

158. Defendants' argument would imply that all MA insurers in almost any county could merge to monopoly because, according to Defendants, competition from Original Medicare and its supplements would suffice to protect consumers. *See* Tr. 3227:1-3230:9 (Orszag). In other words, their position is that, in almost all geographic markets, competition among MA insurers is not significant. This is inconsistent with the weight of the record evidence, including evidence of the importance of head-to-head competition between Aetna and Humana in MA. *See infra* Section IV.D.2.

C. The Proposed Merger Is Presumptively Illegal in the Complaint Counties

1. Applicable Legal Standards

159. The government establishes a prima facie violation of Section 7 by showing that the transaction "will lead to undue concentration" in a properly defined relevant market. *Baker Hughes*, 908 F.2d at 982. Courts use two different measures of market concentration to establish the presumption. One is based on the percentage of the relevant market that would be controlled by the merged firm. In *Philadelphia National Bank*, the Supreme Court found a relevant market unduly concentrated where the merging parties controlled 30% of the market. 374 U.S. at 364; *see also FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 52 (D.D.C. 1998) ("Subsequent cases have lowered the presumption somewhat to even 25% or less."); *Sysco*, 113 F. Supp. 3d at 55;

Swedish Match, 131 F. Supp. 2d at 166.

160. Courts also routinely apply the Herfindahl-Hirschmann Index (HHI) thresholds in the Merger Guidelines to determine whether the government has established the presumption of anticompetitiveness. *See, e.g.*, *Sysco*, 113 F. Supp. 3d at 52; *H&R Block*, 833 F. Supp. 2d at 71; *Arch Coal*, 329 F. Supp. 2d at 124. HHI figures are "calculated by summing the squares of the individual firms' market shares," a calculation that "gives proportionately greater weight to the larger market shares." Merger Guidelines § 5.3. "Mergers resulting in highly concentrated markets [HHI above 2,500] that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power." *Id.*; *see also Staples II*, 2016 WL 2899222, at *17; *Sysco*, 113 F. Supp. 3d at 52.

161. The presumption of illegality reflects the judgment that a merger resulting in such increases in concentration "is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Phila. Nat'l Bank*, 374 U.S. at 363; *Swedish Match*, 131 F. Supp. 2d at 166-67. In other words, "[m]arket concentration is a useful indicator of the likely competitive, or anticompetitive, effects of a merger." *Penn State Hershey Med. Ctr.*, 838 F.3d at 346; *see also Heinz*, 246 F.3d at 715-16; Merger Guidelines § 5.3 ("Market concentration is often one useful indicator of likely competitive effects of a merger.").

2. Professor Nevo's Testimony Establishes that the Merger Presumptively Violates Section 7 in the Complaint Counties

162. Under these standards, all 364 relevant markets would meet the Merger Guidelines' thresholds for triggering a presumption of illegality, and the concentration levels and increases in concentration resulting from the merger would significantly exceed the thresholds in most of them. Tr. 1622:11-20 (Nevo); PX0551 (Nevo Report) ¶ 199, Ex. 16. Over 75% of the Complaint

counties would have post-merger HHIs of 5,000 or greater and over 70% would have HHI increases of 1,000 or greater. PX0551 (Nevo Report) ¶ 196, Ex. 15. In 70 of the Complaint counties, the merged firm would control 100% of the individual MA market. Tr. 1622:25-1623:2 (Nevo). And in every Complaint county, Defendants' combined market share would be at least 35%. PX0564 (Nevo Report App. I).

163. This is a clear case for applying the presumption. *See Heinz,* 246 F.3d at 716 (merger that would increase HHI by 510 points from 4,775 created a presumption of anticompetitive effects by a "wide margin"); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 568 (6th Cir. 2014) (merger that would increase HHI by 1,078 to 4,391 "blew through [Merger Guidelines'] barriers in spectacular fashion"). If the Court agrees with Plaintiffs that the relevant product market is individual MA, it also must find that there is a presumption of illegality, as Defendants have introduced no evidence to the contrary.

3. Even under Defendants' Flawed Market Definition, the Transaction Would Be Unlawful Because Its Anticompetitive Effects Were Proved

164. Even if the relevant market includes MA and Original Medicare options, Professor Nevo's simulation of the proposed merger demonstrates that the merger would have an anticompetitive effect in that broader market.[11]

165. Direct proof of anticompetitive effect (i.e., without proceeding by way of establishing

[11] In his initial report, Mr. Orszag argued for treating Original Medicare as a monolith. While Mr. Orszag now appears to have backed away from that approach, even under his incorrect argument that Original Medicare is in the same relevant market as MA, when using his calculations 100 of the 364 Complaint counties would meet the Merger Guidelines' thresholds for presuming harm. PX0552 (Nevo Rebuttal Report) ¶ 71; PX0714; DX0419 (Orszag Report) ¶ 114 n.266; Tr. 3268:21-3269:9, 3277:15-3281:4 (Orszag); Tr. 3514:16-3515:10 (Nevo). These counties represent 46% of Defendants' total individual MA enrollment in the Complaint counties. PX0552 (Nevo Rebuttal Report) ¶ 71.

a market share presumption) is an alternative basis for a finding that the merger is unlawful even if the relevant product market is defined to include Original Medicare options. *See* Merger Guidelines § 4 ("Evidence of competitive effects can inform market definition, just as market definition can be informative regarding competitive effects."); *see also, e.g.*, *Penn State Hershey Med. Ctr.*, 838 F.3d at 345-46 (holding government met its burden of proving relevant market based on evidence "showing that [customers] would have no choice but to accept a price increase" from the merged firm); *Staples I*, 970 F. Supp. at 1075-76 (considering pricing evidence in analyzing relevant product market).

166. Defendants argue that Plaintiffs could not make their prima facie showing if Original Medicare is included in the relevant market because the federal government "is not a profit-maximizing entity" and therefore standard merger analysis cannot apply. Defs. Pretrial Br. at 19. But Defendants' sweeping proposition would immunize any merger of the "Big Five" insurers, or even of all MA insurers in most markets. It is also inconsistent with the case law.

167. Courts apply standard merger analysis in cases involving nonprofit entities. *See, e.g.*, *Penn State Hershey Med. Ctr.*, 838 F.3d at 334 (enjoining acquisition by state university's "primary teaching hospital" of competing private hospital network); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1224 (11th Cir. 1991) (rejecting argument that hospital's "nonprofit status supports their position that the proposed acquisition would not result in substantially less competition"). Courts also do not deviate from standard merger analysis when a government entity is a competitor in the relevant market. *See, e.g.*, *United States v. Waste Mgmt.*, 588 F. Supp. 498, 502, 511-12 (S.D.N.Y. 1983) (holding merger presumptively unlawful based on market concentration including municipal competitor), *rev'd on other grounds*, 743 F.2d 976 (2d Cir. 1984). Defendants' position is also inconsistent with cases in which the presence of a

government-provided option for consumers did not alter the nature of the court's relevant market inquiry. *See, e.g.*, *H&R Block*, 833 F. Supp. 2d at 57-60 (rejecting argument that manual tax preparation using government instructions was in relevant market); *Visa U.S.A.*, 163 F. Supp. 2d at 338 (explaining why cash should be excluded from relevant market even though credit cards compete to some extent with cash).

168. Professor Nevo's merger simulation shows that the merger would have an anticompetitive effect in a market including Original Medicare options because it asks the question: Would a merger of Aetna and Humana lead to a price increase, considering all the possibly available competitive responses, *including both* all other MA plans *and* all the available Original Medicare options?

169. Professor Nevo's answer to this question is based on the millions of real-world choices made by seniors reflected in the data that he used. All of these seniors had available MA and Original Medicare choices (consistent with eligibility rules). Professor Nevo's merger simulation includes Original Medicare options as products to which seniors can switch if the prices of MA plans increase. Tr. 1627:3-20 (Nevo). Neither his merger simulation nor his econometric demand estimation on which the merger simulation depends relies upon the relevant product market being limited to MA. Tr. 1626:24-1627:2 (Nevo). The fact that Professor Nevo's merger simulation incorporates the effect of any constraints provided by Original Medicare options was not controverted at trial.

170. The answer to the question posed by Professor Nevo's simulation is that the merger would lead to a price increase, and would harm seniors by reducing competition that would otherwise benefit them. Tr. 1631:13-19 (Nevo) (estimating seniors would pay $360 million more in rebate-adjusted premiums each year); *infra* Section IV.D.4 Thus, Professor Nevo's merger

simulation predicts the likely effect of the merger as if Original Medicare were included in the market. Tr. 1627:10-20 (Nevo); PX0552 (Nevo Rebuttal Report) ¶ 80.

171. Because Professor Nevo's merger simulation evidence incorporates the competitive constraint provided by Original Medicare and all of its options, it demonstrates that the merger would have an anticompetitive effect, that is, it would substantially lessen competition. This establishes Plaintiffs' prima facie case even if Original Medicare is included in the relevant market.

D. Eliminating Direct Competition between Aetna and Humana Likely Would Increase Prices and Decrease Benefits for Seniors

172. As outlined above, the market concentration levels that would result from this merger establish Plaintiffs' prima facie case. This evidence alone triggers a presumption of illegality and shifts the burden to Defendants to show that the market concentration evidence presents an "'inaccurate account of the [merger's] probable effects on competition.'" *See Heinz*, 246 F.3d at 715 (citation omitted, alteration in original). Defendants cannot rebut this presumption. *See infra* Sections IV.E. Even if they could, however, Plaintiffs have introduced sufficient additional evidence of anticompetitive effects to meet their ultimate burden of persuasion.

173. Plaintiffs have shown through economic evidence and Defendants' own statements and documents that eliminating direct competition between them is likely to harm consumers. *See Heinz*, 246 F.3d at 717 ("the FTC's market concentration statistics are bolstered by the indisputable fact that the merger will eliminate competition between the two merging parties"); *Sysco*, 113 F. Supp. 3d at 65 ("Evidence of probable unilateral effects strengthens the FTC's *prima facie* case that the merger will lessen competition in the national customer market.").

1. Legal Framework

174. "Mergers that eliminate head-to-head competition between close competitors often

result in a lessening of competition." *Staples II*, 2016 WL 2899222, at *20; *see also Sysco*, 113 F. Supp. 3d at 61 ("Courts have recognized that a merger that eliminates head-to-head competition between close competitors can result in a substantial lessening of competition."); Merger Guidelines § 6 ("The elimination of competition between two firms that results from their merger may alone constitute a substantial lessening of competition.").

175. In particular, a merger between two significant direct competitors may have "unilateral effects," meaning that "the acquiring firm will have the incentive to raise prices or reduce quality after the acquisition, independent of competitive responses from other firms." *H&R Block*, 833 F. Supp. 2d at 81. In *Heinz*, the D.C. Circuit enjoined the merger of two baby food companies, noting that where "both [companies] are present in the same areas, they depress each other's prices," and their merger would end this competition. 246 F.3d at 718 (internal citation omitted); *see also Swedish Match*, 131 F. Supp. 2d at 169 (finding likelihood of unilateral price increase where merger would eliminate one of Swedish Match's "primary direct competitors"); *Staples I*, 970 F. Supp. at 1083 (finding likely anticompetitive effects where "merger would eliminate significant head-to-head competition between the two lowest cost and lowest priced firms"); *Sysco*, 113 F. Supp. 3d at 65 ("because the proposed merger would eliminate head-to-head competition between the number one and number two competitors in the market for national customers, the merger is likely to lead to unilateral anticompetitive effects").

176. Harmful unilateral effects are possible even if the merging firms are not the two largest or the only close competitors in the market. *Sysco*, 113 F.3d at 62 ("the merging parties need not be the top two firms to cause unilateral effects"). In *H&R Block*, for example, a company not part of the proposed merger—Intuit, the maker of Turbo Tax—had a market share of over 60% and was the closest competitor to both merging companies, but the court

nonetheless enjoined the merger. 833 F. Supp. 2d at 45, 83-84. Similarly, in *Heinz*, the D.C. Circuit enjoined the merger of two baby food manufacturers even though a third company, Gerber, was the largest and closest competitor of both defendants. 246 F.3d at 718-19, 727.

2. Seniors Benefit from Direct Competition between Aetna and Humana

177. Aetna and Humana are important direct competitors for the sale of individual MA plans to many seniors throughout the United States. Together, they account for over 25% of individual MA enrollment in the United States. PX0551 (Nevo Report) ¶¶ 39-41, Ex. 3. As of 2016, 23.7 million Medicare-eligible individuals live in the 675 counties where Aetna and Humana sell MA plans in direct competition with each other. PX0551 (Nevo Report) ¶¶ 220, 221, Ex. 20. As of 2016, there are 1.7 million individual MA enrollees in the 364 Complaint counties. Fifty-nine percent of the MA enrollees in the Complaint counties, or almost 972,000 seniors, are enrolled in either an Aetna or Humana plan. Tr. 1582:5-19 (Nevo).

178. Defendants' documents and testimony highlight the intensity of this head-to-head competition: "Humana will be our most serious threat in the near future," PX0397 at -647; "Aetna—only strong competitor to worry about," PX0512 at -200; "Humana and Aetna dominate the Kansas City Market," PX0455 at -601; and "Our #1 NC Competitor Aetna," PX0050 at -116. Humana has observed that "Aetna offer[s] very competitive plans with excellent network and brand recognition," PX0037 at 4, while, in the words of Mr. Bertolini, "Humana gets it," "they are strong in Medicare, they are strong in the local community," Tr. 1400:21, 1402:13-14 (Bertolini). The companies bring to the market similar perspectives on the health care system and a desire to bring change to the industry. Tr. 1837:1-15 (Broussard) ("The first time that Mark [Bertolini] and I got together to talk about [a possible transaction], I remember it was a rainy day and we were talking about it. And we almost finished each other's sentences. We almost finished the—when I was talking about strategy, he was able to fill in the words. And when he

was talking about strategies, I was able to fill in the words.").

179. Aetna and Humana each recognize the other as one of its most important MA competitors. Ms. Cocozza described Humana as Aetna's "most formidable competitor," emphasizing that Aetna "compete[s] with them everywhere and they have momentum." PX0007 at -847; *see also* PX0027 at -229 (describing Humana as "our primary MA competitor"). Humana also views Aetna as a "formidable competitor." PX0216 at -737; *see also* PX0480 at -344 (Aetna's acquisition of Coventry "could turn Aetna into a formidable MA competitor"); PX0032 at -202 (regarding Aetna MA activity in Texas, "they have upped the ante in terms of competition!").

180. As discussed below, this competition between Aetna and Humana to offer the best possible individual MA plans at the lowest cost has benefited seniors in the Complaint counties.

a. MA Competition Focuses on the Plan Bidding Process

181. Competition between Aetna and Humana within individual MA markets is embedded in the development of the MA plan bids submitted to CMS each year. Tr. 1996:14-1997:21 (Paprocki). Every insurer must submit a bid to CMS in June to sell an MA plan for the following calendar year. Tr. 309:9-11 (Cocozza). The bid describes the benefits, prices, and networks of the MA plan the insurer wishes to sell. PX0059 at -156; Tr. 1909:21-1910:6, 1912:15-1917:12 (Paprocki). For example, bids for MA plans sold during the 2017 annual election period (AEP), which lasted from October 15 to December 7, 2016, were submitted to CMS in June 2016. *See* PX0046 at -282; PX0059 at -167. Since bids from all insurers are due on the same date, insurers do not know the specific features or prices of the plans that their competitors intend to sell during the next calendar year. *See* Tr. 311:11-312:8, 447:21-448:1 (Cocozza).

182. In deciding what products to market, Aetna, Humana, and other insurers try to predict what their competitors will offer based on what they offered the prior year and sales results. Tr.

2074:21-2076:3, 2084:23-2085:7 (Follmer) (describing meetings with brokers to learn about Aetna's perception in the market, "how our competitors are doing in the market," and "how we can do better as I'm beginning to prepare for the next bid"); Tr. 506:22-507:22 (Wheatley); *see generally* PX0387. Defendants begin working on their bids for the next annual AEP soon after the prior election period is over. Tr. 309:16-18 (Cocozza); Tr. 2075:20-2076:3 (Follmer); Tr. 605:6-22 (Wheatley) (in January, Humana leadership begins the process of evaluating its changes in costs and the competitive landscape and the changes it will need to make to its bids in the upcoming cycle). CMS publishes tentative county-level benchmarks in February, which are issued in final form in early April. Tr. 1914:18-1915:11 (Paprocki). Defendants gather information about competitors' product offerings from the prior year and their own sales performance. Tr. 241:12-242:17, 311:11-22, 312:9-17 (Cocozza); Tr. 765:4-13 (Farley); *see generally* PX0046; PX0154; PX0353 at -609; PX0063. They use this competitive information, along with target margins and other bid guidance from senior management, to develop bids for plans to be sold in the upcoming AEP. Tr. 308:12-310:10-13 (Cocozza); 1912:15-1917:12 (Paprocki). Draft bids are refined in response to competitive events and CMS guidance on benchmarks. At Aetna, bids are reviewed by national managers, including Ms. Cocozza, and ultimately by Mr. Bertolini. Tr. 308:19-309:8 (Cocozza); PX0039 at -672; PX0040 at -413.

183. Head-to-head competition between Aetna and Humana is thus reflected in the bids that each submits to CMS for their MA plans to be marketed for the next year. That competition between Aetna and Humana is intense, and seniors would be harmed by its elimination.

b. Competition between Aetna and Humana Has Resulted in Better Quality MA Products for Consumers

i. Aetna and Humana Compete on Provider Networks

184. The cost of an MA plan is important to seniors. *See, e.g.*, Tr. 271:14-24 (Cocozza);

supra ¶¶ 85, 93, 99-100. One way that Aetna and Humana compete to offer the best value plans is by developing networks built around value-based contracts with providers. Tr. 1846:1-9 (Broussard). These contracts give Defendants' MA plans a competitive edge because, as Mr. Wheatley explained, they "improve health and lower cost." Tr. 544:1-4 (Wheatley); PX0538 at -782. Because of the importance of value-based contracts in being able to offer $0 premium plans, Aetna set a goal to "achieve 75% of claims paid through [value-based contracts] by 2020." PX0036 at -427; *see also supra* ¶ 53.

185. Ms. Cocozza explained that Humana is often viewed as Aetna's toughest competitor because Humana, like Aetna, has followed a strategy of building "networks around value-based arrangements." Tr. 327:1-19 (Cocozza); *see also* Tr. 2106:13-18 (Follmer). Aetna sees Humana as the leader "in terms of aggressive pursuit of strategic provider relationships and [they] are willing to deploy capital in many forms to secure preferred standing and exclusivity." PX0007 at -847; *see also* Tr. 551:18-25 (Wheatley) (60-70% of Humana contracts are value-based). On the other hand, in North Carolina, for example, Humana perceives Aetna's strategy to be leveraging its provider collaborations and its high star ratings to maintain $0 premium MA plans to compete successfully against Humana. Tr. 820:1-821:11 (Farley).

186. A plan's provider network is an important selling point for seniors. *See, e.g.*, Tr. 432:10-16 (Cocozza); PX0523 at -561; DX0516-045 ("Assurance that one's current doctor is in the plan is just as important as the reputation of the carrier and the cost of the plan."). Aetna and Humana compete to offer networks with popular local providers, and both companies usually offer better provider networks than CMS requires to enhance the marketability of their plans. Tr. 291:14-293:8 (Cocozza); Tr. 547:8-11, 548:5-14 (Wheatley). When developing plan bids, Defendants compare each other's provider networks to see if they need to improve their

networks to compete more effectively. PX0394 at -862 (Aetna compared all providers in Humana's MA network in [redacted] against its own and concluded that it needed "some network fortification"); PX0013 at -344 ("[Aetna has an] aggressive network in NE GA area with [a hospital] . . . that [Humana does] not have"); *see also infra* ¶ 189 (Humana improved provider network in Wake County, North Carolina, in response to competition from Aetna). As Aetna's Ms. Cocozza testified, when faced with a situation where a competitor has a broader network, she would want Aetna's MA plan also to have a broader network if "it was going to make me more competitive." Tr. 340:24-341:5 (Cocozza).

ii. Aetna and Humana Compete on Benefits

187. Aetna and Humana also compete to offer new and innovative benefits for MA plan enrollees. Aetna has plans to test a "US Travel Advantage Program" that would create a competitive advantage by better meeting the needs of mobile seniors. This benefit would be a "selling point/differentiator" and "something our competitor can't offer." PX0078 at -659. Humana has sought to differentiate itself from Aetna and other insurers through its "Humana at Home" offering. The program, launched in 2013, provides localized health coordination and homecare to Humana's "sickest" MA members, and is designed to help seniors stay at home rather than move to an assisted care facility. PX0514 at -239. In response to Humana, Aetna initiated a similar program to engage more directly with chronically ill seniors, but Aetna still views Humana as having "better capabilities" in this area. Tr. 1406:10-24 (Bertolini).

c. Specific Examples of Head-to-Head Competition

188. Evidence concerning competition between Aetna and Humana in North Carolina illustrates the extent to which seniors are likely to be harmed if the proposed merger takes place. In 2016, Humana had 133,000 MA enrollees and the largest market share in North Carolina. Tr. 762:8-11, 731:4-14 (Farley). Humana offers plans in all 100 counties in the state, while Aetna

has plans in 25 counties. Tr. 835:4-9 (Farley). But Aetna is "an up-and-coming fast-growing competitor" in North Carolina, and it increasingly is competing with Humana by offering "superior benefits." Tr. 769:5-6, 783:1-6 (Farley); *see also* Tr. 786:1-10 (Farley) ("Aetna had superior product price and benefits in the Charlotte, Greensboro, and Raleigh area[s]").

189. When Aetna launched a new $0 premium PPO plan in Wake County (Raleigh), North Carolina, in 2014, Aetna hoped that its "pricing and benefits" would be a "major market disruptor." PX0397 at -651; Tr. 769:11-13 (Farley). Humana agreed that Aetna had a superior product in 2014 and 2015. Tr. 783:1-6 (Farley); PX0016 at -255. Aetna partnered with Duke University Hospital, which is selective in its payor relationships, giving it a distinct advantage over Humana. Tr. 333:12-334:19 (Cocozza); PX0537 at 5. By 2015, Aetna had gained a "dominating position" in Wake County because of its low premium and broad network. Tr. 781:20-23 (Farley); PX0038 at -804 ("Aetna again is dominating in [W]ake County with the $0 PPO [with] full access to all hospitals and affiliated providers."). In marketing its plan, Aetna exploited Humana's "limited provider network," including the absence of Duke. PX0295 at -285; Tr. 779:2-15 (Farley). Although Humana offered a $0 premium HMO, Aetna's $0 premium PPO offered a much broader provider network. *See* Tr. 773:5-774:16 (Farley). In response to this competition from Aetna, Humana expanded its network for its $0 premium HMO plan for the 2017 AEP. Tr. 819:21-25, 820:6-15 (Farley); PX0352 at -884.

190. Humana has a large individual MA business in Texas. PX0303 at 20 (after Florida, Texas has Humana's second largest MA enrollment); PX0042 at -854 (showing 210,000 enrollees in 2015 and over $2.2 billion in revenue for individual MA). In recent years, Aetna has competed aggressively against Humana in Texas to gain enrollees and market share. In 2016, Aetna grew faster than any other insurer in Texas. PX0036 at -431, -432.

191. In the San Antonio market, Aetna and Humana have been "pushing each other to be more competitive" by offering HMO and PPO plans that are "aggressively priced" with "very strong networks." Tr. 1059:13-14, 1037:6-11 (Gonzalez). United Healthcare, Humana, and Aetna account for 90% of MA enrollment in San Antonio, with Aetna the smallest of the three. Tr. 2169:16-2170:2 (Fernandez). Aetna and Humana offered PPO plans with similar networks and monthly premiums within one dollar of each other in the 2016 AEP. Tr. 1039:5-7, 1039:12-14 (Gonzalez). After the AEP ended, Humana studied Aetna's competitive offering and growth in San Antonio. PX0042 at -835 ("Austin and San Antonio—United and UNCLE Aetna both IMPROVED benefits pretty drastically pushing Hum MCVAT down to #6 and #9 respectively."). In the 2017 AEP, Humana responded to Aetna's competitive threat by offering a new PPO product with a $16.90 premium—a reduction of 15% from the prior year's PPO. Tr.1039:15-1040:2 (Gonzalez).

192. Aetna and Humana also compete intensively with HMO plans in San Antonio. For 2016, Aetna's pricing strategy was to [redacted] PX0039 at -711. Mr. Gonzalez testified that in the 2016 AEP he moved seniors from a Humana HMO to an Aetna HMO because, while the plans had similar networks, Aetna offered lower co-payments for specialist visits. Tr. 1040:15-1041:12, (Gonzalez) (Aetna HMO specialist copayment was $24; Humana's was $40). These seniors "wanted to stay with their same doctors and save some money," so it was "an easy transition" from Humana to Aetna. Tr. 1040:21-1042:9 (Gonzalez). Again in response to Aetna's competitive threat, Humana dropped its specialist co-payment to $25 for 2017, matching Aetna. Tr. 1042:3-9 (Gonzalez).

193. As in Texas and North Carolina, Aetna has introduced aggressively priced MA plans

in Georgia that have attracted new members largely at Humana's expense. For the 2015 plan year, Aetna disrupted the Atlanta market by offering a $0 premium PPO MA plan. Tr. 2100:1-2101:21 (Follmer). At the same time, Humana, one of the two largest MA plans in Georgia, raised the premium of its PPO plan. Tr. 2100:1-2101:21 (Follmer). This created a "bonanza" for Aetna as Humana members switched to Aetna. PX0393 at -185. Such "bonanzas" are not uncommon; when one MA insurer makes a significant change to its plan, the other MA insurers in that area benefit. Tr. 2111:6-16 (Follmer). This further illustrates the business reality that MA insurers primarily compete with each other.

194. Even with its popular $0 premium PPO plan, Aetna views Humana as one of its "strongest competitors" in Georgia today, in part because Humana's value-based contracts with providers are "more advanced" than those of other MA insurers. Tr. 2106:10-18 (Follmer). Aetna and Humana are two of the only MA insurers in the Atlanta area to have offered consistently strong products over the last several years. *See* Tr. 1085:13-1086:3 (Fitzgerald) (noting that both United Healthcare and Anthem have become less competitive); Tr. 461:18-21 (Cocozza) (provider-owned Piedmont-WellStar has exited the market).

3. Eliminating a Fast-Growing Competitor like Aetna Likely Would Substantially Lessen Competition in Medicare Advantage

195. Aetna is not only an important direct competitor for Humana, it is also the fastest growing individual MA insurer nationwide. Courts recognize that "an 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." *Staples I*, 970 F. Supp. at 1083; *see also H&R Block*, 833 F. Supp. 2d at 80 (finding that "TaxACT's competition does play a special role in this market that constrains prices" and merged firm would have "a greater incentive to migrate customers into its higher-priced offerings"); *FTC v. Libbey*,

Inc., 211 F. Supp. 2d 34, 47 (D.D.C. 2002) (merger would eliminate "one of Libbey's strongest competitors in a market that is already highly concentrated"); Merger Guidelines § 2.1.5 ("The Agencies consider whether a merger may lessen competition by eliminating a 'maverick' firm, i.e., a firm that plays a disruptive role in the market to the benefit of customers.").

196. After completing its acquisition of Coventry in 2013, Aetna jumped from the seventh-largest MA insurer nationwide to the fourth-largest. DX0290-113. By 2014, MA had become a "key component of our strategy to grow our Government business," PX0426 at -005, and in 2015, a "growth engine" for the company, PX0029 at -541; *see also* PX0426 at -943 ("Medicare growth driven by Medicare Advantage"). As Mr. Bertolini testified, Aetna has "been more aggressive in [its] approach to expanding into . . . markets over the last five years" and pursued a "significant expansion of the program." Tr. 1330:6-19 (Bertolini).

197. Geographic expansion has been a central component of Aetna's individual MA strategy. *See, e.g.*, PX0075 at -358, -361, -367; Tr. 252:5-7 (Cocozza) (Aetna undertook one of its biggest expansion efforts in 2016). In the past four years, Aetna has expanded into 640 counties—significantly more than the nearest competitor. PX0551 (Nevo Report) ¶ 218, Ex. 18. The number of counties in which Aetna and Humana compete head-to-head for the sale of individual MA plans has increased dramatically, from 79 in 2011 to 675 in 2016. PX0551 (Nevo Report) ¶ 220, Ex. 19. Defendants do not dispute any of this evidence.

198. In addition to this geographic expansion, Professor Nevo found that when Aetna enters a county, it captures and maintains more share than other entrants, and it is less likely to exit a county after entry than other entrants are. Tr. 1635:11-23 (Nevo). Switching data confirms Aetna's increased importance as a competitor to Humana. In 2014, Aetna plans were the ninth most likely choice of individuals disenrolling from Humana plans; in 2016, Aetna plans were the

second most likely choice. PX0551 (Nevo Report) ¶ 222.

199. When Aetna enters a new market, it often introduces a $0 premium PPO plan to take share away from incumbents. *See* Tr. 347:4-7, 347:18-25 (Cocozza). This type of plan is Aetna's "[redacted]" PX0046 at -324. In North Carolina, Aetna's $0 premium PPO was a "different type of model that we had never experienced before." Tr. 788:13-789:7 (Farley); PX0461 at -119; PX0024 at -129 (Humana manager emailing Mr. Farley regarding Aetna's plan: "Wow. A $0 premium on a PPO plan."); *see also* PX0018 at -457 (in Humana's North Central area "another challenge are the numerous markets where Aetna has $0 premium HMOs competing against our significant premium plans").

200. This strategy has driven significant growth in Aetna's individual MA business. Following the 2015 AEP, Aetna ranked second in membership growth only to Humana (from a much smaller base). PX0154 at -616. One year later, Aetna ranked third in membership growth, again behind Humana. PX0036 at -429. Much of Aetna's growth has been in $0 plans rated four stars or more. *See* Tr. 354:14-357:25 (Cocozza).

201. Eliminating Aetna as a competitor to Humana would be felt by consumers not only in the counties where they already compete head-to-head, but also in areas where Aetna would have expanded but for the merger. Shortly before the merger was announced, Aetna presented to its board a plan to maintain its "high-growth trajectory." PX0354 at -444; PX0056 at -369 (July 2015 Aetna document examining likely MA expansion markets where Humana has more than 35% market share). Aetna projected MA growth of [redacted] and geographic expansion that would reach [redacted] million more Medicare-eligible customers in 2017 alone. PX0036 at -438, -442 (describing 2017 growth as its [redacted]).

202. This evidence shows that the merger likely would harm consumers by eliminating

Aetna—an aggressive firm that has been offering attractive plans to expand its market share and that would continue to do so in the future but for the merger—as an independent competitor in the market.

4. Professor Nevo's Economic Analysis Shows that the Proposed Merger Likely Would Lead to Price Increases or Reduced Benefits

203. Professor Nevo's economic analysis confirms that the merger likely would lead to harmful unilateral effects. As discussed above, *supra* ¶ 135, he conducted a merger simulation and found that the proposed transaction would cause the merged firm and other insurers in the relevant markets to charge higher premiums net of rebates. Tr. 1626:20-23 (Nevo).

204. A merger simulation is an econometric tool commonly used to quantify the expected harm from a merger. *See Sysco*, 113 F. Supp. 3d at 67 ("merger simulation model strengthens the FTC's *prima facie* case that the merger will substantially lessen competition in the market for national customers"); *H&R Block*, 833 F. Supp. 2d at 88.

205. Professor Nevo's baseline merger simulation projected that, as a result of the merger, MA premiums in the Complaint counties would increase by 60%. Tr. 1630:3-8 (Nevo). He estimates that in total seniors would likely pay $360 million more in rebate-adjusted premiums each year. Tr. 1631:16-19 (Nevo). The merger also would cost taxpayers an additional estimated $140 million per year in the form of higher payments by CMS to insurers as a result of higher bids by insurers. Tr. 1631:20-21 (Nevo). Together, there would be $500 million per year in combined harm to seniors and taxpayers. Tr. 1631:21-23 (Nevo).

206. Professor Nevo also ran the merger simulation using Mr. Orszag's demand estimates and found that "all of these results predict the price increase and harm to consumers." Tr. 1630:9-17 (Nevo). Indeed, using two of Mr. Orszag's demand estimates predicts more harm than does using Professor Nevo's preferred demand estimates. Tr. 1630:3-17 (Nevo).

E. Defendants Cannot Rebut the Government's Case

207. The evidence discussed above in Section IV.C establishes Plaintiffs' prima facie case, which shifts the burden to Defendants to rebut the presumption by offering proof that the concentration statistics give "'an inaccurate account of the [merger's] probable effects on competition in the relevant market.'" *Heinz*, 246 F.3d at 715 (citation omitted, alterations in original); *Baker Hughes*, 908 F.2d at 991. Given Plaintiffs' additional evidence showing that the proposed merger is likely to have harmful unilateral effects in the relevant markets due to the elimination of head-to-head competition between Aetna and Humana, Defendants' rebuttal needs to be all the more compelling. *See ProMedica*, 749 F.3d at 571 ("That the Commission did not merely rest upon the presumption, but instead discussed a wide range of evidence that buttresses it, makes [defendant's] task more difficult still."); *Sysco*, 113 F. Supp. 3d at 61, 65-66.

208. None of Defendants' arguments alter the conclusion that the merger is likely to harm competition for the sale of individual MA plans in the Complaint counties. The record does not support Defendants' contention that CMS regulation and changes in the MA program ushered in with the ACA will prevent any exercise of market power by the merged firm. The proposed divestiture of Aetna and Humana MA enrollees to Molina cannot rebut Plaintiffs' prima facie showing because (1) Molina lacks MA experience; (2) Molina would not acquire the necessary assets to replace the competition that would be lost through the merger; and (3) the Molina transaction may not close. Lastly, the evidence shows that new entry in the relevant markets would not be likely, timely, or sufficient to replace the lost competition.

1. CMS Regulation and Oversight of the Bid Process Will Not Prevent Harm from the Merger

209. While CMS's role in overseeing MA plans is part of the "context of [this] particular industry," *Brown Shoe*, 370 U.S. at 321-22, there is no legal or factual support for

Defendants' contention that the "regulatory scheme governing Medicare Advantage plans precludes the possibility of anticompetitive behavior." Defs. Pretrial Br. at 20 (capitalization and bold omitted). Their categorical claim that the government's role in the MA markets would "prevent any imaginable harm to consumers post-merger," *id.*, amounts to an argument for implied immunity from the antitrust laws.[12] This position founders both on a long line of Supreme Court precedents rejecting similar attempts to avoid antitrust scrutiny in regulated industries and the record evidence showing that CMS's role in the MA markets would not prevent the merger from harming consumers.

a. Applicable Legal Standards

210. The Supreme Court has "long recognized that the antitrust laws represent a fundamental national economic policy" and that "we cannot lightly assume that the enactment of a special regulatory scheme for particular aspects of an industry was intended to render the more general provisions of the antitrust laws wholly inapplicable to that industry." *Carnation Co. v. Pac. Westbound Conference*, 383 U.S. 213, 218 (1966). Because of the "indispensable role of antitrust policy in the maintenance of a free economy," implied immunity from the antitrust laws may be found only "in cases of plain repugnancy between the antitrust and regulatory provisions." *Phila. Nat'l Bank*, 374 U.S. at 348, 350-51. "Repeal is to be regarded as implied only if necessary to make the [subsequent law passed by Congress] work, and even then only to the minimum extent necessary." *Silver v. N.Y. Stock Exch.*, 373 U.S. 341, 357 (1963).

211. "Even when an industry is regulated substantially, this does not necessarily

[12] It is unclear whether Defendants still stand by their categorical claim, because defense counsel stated in argument at the end of trial: "It is not the defendants' contention in this case that, because there are regulations, don't worry about competition." Tr. 3653:20-23 (Majoras).

evidence an intent to repeal the antitrust laws . . . .” *Nat’l Gerimed. Hosp. and Gerentology Ctr. v. Blue Cross of Kansas City*, 452 U.S. 378, 389 (1981). Where possible, courts should “reconcile[] the operation of both” antitrust and regulatory schemes, “rather than holding one completely ousted.” *Id.* at 392. In general, “[i]ntent to repeal the antitrust laws is much clearer when a regulatory agency has been empowered to authorize or require the type of conduct under antitrust challenge.” *Id.* at 389; *see also Credit Suisse Sec. (USA) LLC v. Billing*, 551 U.S. 264, 276-77 (2007) (fact that SEC has authority and uses that authority to address conduct at issue “considerably narrow[s] our legal task”). Conversely, an argument for implied immunity is “weaker” if there is no showing that “application of the antitrust laws . . . would frustrate a particular provision of [a statute] or create a conflict with the orders of any regulatory body.” *Nat’l Gerimed. Hosp.*, 452 U.S. at 390; *see also Credit Suisse*, 551 U.S. at 275-76 (considering whether “the [statutory scheme] and antitrust laws, if both applicable, would produce conflicting guidance, requirements, duties, privileges, or standards of conduct”).

212. Applying these principles, courts have rejected arguments for implied immunity in a variety of contexts, including (1) merger review, *see Phila. Nat’l Bank*, 374 U.S. at 350-52 (holding Bank Merger Act of 1960, “by directing the banking agencies to consider competitive factors before approving mergers,” did not create implied immunity to merger review under Section 7); *United States v. Rockford Mem’l Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990) (in hospital merger case, “neither generally nor in this instance does the existence of regulation work an implied repeal of the antitrust laws”); (2) health care settings, *see Nat’l Gerimed. Hosp.*, 452 U.S. at 383-84, 386-87, 393 (holding Blue Cross not immune from antitrust suit where challenged refusal to deal was based on hospital’s failure to obtain construction approval from a federally funded organization charged with health system planning for the local area); *Steward*

Health Care Sys., LLC v. Blue Cross & Blue Shield of R.I., 997 F. Supp. 2d 142, 153 n.6 (D.R.I. 2014) (rejecting argument that "the heavily regulated nature of health care markets makes it improper for courts to intervene on antitrust grounds"); (3) pricing and rate review, *see MCI Commc'ns Corp. v. Am. Tel. & Tel. Co.*, 708 F.2d 1081, 1104-05 (7th Cir. 1983) (holding AT&T not immune from predatory pricing claim on ground that AT&T's "rates and rate making methodology are subject to continuing supervision by the FCC"); and (4) where the agency has the authority to prevent the competitive harm, *see Otter Tail Power Co. v. United States*, 410 U.S. 366, 373-75 (1973) (rejecting argument that "refusals to deal should be immune from antitrust prosecution because the Federal Power Commission has the authority to compel involuntary interconnections of power").

213. There is no basis for finding that Defendants' proposed merger is impliedly immune from Section 7 review under these precedents. Defendants do not contend that immunity is "necessary" for the MA program to work, *see Silver*, 373 U.S. at 357, or that review of their merger "would frustrate" any relevant statute or "conflict with the orders of any regulatory body," such as CMS, *see Nat'l Gerimed. Hosp.*, 452 U.S. at 390. Plaintiffs are not aware of any case—and Defendants cite none in their Pretrial Brief—in which the court held that an otherwise anticompetitive merger was immunized by the presence of regulation.[13]

[13] The cases Defendants cite in their Pretrial Brief (at 20-21) are inapt and do not support their position that there is no need for antitrust scrutiny of their merger because of CMS's involvement in the MA program. *See, e.g.*, *United States v. FCC*, 652 F.2d 72, 106 (D.C. Cir. 1980) (affirming FCC order finding entry by satellite communications joint venture unlikely to produce anticompetitive effects, where FCC "took a hard look at suggested antitrust problems" under Section 7 and would have continuing authority to prevent anticompetitive effects should they arise); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 145 (E.D.N.Y. 1997) (finding anticompetitive effects from hospital merger unlikely where merged entity would not have an undue share of the relevant market); *United States v. Nat'l Ass'n of Broadcasters*,

(continued on next page)

214. Defendants' arguments show only that MA is a regulated business—one of many. *See* Tr. 3252:3-12 (Orszag) (explaining that MA is regulated, but not to the degree of a rate-regulated industry). Section 7 review of Defendants' merger in no way conflicts with or impedes CMS's consumer-protection-oriented regulations. Without more, the Supreme Court has rejected the argument that the antitrust laws have no role in heavily regulated industries. In *Philadelphia National Bank*, the Court detailed the "manifold" "governmental controls of American banking," such as indirect regulation of interest rates on loans, state usury laws, laws governing entry, branching, and acquisitions, and the "broad visitorial power of federal bank examiners" through which government agencies "maintain virtually a day-to-day surveillance of the American banking system." 374 U.S. at 327-29. But this pervasive regulation did not make application of the merger laws unnecessary or inappropriate. To the contrary, Section 7 requires "that the forces of competition be allowed to operate within the broad framework of governmental regulation of the industry. The fact that banking is a highly regulated industry critical to the Nation's welfare makes the play of competition not less important but more so." *Id.* at 371-72.

215. Furthermore, the Supreme Court has specifically rejected arguments that price regulation makes the antitrust laws irrelevant in situations where some degree of pricing competition remains possible. For example, while an agency's approval of filed rates may establish that they are "reasonable and non-discriminatory," it does not "foreclose the possibility that slightly lower rates would also have been within the zone of reasonableness," or "that the combination among [competitors] violated the Sherman Act." *Square D Co. v. Niagara Frontier*

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536 F. Supp. 149, 156-61 (D.D.C. 1982) (finding that certain advertising standards in a Section 1 challenge were per se unlawful and others warranted trial under rule of reason).

Tariff Bureau, 476 U.S. 409, 415 (1986) (reviewing *Keogh v. Chi. & Nw. Ry. Co.*, 260 U.S. 156 (1922)), and reaffirming that filed rates are subject to antitrust scrutiny). Similarly, when filed rates in a regulated industry are restricted to a "'zone of reasonableness' [that] exists between maxima and mimima," anticompetitive conduct "within that zone" can "constitute violations of the antitrust laws." *Georgia v. Pa. R. Co.*, 324 U.S. 439, 460-61 (1945).

216. In the merger context, courts have explicitly held that mergers in industries in which rate regulation is prevalent are nonetheless subject to antitrust scrutiny. *Town of Norwood v. New England Power Co.*, 202 F.3d 408, 422 (1st Cir. 2000) ("mergers or sales of assets by federally regulated utilities have been left open to antitrust challenge even though the resulting rates were subject to federal regulation and even though the merger or sale had been explicitly approved by the regulator"); *California ex rel. Lockyer v. Mirant Corp.*, 266 F. Supp. 2d 1046, 1057 (N.D. Cal. 2003) (declining to dismiss California's claim challenging acquisitions in wholesale electricity market under Section 7 of Clayton Act).

217. If anything, here, merger review under Section 7 is necessary for the MA program to succeed, as that program depends on competition to accomplish its mandate. Congress introduced MA specifically to harness the benefits of competition to improve health care coverage for seniors and to reduce program costs for taxpayers. *See supra* ¶ 34; *see also* MA Report at 8 (in adopting MA program, "Congress and other policymakers have attempted to . . . promote competition among MAOs"). In *Otter Tail*, the Supreme Court explained that the fact that Congress, in passing the statute at issue, "was concerned with 'restraint of free and independent competition,'" reinforced the Court's conclusion that "the limited authority" of the Federal Power Commission was not "intended to be a substitute for, or to immunize Otter Tail from, antitrust regulation." 410 U.S. at 374-75 (citation omitted); *see also Nat'l Gerimed. Hosp.*,

452 U.S. at 392-93 (emphasizing that Congress "made plain its intent that 'competition and consumer choice' are to be favored") (citation omitted).

218. The failure of Defendants' argument that the antitrust laws have at most a limited role here is made all the more clear by the evidence regarding CMS's oversight function. As discussed in the sections that follow, CMS's consumer-protection role is not a substitute for antitrust enforcement. In short, "[t]here is nothing built into the regulatory scheme which performs the antitrust function." *Silver*, 373 U.S. at 358.

b. CMS Regulation Is Not a Substitute for Antitrust Enforcement

219. Defendants argue that the merged firm will not be able to exploit the loss of competition to raise prices or reduce quality because of CMS's oversight of the MA program. This argument ignores the extensive evidence that MA plans compete across many dimensions of price and quality, and is contrary to CMS's vision for "the [MA] market to be competitive." Tr. 1220:2-3 (Cavanaugh).

220. CMS's oversight of conduct in the MA market is not designed to perform an antitrust function and cannot substitute for antitrust enforcement. CMS has no authority to enforce Section 7 of the Clayton Act or any of the other antitrust laws. Nor is there anything in the MA statutes or regulations to indicate that CMS is performing an antitrust function. *See* Tr. 149:22-24 (Frank) ("I think that the types of regulations that we've discussed here today were not meant to nor do they constrain the exercise of market power"). Much of CMS's oversight of MA is directed at consumer protection, such as appeal rights, measuring quality, and ensuring that information provided to seniors is accurate and clear. Tr. 1136:11-1137:3 (Cavanaugh); Tr. 2549:17-2550:2 (Coleman) (CMS reviews MA marketing materials to ensure they are accurate and understandable); Tr. 2559:22-2560:12 (Coleman) (rules to ensure each MA plan in a service area is meaningfully different are designed to reduce potential confusion); Tr. 2149:7-10

(Fernandez) ("there are CMS regulations that, in the rules and guidelines that they set up to protect the consumer—they're actually set up as consumer protection tests"); Tr. 1983:21-1984:25 (Paprocki).

221. CMS regulations do not displace competition. Tr. 138:15-16 (Frank) (MA regulations are "really not there to provide the discipline that a market provides."). At most, as Mr. Orszag admitted, CMS regulation amounts to the government's "setting the boundaries or the contours that the firms then would compete in." Tr. 3039:10-12 (Orszag). In other words, as Mr. Orszag further explained, "they're setting the terms of how the private firms then compete in the marketplace." Tr. 3039:17-19 (Orszag); *see also* Tr. 138:11-13 (Frank) (MA regulations are about "setting the standards for competition, defining the outer limits and the contours within which competition has to occur"); Tr. 1137:6-7 (Cavanaugh) (CMS "think[s] of [its] work as creating the framework that competition will happen within").

222. For example, CMS sets benchmarks for the maximum amount that the government will pay for individuals covered under MA plans based on how much it expends on Original Medicare. But the benchmarks act only as a "reference point"—"the starting point of the competition" against which MA plans bid. Tr. 1137:18-20 (Cavanaugh). MA plans are free to bid above the benchmark and charge seniors for the difference, and they are free to bid below the benchmark and offer better benefits. *See* Tr. 3252:10-12 (Orszag) ("[T]hey are not telling an MAO that you have to set a price of $26 instead of $27 unless it violates some other regulatory regulation that CMS has."); Tr. 122:19-123:11 (Frank). Indeed, competition drives most MA plans to be bid below the benchmark. In 2016, 94% of seniors in individual MA plans were enrolled in plans that bid below the benchmark. PX0551 (Nevo Report) ¶ 67.

223. Competition among MA insurers has led to better plans—more benefits and lower

costs—than mandated by CMS regulation. For example, CMS regulation dictates that an MA plan must meet a "network adequacy requirement" in any county in which it is sold. PX0104 at -215; Tr. 393:22-24 (Cocozza); Tr. 1140:2-16 (Cavanaugh); 42 C.F.R. § 422.112. Network adequacy is based on a formula for how many and how geographically close various providers, including hospitals and specialists, must be to beneficiaries. Tr. 1140:6-8 (Cavanaugh). These requirements are a "consumer protection" tool to "make sure the promise of the benefits is fulfilled." Tr. 1140:12, 15-16 (Cavanaugh).

224. But this minimum network requirement does not prevent MA plans from using "different strategies on network composition" to develop attractive plans and to control cost and quality, the result of which is "a lot of variation." Tr. 1140:19-1141:1 (Cavanaugh); *see also* Tr. 2193:9-13 (Fernandez) (Humana builds networks that are better than CMS minimum requirements because it tries to make its network "as competitive as possible"); Tr. 290:19-296:24 (Cocozza) (discussing provider network as an element of competition among MA plans); Tr. 3242:10-11 (Orszag) ("You have wide networks and narrow networks within MA").

225. As another example, while CMS caps at $6,700 the maximum out-of-pocket costs MA plans can charge seniors, most MA plans feature out-of-pocket cost limits significantly below the CMS cap. PX0551 (Nevo Report) ¶ 54 (61% of MA plans offered an out-of-pocket limit below the CMS requirement); PX0348 at 1 (2016 Kaiser Family Foundation MA market update reporting the average MA plan enrollee had an out-of-pocket limit of $5,223). Because there is no corresponding limit on the amount that seniors selecting Original Medicare pay out of pocket, Tr. 287:8-11 (Cocozza), this lower-than-required out-of-pocket limit reflects competition among MA plans. *See* PX0551 (Nevo Report) ¶ 54 n.68; *see also* PX0461 at -119 (describing Aetna as a "strong competitor" because of its lower maximum out-of-pocket limit); Tr. 788:13-

789:1 (Farley) (discussing PX0461).

226. Taken together, MA plans compete across many dimensions of price and quality within the boundaries established by CMS. CMS does not establish premiums, copays, networks, provider reimbursement rates, or coinsurance structures. *See generally* PX0104; *see also* Establishment of MA Program, 70 Fed. Reg. at 4589 (MA program was designed to "[u]se open season competition among MA plans to improve service, improve benefits, invest in preventive care, and hold costs down in ways that attract enrollees"); Tr. 1126:2-5 (Cavanaugh) ("They differ in premiums, they differ in cost sharing, they differ in the supplemental benefits they provide. They often have very different strategies around the network of providers that they include."); Tr. 3258:9-18 (Orszag) (agreeing that MA plans vary on many features and those differences may be important depending on the senior and the circumstances). And, of course, there are also aspects of how MA plans compete and do business over which CMS has no control, such as the combination of supplemental benefits they choose to offer in a particular market or their relationships with providers. *See, e.g.*, Tr. 1219:19-20 (Cavanaugh) (CMS has "no tools to dictate how the MA plans will reimburse the providers.").

227. Consequently, by significantly increasing concentration in the relevant markets, Aetna's proposed merger with Humana would put at risk the benefits to consumers derived from competition among MA insurers that takes place within the boundaries set by CMS.

c. The CMS Regulations on Which Defendants Rely Cannot Prevent the Exercise of Market Power

228. Whether taken alone or together, none of the CMS regulations Defendants raised at trial would prevent the merged firm from exercising market power post-merger, whether by increasing prices, reducing benefits, or otherwise decreasing the quality of its plans.

i. Limits on Changes in Total Beneficiary Costs Will Not Prevent a Price Increase

229. Defendants argue that CMS's total beneficiary cost rule would preclude anticompetitive price increases and benefit reductions. *See* Defs. Pretrial Br. at 22. This rule generally limits an MA plans' increase in total beneficiary cost to $32 per member per month, or $384 annually. PX0552 (Nevo Rebuttal Report) ¶129 n.161; Tr. 1943:20-1945:6 (Paprocki).

230. The total beneficiary cost rule would not prevent Aetna from exercising market power because it leaves insurers free to increase premiums or lower beneficiary coverage up to $32 per member per month. Tr. 1145:13-18 (Cavanaugh); *see also* Tr. 2014:8-14 (Paprocki) (confirming that an insurer could increase premium by 5-10% without triggering $32 total beneficiary cost test). Additionally, the total beneficiary cost rule does not prohibit an insurer from increasing premiums or decreasing benefits by up to $32 per month in consecutive years, which would allow for an increase of up to $64 per month after one year, or $96 after two. *See* Tr. 1226:22-1227:3 (Cavanaugh). Professor Nevo's merger simulation estimates that the proposed merger would cause the average rebate-adjusted premium for Aetna and Humana plans in the Complaint counties to increase by $29.21 per month, an amount below the yearly limit set by the total beneficiary cost rule. PX0552 (Nevo Rebuttal Report) ¶ 129 & n.162.

ii. Review of MA Plan Margins Will Not Prevent Aetna from Increasing Prices or Decreasing Quality

231. Defendants next argue that CMS review of individual MA plan margins will prevent Aetna from raising prices after it acquires Humana. As an initial matter, however, the extent of CMS's authority to restrict high margins for individual plans is unclear. Mr. Wheatley testified that he believes there is no regulation that allows CMS to regulate the margin for individual MA plans. Tr. 578:4-11 (Wheatley); *see also* Tr. 2005:10-18 (Paprocki) (he is not aware of any CMS rule identifying a specific margin cap). CMS Director Cavanaugh testified

that he is not aware of *any* rejected bids during his tenure, and is uncertain whether CMS even has the authority to reject a bid altogether. Tr. 1143:10-1144:7 (Cavanaugh).

232. Moreover, under the current regulatory regime, margins for individual plans vary significantly, including margins for Aetna and Humana plans, leaving the merged firm ample room to raise prices well above competitive levels. Humana's target bid margin for 2017 for all of its MA plans is about 4%, Tr. 569:20-23 (Wheatley), but Humana's target margins across its 20 geographic regions vary widely—from 0% to 10%. Tr. 572:8-19 (Wheatley). Humana's actual margins for individual plans have ranged from approximately negative 20% to positive 20%. Wheatley Apr. 22, 2016 Dep. 138:11-23, admitted into evidence at Tr. 579:25-580:6; *see also* Tr. 2196:4-9, 2196:16-18 (Fernandez) (Humana MA plans have margins that exceed 12%). Similarly, Aetna has a target bid margin of [redacted] for all individual MA plans in 2017, but Aetna's actual margins vary by region from [redacted] to [redacted]. PX0046 at -284 to -288. Aetna's individual MA plans have margins that vary even further, [redacted]. PX0039 at -675 (setting margin targets for 2016 [redacted]); Tr. 2004:7-15 (Paprocki) (CMS has approved Aetna bids with margins of 13% and 14%).

233. Finally, in practice, CMS rarely challenges insurers' margins, and when it does, the resulting process is a negotiation between CMS and the insurer. In 2017, for example, CMS raised objections to just three of Aetna's 239 bids, and all three of those bids went forward with small margin reductions after negotiation between Aetna and CMS. Tr. 1930:17-19, 2006:9-17 (Paprocki). The 2017 result is typical. Mr. Paprocki testified that in the few instances where CMS asks Aetna to lower its margin, Aetna will negotiate a small reduction. Tr. 2006:15-17 (Paprocki). CMS does not dictate what the margin will be; instead, Aetna lowers its margins by

"baby steps" until CMS stops asking for further reductions. Tr. 2006:6-2007:12 (Paprocki).

234. When CMS asks Humana to lower its bid margin, Mr. Wheatley testified that Humana similarly pushes back, "because bid margin management, to my knowledge, isn't a regulation that exists." Tr.576:22-577:1 (Wheatley); *see also* PX0581 (in response to discussion with CMS regarding bids with pretax target profit margins over 12%, Mr. Wheatley responded: "We've got to fight CMS regarding their ability to regulate our individual bid margins.").

235. Defendants also argue that insurers cannot exercise market power because CMS requires that an insurer's MA bid margins align with its actual margins over the long term and that those margins fall within 1.5% of the organization's non-MA margins. These margin parity rules are based on the aggregate margins across all of an insurer's individual MA plans, allowing for significant pricing flexibility at the individual plan level. Tr. 1938:22-1939:12, 2004:7-11 (Paprocki). Additionally, insurers can choose the level of aggregation they use for the 1.5% parity requirement; they even may aggregate plans across the entire corporation. Tr. 2004:7-2005:9 (Paprocki).

236. Neither the margin parity rules nor CMS's review of individual MA plan margins would prevent Defendants from increasing prices or reducing quality after the merger.

iii. The Medical Loss Ratio Regulation Will Not Prevent Aetna from Increasing Prices or Decreasing Quality

237. Defendants argue that CMS's medical loss ratio regulation will prevent anticompetitive price increases. But this regulation affords Aetna ample opportunity to raise prices on individual plans in the Complaint counties.

238. Under the medical loss ratio regulation, an MA organization must spend at least 85% of the premiums from each contract the organization has with CMS on benefits or quality improvement activities. 42 U.S.C. § 1395w-27(e)(4); Tr. 136:22-137:6 (Frank). If an MA

insurer's contract as a whole has a medical loss ratio below 85% in a given year, the insurer must make remittances back to beneficiaries. Tr. 1148:6-13 (Cavanaugh).

239. CMS calculates the medical loss ratio at the contract, rather than individual plan, level, which gives insurers significant flexibility to raise prices on individual plans. CMS contracts typically contain numerous individual plans, and contracts also can cover disparate and non-contiguous geographic areas. Tr. 2007:17-2008:21 (Paprocki) (Aetna has contracts with as many as 40 plans); Tr. 361:10-13 (Cocozza) (Aetna has a contract with plans in Iowa and Florida). As a result, medical loss ratios "could vary, and probably do[] vary substantially regionally." Tr. 1148:4-5 (Cavanaugh).

240. In practice, MA insurers have plans with medical loss ratios below 85%. Tr. 2009:3-8 (Paprocki); *see also*, *e.g.*, PX0362 at -779 (Aetna MA plans in [redacted] have projected 2016 medical loss ratios as low as [redacted]); PX0035 at -832 (Humana MA plan in [redacted] a 2016 medical loss ratio of [redacted]). And, even if a contract consists of only one plan, an insurer can raise the price of that plan if it has a medical loss ratio above 85%. Furthermore, the effect of the medical loss ratio rule on competition is not yet known because CMS has been collecting data only since 2014 and is only now ready to announce those initial results. Tr. 1148:14-17 (Cavanaugh).

241. At bottom, the medical loss ratio rule does not give insurers an incentive to bid at their costs or submit the lowest possible bid, and MA plans are under no obligation to do so. Tr. 137:20-25 (Frank); PX0553 (Frank Report) ¶ 68. Rather, vigorous competition among insurers creates an incentive to bid lower or offer enrollees more benefits. PX0553 (Frank Report) ¶ 68.

iv. The Meaningful Difference Rule Would Not Prevent Price Increases

242. Defendants are wrong to argue that CMS's meaningful difference rule would

prevent anticompetitive behavior. *See* Defs. Pretrial Br. at 4. The meaningful difference rule requires that an insurer's MA plans in any one county have a minimum difference in beneficiary expected out-of-pocket costs of $20. This is a consumer protection tool designed to reduce "potential confusion for beneficiaries choosing between multiple plan options." DX0613-001; Tr. 2559:18-2560:16 (Coleman); DX0014-162. The meaningful difference rule on its face does not prevent the merged firm from increasing prices, reducing benefits, or lowering the quality of its MA plans. In fact, the rule would not prevent an insurer from increasing the prices of all of its plans, so long as the insurer maintained the required $20 difference between plans.

243. The meaningful difference rule also has significant exceptions that allow insurers to offer plans in the same county with expected out-of-pocket costs within $20 of each other. The rule allows an insurer to offer two plans with the same expected out-of-pocket costs so long as the plans are of a different type (e.g., HMO vs. PPO) or they are offered under different CMS contracts, even if the plans are of the same type. Tr. 2009:22-2012:5 (Paprocki).

d. CMS Regulation Has Not Prevented MA Organizations from Exercising Market Power

244. Evidence shows that MA markets are susceptible to market power. The academic literature, through several kinds of evidence, finds that MA plans consistently bid above their costs, Tr. 129:3-132:1 (Frank), and bids are higher "in places where there is either more concentration or fewer plans," Tr. 131:17-19 (Frank). On average, MA insurers pass on only 50% of CMS benchmark increases to plan enrollees in the form of increased benefits or lower premiums, whereas in a market characterized by vigorous competition, all of the benchmark increase would be passed through to enrollees. Tr. 129:8-130:18 (Frank).

245. Professor Nevo also found substantial empirical evidence that CMS regulation has not constrained MA organizations from exercising market power. He found that premiums

increased following the Humana-Arcadian merger in markets where the two firms previously competed, despite CMS oversight. Tr. 1642:19-1643:23 (Nevo); *see also infra* ¶ 314. In addition, Professor Nevo's regressions relating to market concentration and premium prices showed that rebate-adjusted premiums increase as the number of MA competitors in a market decreases, again despite regulation by CMS. PX0552 (Nevo Rebuttal Report) ¶¶ 63-70.

2. Regulatory Changes to Medicare Will Not Prevent Harm from the Merger

246. Defendants contend that statutory decreases in the MA benchmarks and the formation of ACOs would prevent the merged firm from exercising market power because MA enrollees would substitute to Original Medicare instead. But the evidence shows that the benchmark reductions and formation of ACOs have not decreased MA enrollment or otherwise changed the competitive dynamic between MA and Original Medicare.

a. Reductions in MA Benchmarks Have Not Changed the Important Differences between Original Medicare and MA

247. The ACA instituted reductions in MA benchmark rates relative to Original Medicare to be phased in over a six-year period beginning in 2012 and concluding in 2017. 42 U.S.C. § 1395w-23(n), *as amended by* 21st Century Cures Act; *see also* Tr. 1127:13-1128:7 (Cavanaugh); DX0419 (Orszag Report) ¶ 37 (noting phase-in began in 2012 and will conclude in 2017). Congress reduced the MA benchmark because MA was attracting a distinct patient population that was "below-average cost," Tr. 1129:11 (Cavanaugh), and CMS was paying "more and in some cases substantially more" for MA coverage than for Original Medicare, Tr. 1127:21-24 (Cavanaugh).

248. Defendants offer no evidence beyond Mr. Orszag's unsupported speculation that the benchmark reductions have resulted in MA and Original Medicare becoming closer substitutes. Rather, the ACA benchmark reductions are nearly fully phased in, and MA

enrollment has consistently grown despite those reductions. PX0554 (Frank Rebuttal Report) ¶ 40, Ex. 6; Tr. 1846:25-1847:3, 1848:20-24 (Broussard); Tr. 637:11-638:1 (Wheatley). MA enrollment is forecast to grow by another million beneficiaries next year. Tr. 1118:6-11 (Cavanaugh).

249. Moreover, as discussed above, benchmarks are merely "the starting point of the competition." Tr. 1137:18 (Cavanaugh). MA plans can bid higher or lower than a benchmark, even when that benchmark shifts. And, regardless of the benchmark, MA retains "big picture" differences with Original Medicare in terms of limited networks, care management, out-of-pocket limits, and additional benefits such as dental, vision, hearing, and fitness. *See* Tr. 1130:21-1131:4 (Cavanaugh). In fact, the number of MA plans offering additional benefits has continued to increase each year. Tr. 1130:3-12 (Cavanaugh). During the period when the benchmark reductions were implemented, MA plans have continued to become more efficient and quality-focused, and they continue to bid below benchmark. *See, e.g.*, Tr. 602:11-20 (Wheatley); PX0551 (Nevo Report) ¶ 67 (in 2016, 94% of enrollees are in MA plans that bid below benchmark).

b. ACOs Do Not Make Original Medicare a Closer Substitute for MA

250. Defendants argue that ACOs will lower the cost of Original Medicare, make Original Medicare a closer substitute for MA, and therefore prevent the merged firm from exercising market power. Defs. Pretrial Br. at 22-23. An ACO is a network of health care providers that join together to coordinate and more efficiently deliver care to patients. PX0554 (Frank Rebuttal Report) ¶ 42. Created by the ACA, ACOs are paid on the fee-for-service Original Medicare model, but they may receive a bonus if they keep costs low for attributed patients and meet certain quality standards. PX0554 (Frank Rebuttal Report) ¶ 42.

251. ACOs do not reduce the many material differences between Original Medicare and MA. An Original Medicare enrollee in an ACO can continue to see providers outside of the ACO at no penalty. Tr. 132:21-133:7 (Frank); *see also* PX0554 (Frank Rebuttal Report) ¶ 44. An Original Medicare enrollee in an ACO does not receive expanded coverage, and is subject to the standard cost-sharing obligations under Original Medicare. PX0554 (Frank Rebuttal Report) ¶¶ 42, 44. Individuals do not choose to join an ACO, but rather are "passively attributed" to an ACO's network of providers. PX0554 (Frank Rebuttal Report) ¶ 46; Tr.1214:5-14 (Cavanaugh) ("they don't enroll in any sense"); Tr. 132:21-133:7 (Frank). In contrast, seniors who enroll in an MA plan select that plan from among competing options in their service area. DX0511-007 (MA is "more responsive to consumer needs [than ACOs] as it requires beneficiaries to enroll; thus consumer choice and market competitiveness is core to its program.").

252. ACOs have different incentives from MA plans. About 95% of ACOs are not at risk for losses due to patient expenditures and outcomes. Tr. 133:11-133:21 (Frank). Additionally, ACOs do not receive incentives to control patient drug costs under Part D. PX0554 (Frank Rebuttal Report) ¶ 44. MA plans have a much greater incentive to improve patient health and control costs than do ACOs because MA plans bear all of the risk for enrollees' health expenditures. Tr.1214:2-4 (Cavanaugh); Tr. 647:6-648:1 (Wheatley) (Unlike MA, "[a]ccountable care organizations do not take global risk").

253. Only about 16% of individuals in traditional Medicare are enrolled in an ACO. Tr. 132:4-16 (Frank). No evidence shows that ACOs affect MA competition or MA enrollment growth. Tr.1214:17 (Cavanaugh) (explaining that ACOs do not compete, "in any sense that I can think of"); Tr. 134:9-134:10, 134:21-24 (Frank) ("We've looked into this, and I have not found any evidence of that"). Rather, MA enrollment has grown steadily before and after the

implementation of ACOs. Tr. 134:6-14 (Frank)*; see also* PX0554 (Frank Rebuttal Report) ¶ 46, Ex. 6.

3. Defendants Cannot Rebut the Presumption by Divesting Enrollees to Molina

254. In an attempt to address competitive concerns with the proposed merger, Aetna and Humana have agreed to divest to Molina members enrolled in individual MA plans under CMS contracts in the 364 counties at issue. The divestiture would transfer approximately 290,000 seniors—without their consent—from their insurer of choice—Aetna or Humana—to Molina, a Medicaid company with a limited and largely unsuccessful experience in MA. For a number of reasons, the proposed divestiture is unlikely to preserve competition in the markets at issue.

255. To start, the divestiture is contingent on federal and state regulatory action and thus may not happen. Moreover, the divestiture is not the sale of an existing business entity, meaning that Molina—which currently does not operate in 323 of the 364 Complaint counties, and which has less than 500 MA enrollees after previous failures in the business—would need to develop critical competitive assets like provider networks, skilled employees, sales infrastructure, data analysis and IT systems, and an individual MA brand. This would be a "big fricken lift," in the words of the Molina executive responsible for the divestiture, Tr. 2502:7-13 (Rubino), and likely an unsuccessful one on based on expert analysis of past divestitures. Finally, Molina conceded at trial that it may exit counties with low volume or potential. Tr. 2492:13-2493:11 (Rubino). Thus, while the divestiture would be a bargain at a "screaming good price" for Molina, Tr. 2328:24-2329:10 (M. Molina) (words of Molina board member), it likely would not preserve competition in the Complaint counties or be a good deal for seniors.

a. Applicable Legal Standards

i. The Divestiture Must Replace the Lost Competition

256. A divestiture cannot save an otherwise unlawful merger unless it would "'restore competition,'" which "'requires replacing the *competitive intensity* lost as a result of the merger.'" *Sysco*, 113 F. Supp. 3d at 72 (citations omitted) (emphasis in original). Put otherwise, the divestiture "'must effectively preserve competition in the relevant market.'" *Id.* at 73 (quoting U.S. Dep't of Justice, Antitrust Division Policy Guide to Merger Remedies 1 (2011) (Remedy Guide)). An "effective divestiture addresses whatever obstacles (for example, lack of a distribution system or necessary know-how) led to the conclusion" that new entry in the market would not prevent competitive harm from the merger. Remedy Guide at 8.

257. Applying these principles, courts have rejected merging parties' attempts to justify otherwise anticompetitive mergers by proposing divestitures that would not create fully effective competition for the merged entity. *See Sysco*, 113 F. Supp. 3d at 73-78 (discussing reasons proposed divestiture would not remedy anticompetitive effects of merger); *Libbey*, 211 F. Supp. 2d at 47-49 (discussing evidence showing that revised transaction would not create a "viable competitor" in relevant market); *FTC v. CCC Holdings Inc.*, 605 F. Supp. 2d 26, 57-59 (D.D.C. 2009) (licensing of new firm unlikely to create effective competition in reasonable amount of time).

258. Where the record shows that the divestiture would not create an effective competitor, or that the divestiture might not occur at all, courts analyze the likely effects of the transaction absent the divestiture. *See, e.g.*, *Libbey*, 211 F. Supp. 2d at 50, 55 (shares without divestiture were "best evidence" of impact of merger); *White Consol. Indus., Inc. v. Whirlpool Corp.*, 612 F. Supp. 1009, 1029 (N.D. Ohio 1985) (because divestiture would not create effective competitor, divestiture buyer's shares immediately following transaction "would be fairly attributed to"

defendant), *vacated following amendment of parties' agreement*, 619 F. Supp. 1022 (N.D. Ohio 1985), *aff'd*, 781 F.2d 1224 (6th Cir. 1986); *see also CCC Holdings*, 605 F. Supp. 2d at 44-46, 56-59 (analyzing market concentration data without adjusting for growth in share of firm benefiting from divestiture); *United States v. Franklin Elec. Co., Inc.*, 130 F. Supp. 2d 1025, 1035 (W.D. Wis. 2000) ("However market share is analyzed and determined is irrelevant in this case, because defendants have failed to show that their agreements . . . change the manner in which their joint venture should be viewed . . . .").

259. "[T]o ensure an effective structural remedy, any divestiture must include all the assets, physical and intangible, necessary for the purchaser to compete effectively with the merged entity. This often will require divestiture of an existing business entity." Remedy Guide at 7; *see also Sysco*, 113 F. Supp. 3d at 76-77 (discussing buyer's "disadvantages in terms of human resources" and lack of industry expertise). The sale of a business unit with a track record of "competing in the market" is more likely to succeed than a piecemeal divestiture that would require an unproven buyer to develop the capabilities needed to compete effectively. Remedy Guide at 8-9.

ii. As With Other Rebuttal Arguments, Defendants Bear the Burden of Showing that the Divestiture Undermines Plaintiffs' Prima Face Case

260. Defendants argue that Plaintiffs bear the burden of showing that "the merger as a whole—including any divestitures the Court might order—will unlawfully restrict competition," citing this Court's decision in *Arch Coal*. Defs. Pretrial Br. at 26. *Arch Coal* differs from this case in at least two important respects. First, this Court in *Arch Coal* did not doubt that the divestiture of the Buckskin mine to Kiewit would take place if the merger were allowed to proceed. *See FTC v. Arch Coal, Inc.*, No. 04-0534 (JDB), slip op. at 5 (D.D.C. July 7, 2004) (concluding that "the Buckskin sale will definitely occur"). Under those circumstances, the Court

reasoned that excluding all evidence of the divestiture—as the FTC requested—"would be tantamount to turning a blind eye to the elephant in the room." *Id.* at 7-8. Here, on the other hand, there is significant uncertainty about whether the divestiture will be consummated. *See infra* Section IV.E.3.d.

261. Second, in *Arch Coal*, there was no issue about whether Kiewit could compete effectively after its acquisition of the working Buckskin coal mine. The record showed that Kiewit, a large, sophisticated firm with other mining interests, had both the ability and intent "to increase production at Buckskin by several million tons per year." 329 F. Supp. 2d at 147-48. Indeed, the record indicated that Kiewit "will be a stronger competitive force in a post-merger market than Triton has been or will be if no merger occurs." *Id.* at 157.

262. Similarly, in *United States v. Atlantic Richfield Co.*, 297 F. Supp. 1061 (S.D.N.Y. 1969), *aff'd sub nom. Bartlett v. United States*, 401 U.S. 986 (1971), also cited by Defendants, the court held that the proposed divestiture to BP of the acquired firm's retail gasoline assets in the northeast could not be "completely ignored," as the government requested, because the record showed that "there is no doubt that if the sale is made BP will actively and vigorously market gasoline in that area through the extensive Sinclair facilities it has acquired" and that, "[b]acked by its parent, British Petroleum Co. Ltd., it appears to have ample strength and resources to do so." 297 F. Supp. at 1068. In stark contrast to the situations in *Arch Coal* and *Atlantic Richfield*, the record here shows that the bare-bones divestiture to Molina proposed by Defendants is unlikely to replace the competition that would be lost through the merger. *See infra* Sections IV.E.3.f-g.

263. Within the burden-shifting framework used in this circuit, *see Baker Hughes*, 908 F.2d at 982-83, Defendants bear the burden of establishing the effectiveness of the proposed

divestiture to replace the competition that otherwise would be lost through the merger, just as Defendants bear the burden on other rebuttal arguments to Plaintiffs' prima facie case. *See Staples II*, 2016 WL 2899222, at *25 n.15 ("Defendants bear the burden of showing that any proposed remedy would negate any anticompetitive effects of the merger"); *Sysco*, 113 F. Supp. 3d at 72-78 (addressing divestiture as part of Defendants' rebuttal case); *CCC Holdings*, 605 F. Supp. 2d at 56-59 (discussing proposed "fix" in context of Defendants' rebuttal arguments); *Franklin Elec.*, 130 F. Supp. 2d at 1033 ("[D]efendants have the burden of proving their contention that because of the proposed licensing and supply agreements with Environ the number of competitors will not change.").

264. Plaintiffs are not asking the Court to "turn a blind eye" to the proposed Molina divestiture. To the contrary, Plaintiffs presented substantial evidence concerning the likely ineffectiveness of the divestiture. In a case such as this one, however, where the divestiture is unlikely to create a viable new competitor, Plaintiffs should not be required to prove a violation using post-divestiture market share and concentration data. Requiring Plaintiffs to do so would assume away the threshold questions of whether the divestiture would be consummated or Molina would function as an effective competitive replacement for Aetna and Humana.[14] *See, e.g.*, *Libbey*, 211 F. Supp. 2d at 50 ("Although no statistics were presented regarding what effect the amended agreement might have on the market, the best evidence of its potential effect is the

[14] Moreover, even if the Court concludes that Plaintiffs failed to make their prima facie showing based on market shares that do not reflect the divestiture, Plaintiffs' separate proof that the elimination of direct competition between Aetna and Humana likely would harm consumers, *supra* Section IV.D, is sufficient for a finding of liability under Section 7. *See Sysco*, 113 F. Supp. 3d at 61 ("[c]ourts have recognized that a merger that eliminates head-to-head competition between close competitors can result in a substantial lessening of competition").

impact of the original agreement [i.e., with no divestiture] . . . ."); *White Consol. Indus.*, 612 F. Supp. at 1029 (where divestiture would not create effective competitor, "[t]he Court must, therefore, determine whether the defendants have overcome the *prima facie* case made out by the statistics" that do not reflect the divestiture).

b. The Divestiture Process

265. In June 2016, Aetna approached 14 potential buyers about a sale of select Aetna and Humana assets. PX0536 at 7. Although 13 buyers initially expressed interest, only five submitted bids. PX0536 at 7; Tr. 1346:7-14 (Bertolini). Of those, only InnovaCare, WellCare, and Molina submitted bids for all of the divestiture assets. PX0536 at 7.

266. Each potential buyer had significant deficiencies. *See, e.g.*, PX0433 at 3. InnovaCare is a small insurer that operates exclusively in Puerto Rico. Tr. 392:11-18 (Cocozza). In Aetna's view, it had [redacted] PX0433 at 3. WellCare has had difficulties with CMS regulations and sanctions, as well as trouble with law enforcement. Tr. 393:8-14 (Cocozza); Tr. 1348:6-12 (Bertolini). Finally, Molina has, in Aetna's words, "limited breadth of experience in the Medicare market," which is "limited to a different type of Medicare market" and generally is in different geographic areas. PX0433 at 3; *see also* Tr. 1349:8-15, 1350:3-9 (Bertolini). Aetna noted that "Molina may have some challenges in building infrastrucutre [sic] to support this large block of business." PX0433 at 3.

267. Aetna selected Molina as the winning bidder. On August 2, 2016, Molina entered into separate Asset Purchase Agreements with Aetna and Humana (together, APA), as well as Administrative Services Agreements with both Aetna and Humana (ASA). PX095; PX096.

c. Molina Is Not a Suitable Divestiture Buyer

i. Molina Is a Medicaid Company

268. Molina's core business is Medicaid. Tr. 2336:21-23 (M. Molina). Its product offerings to date have all been extensions of its Medicaid business, and it has a limited Medicare presence. Molina's membership reflects this: 84% of its members are enrolled in Medicaid plans, Tr. 1241:22-1242:2 (Burns), and 13% are enrolled in plans offered on the ACA public exchanges, which also target low-income individuals near the federal poverty line, Tr. 1242:3-5 (Burns); PX0560 (Burns Rebuttal Report) ¶ 58. Only 2% percent of Molina's membership is enrolled in Medicare programs, and the vast majority of Molina's Medicare business consists of individuals dually eligible for Medicare and Medicaid. Tr. 1242:15-23 (Burns); *see also* Tr. 958:20-960:17 (J. Molina).

269. Defendants point to Molina's past acquisitions as evidence of its ability to take on new business, but these transactions confirm Molina's commitment to *Medicaid*, not Medicare. With the exception of Providence Health (which involved behavioral health services), each of Molina's acquisitions in the past two years involved Medicaid assets, not MA. Tr. 2299:1-11 (M. Molina). Moreover, Molina has consciously decided not to acquire MA plans on other occasions. *See, e.g.*, Tr. 2302:11-2303:4 (passing on Universal American MA assets); *see also* PX0236 at -605 (considering only WellCare's Medicaid, not MA business). Most telling, however, is that with respect to the divestiture here, Molina first reached out to Aetna in January 2016 about purchasing Medicaid, not Medicare, assets. Tr. 962:6-12 (J. Molina); PX0529 at 4-5; PX0585.

270. Indeed, Molina is an insignificant participant in MA and industry participants do not view Molina as a noteworthy Medicare player. *See, e.g.*, Tr. 1216:20-1217:2 (Cavanaugh); Tr. 2506:19-2507:5 (Buckingham). In 2016, Molina's MA business had a total enrollment of 424 members in six counties in two states, PX0532 at -385; Tr. 961:5-7 (J. Molina), accounting for

approximately .01% of its enrollment. Tr. 1243:1-2 (Burns). Molina has approximately 100,000 enrollees in total in its dual-eligible, special needs plans (D-SNP) and Medicare-Medicaid Plans (MMP). Tr. 1242:15-23 (Burns); Tr. 958:20-960:14 (J. Molina). Its D-SNP business is not profitable, Tr. 975:3-7 (J. Molina), and it has a very high medical loss ratio (the percentage of premium used to pay benefits) of 96.5% that is trending upwards, Tr. 2378:2-7 (M. Molina); Tr. 1244:19-1245:8 (Burns). Moreover, Molina's Medicare business overlaps with the Complaint counties only to a limited extent: it has no Medicare presence in 95% of the Complaint counties. Tr. 1244:3-7 (Burns).

271. There are significant differences between the Medicaid and individual MA businesses, as well. Medicaid and MA patients differ demographically and have different health needs. For example, the Medicaid population is heavily weighted toward low-income, younger individuals, as well as pregnant women and children. Tr. 1240:3-24 (Burns). In contrast, most MA beneficiaries are 65 years of age or older, tend to be more affluent than Medicaid beneficiaries, and typically age into Medicare from employer-based health insurance. Tr. 1240:3-24 (Burns).

272. Medicaid plans also usually have limited networks built around low cost providers, which are not designed for the older and relatively more affluent individuals enrolled in MA plans. PX0559 (Burns Report) ¶ 87. In addition, in most states, Medicaid beneficiaries are automatically enrolled, while MA plans actively enroll beneficiaries. Tr. 1241:16-21 (Burns). As a Molina board member cautioned Molina's CFO when considering the divestiture, the individual MA business "is a very different business from what we do, including commercial marketing, pricing, contracting, etc." PX0083.

273. In addition, the divestiture departs from Molina's longstanding strategy of

expanding its non-Medicaid business in areas where it has an established Medicaid business and can target a similar demographic. Tr. 2344:6-13 (M. Molina) (describing non-Medicaid expansion as "an extension of [Molina's] Medicaid product"). For example, Molina's past attempt to enter MA was premised on a strategy of capturing individuals slightly above the income level of a dual-eligible enrollee. Tr. 2474:12-24 (Rubino). Moreover, while Molina is considering entering new MA markets in the future, but plans to target Medicare eligibles at less than 250% of the federal poverty line, "consistent with [its] Exchange" business in a service area that is "[a] subset of D-SNP counties." PX0245 at -563.

ii. Molina's Board and Management Recognize its Limited Capabilities

274. The pre-litigation, ordinary course documents from Molina's board and management underscore that Molina lacks the capabilities to take on the divestiture assets, much less compete effectively with them. When Molina was preparing to bid on the divestiture assets, Molina executives and board members candidly expressed serious reservations about Molina's ability to compete in MA markets. A Molina board member—the former CFO and CEO of Coventry, Tr. 967:19-968-17 (J. Molina)—also recognized Molina's lack of experience, stating that MA is a "very different business from what we do" and "[u]nless we can acquire some talent as part of the deal, I think we are woefully under-resourced to be able to take this on." PX0083. Molina's CFO responded, "Agree wholeheartedly." Tr. 968:18-24 (J. Molina); PX0083. Another board member described Molina as "lack[ing] management with the requisite Medicare skills," and a third board member noted that the "sales and marketing of MA is a really different process for us." PX0084; PX0271 at -807. Molina's CFO acknowledged that "Aetna and Humana have had many years to build up name recognition, provider and broker relationships, as well as efficient processes," and Molina does "not have the same level of administrative expertise."

PX0081 at -327; Tr. 966:11-967:8 (J. Molina). In a memorandum to Molina's board, he admitted that he was "not of the mind to pursue such a large transaction, although from a bidding strategy, it may not be a bad approach to put in a low-ball bid for the entirety." PX0103 at -274. Molina's CEO told his board that, "to convince the DOJ that we are the right fit for the divested assets," Molina was working on "shoring up our Medicare marketing and sales capability." PX0533 at -539. In one exchange, Molina's CEO and a board member expressed concern over Molina's ability to handle the divested assets if Molina were successful in its bid: "The image that comes to my mind here is the dog chasing the car and we are the dog. What happens if we catch it?" PX0086.

iii. Molina's Financial and Operational Issues

275. Molina is also financially weaker than Aetna and Humana. Molina's 52.4% debt-to-equity ratio is the highest in the health insurance industry. Tr. 993:15-17 (J. Molina); Tr. 1245:13-20 (Burns). Molina's bonds are rated double B, non-investment grade status, commonly known as "junk bonds." Tr. 1245:21-22 (Burns); Tr. 2297:19-2298:1 (M. Molina).

276. Moreover, Molina has had numerous operational problems in the past year. As Molina's CEO explained to investors earlier this year, the company's many Medicaid acquisitions in 2014-2015 created a "strain" on member and provider services, care and utilization management, provider payment, and information technology. PX0341 at 3-4; *see also* PX0226.

iv. Molina May Withdraw From Many Complaint Counties

277. After the divestiture, Molina may not compete in all the divested states and counties. In an email written just one day prior to the execution of the APA, Lisa Rubino, the Molina executive responsible for the divestiture, stated that in those areas "[w]here there is low

membership volume or potential we might reduce the county footprint." PX090 at -195. At trial, Ms. Rubino confirmed that this was still a possibility. Tr. 2493:8-2494:6 (Rubino).

278. Further, Ms. Rubino testified that Molina's "first priority is to focus on" the 12 of the 21 states that make up "the majority of the membership" with "the additional nine [states being] sort of a second tier." Tr. 2402:16-2403:2 (Rubino); *see also* PX0241 at -460 (identifying 13 of 22 "key states"); PX0248 at -445 (identifying "13 initial target states for immediate action"). As its internal strategy document for the divestiture reflects, Molina has no documented plans for how to offer competitive MA plans to approximately 35,000 beneficiaries in over 120 Complaint counties in Molina's "second tier" states—each of which is a relevant antitrust market. PX0248 at -445 (showing no plans to take any preparatory action in eight states).

d. The Proposed Divestiture to Molina May Not Happen

279. Even if permitted to proceed, it is by no means certain that the divestiture to Molina would be consummated as the transaction faces a number of regulatory and contractual hurdles.

280. First, the divestiture is conditioned on CMS approving the novation of Aetna and Humana MA contracts, that is, the splitting of existing Aetna and Humana contracts to create new contracts between CMS and Molina limited to the counties individually covered by the divestiture. PX0096 at -335; PX0095 at -625. However, these novations would be contrary to longstanding CMS regulations, which restrict novations to a change in ownership of an entire Medicare "book of business." Tr. 1153:11-1154:10 (Cavanaugh); *see also* Tr. 2581:3-7 (Coleman); 42 C.F.R. § 422.550(c) ("A novation agreement is an agreement among the *current owner of the MA organization*, the prospective *new owner*, and CMS") (emphasis added); PX0104 at 539 (Medicare Managed Care Manual stating "CMS review results in a determination that: The proposed owner is in fact, the successor in interest or title of the transferor's entire

Medicare book of business"). These regulations are designed to protect enrollees, who rely on "the benefits, the service, the star rating" of the MA plan they selected, by preventing insurers from selling select portions of their MA plans. Tr. 1153:11-1154:10 (Cavanaugh). And it is not clear "whether [CMS officials] have the authority to or not" to approve the novations for the divestiture, as Defendants are asking CMS to "do something other than what [their] regulations provide." Tr. 1160:13-24; 1163:14-23 (Cavanaugh).[15]

281. Although Defendants may urge the Court to interpret those regulations differently than Director Cavanaugh, CMS's interpretation of its own regulations is "controlling unless plainly erroneous or inconsistent with the regulation." *Auer v. Robbins*, 519 U.S. 452, 461 (1997) (internal citation omitted). The issue of whether to or not to novate contracts was discussed only informally with CMS and CMS has not decided that issue. Tr. 1168:12-1169:4 (Cavanaugh). Moreover, CMS is not a Plaintiff in this litigation. Tr. 2575:9-18 (Court exchange with Aetna counsel); *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 569 (1992) (plurality opinion) (resolution of a legal issue by the district court is not binding on federal agencies where the agencies are "not parties to the suit."); *Nuclear Info. & Res. Serv. v. Nuclear Regulatory Comm'n*, 457 F.3d 941, 955 (9th Cir. 2006) (dismissing a case for lack of standing because non-party agency would "be under no obligation" to change its rule).

282. Second, the divestiture to Molina is also conditioned on Molina's receiving "reasonably adequate assurances from CMS" that Defendants' existing star ratings will transfer

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[15] *See also* Tr. 1153:11-1154:10 (Cavanaugh) ("Forget regulating plans for a second. It goes back to the beneficiary. We want both at a psychological level the beneficiary not to think we're viewing them as a commodity for sale, but also, this is a beneficiary choice program. The beneficiary chose to be in a certain plan. Maybe they didn't reconsider that choice as often as we'd like, but at some point [they chose] . . . based on all the factors that I described, the benefits, the service, the star rating.").

to Molina's new contracts. PX0095 at § 6.02(e); PX0096 at § 6.02(e). The transfer of the star ratings was an important issue for Molina in its negotiations with Aetna. Tr. 986:22-987:3 (J. Molina); Tr. 2484:6-17 (Rubino) (transferring star ratings will assist in continuity of benefit coverage and network development).

283. Yet assigning Defendants' star ratings to new contracts created for Molina would be contrary to CMS practice. DX0349-009. When one company acquires another company, the ownership of a Medicare contract is transferred intact, including its star ratings, to the new owner. DX0151-026 to -027. However, when a new contract is created for a current MA insurer, CMS assigns the new contract the average star rating of their new owner. DX0349-009.

284. Finally, regulators in the states where the divested assets are located may need to approve the transaction and the divestiture. Tr. 985:13-21 (J. Molina). In approving the merger, Florida's Office of Insurance Regulation expressed skepticism about any divestiture, noting that a divestiture "is not in the best interest of policyholders in the state of Florida as it may be disruptive to policyholders and also may be short term in nature.") PX0476 ¶ 22. It also approved the merger on condition that the merged entity expand its on-exchange ACA business into five new counties in 2018, but Aetna has withdrawn from the on-exchange business in Florida. PX0476 ¶ 22; PX0133. Additionally, the Missouri Department of Insurance issued a preliminary order blocking the Aetna and Humana merger. PX0076.[16]

285. In sum, the divestiture to Molina is not certain. As Molina's CEO summarized, "it's not a done deal." Tr. 2381:9-22 (M. Molina); PX0065 (noting that the "divestiture is

[16] The order allows the defendants to submit "a plan to remedy the anticompetitive impact of the acquisition" and provides that the Director would review it to "specify the conditions" under which the transaction, with the proposed remedy, could be approved. PX0076 at 41.

contingent" and that "[i]t is not a certainty").

e. Molina's Prior Failures in MA Reflect the Riskiness of Molina as a Divestiture Buyer

286. Molina's past failures in individual MA show that Molina's experience with D-SNP plans did not provide it with the expertise needed to compete effectively in individual MA. Molina began offering MA plans in 2008 with the "primary rationale" being "to create a safety net for [dual eligible] enrollees who lose Medicaid eligibility." PX0092 at -680. By 2011, Molina was offering individual MA plans in eight states with a combined enrollment of 4,620 members. PX0092 at -680. The plans, however, were "negative earner[s]" and the "benefits, network and formulary by market [were] average or below average compared to [individual MA] competitors." PX0092 at -681; *see also* PX0242 at -605 (internal Molina email stating "given our inability to produce a competitive product, and the ensuing risk of attracting the wrong membership . . . I don't see a clear path for success in this line of business"); PX0107 at -710 ("It seems like we are in the doom loop, so I believe it would make sense to exit").

287. In 2012, Molina decided to terminate its MA plans, citing, in part, its "limited expertise and competitive standing and no clear strategy around our focus in the [MA] market." PX088 at -774.[17] As of 2013, Molina had withdrawn from MA in all states except New Mexico, and it withdrew from New Mexico in 2015. PX0249 at -923; PX0559 (Burns Report) ¶¶ 46-48.

288. All told, Molina has sold individual MA plans in 63 counties. PX0559 (Burns Report) ¶ 42. Today, however, Molina offers individual MA plans in only six counties in two states, California and Utah, with a combined enrollment of only 424 members. PX0532 at -385;

[17] Although Ms. Rubino tried to discount this statement by stating that "[f]our years ago that appears to be right," there is no evidence that Molina has done anything since then to gain expertise in MA. Tr. 2478:22-2479:7 (Rubino).

Tr. 1276:6-1277:2 (Burns); PX0559 (Burns Report) ¶ 42. And Molina will be exiting from California in 2017 after it made a mistake in the bidding process and CMS denied its application. Tr. 2481:3-7 (Rubino); PX0544 at -653. Thus, absent the divestiture, in 2017 Molina would offer MA only in Utah. PX0559 (Burns Report) ¶ 32.

289. Molina's experience in Utah is instructive. When Molina reentered Utah with an MA plan in 2014, it thought that its D-SNP and Medicaid businesses positioned it to succeed. Tr. 2379:1-6 (M. Molina); PX0707 at 1. Molina had been in the state selling Medicaid for 19 years and D-SNP plans for eight years. Tr. 2376: 22-2377:3 (M. Molina). But Molina's Medicaid presence and relative success in D-SNP in Utah did not produce success in MA. Tr. 2380:17-2381:2 (M. Molina); PX0707 at 1. Molina's MA plan in Utah has fewer than 400 enrollees and less than 1% market share. Tr. 2380:17-2381:2 (M. Molina); Tr. 2482:3-8 (Rubino). Mr. Orszag conceded that, under his standard for meaningful entry, Molina is not a significant competitor today in Utah. Tr.3348:17-23 (Orszag).

290. Molina's experience in California is similar. Despite offering an MA plan essentially in the backyard of its corporate headquarters and in counties in which it has offered Medicaid and D-SNP plans for years, Molina has less than 100 enrollees and less than 1% market share. Tr. 2479:19-2481:2 (Rubino).

f. Molina Lacks the Resources to Compete Effectively

291. Success in MA requires competitive provider networks, high star ratings, skilled employees, infrastructure, and broker networks, among other assets. PX0559 (Burns Report) ¶ 67. Molina currently does not have these resources, and would not obtain them with the divestiture. It would be a "big project" for Molina to develop them, Tr. 2499:13-2502:12 (Rubino), and it is unlikely to do so—with or without Aetna's "help" under the ASA.

i. Molina Will Have Difficulty Replicating Aetna's and Humana's Provider Networks

292. Molina not only will need to replicate Aetna and Humana's provider networks of hospitals and physicians, but will need to obtain competitive rate and non-rate terms. Having a competitive provider network generally requires more than merely meeting CMS adequacy requirements, Tr. 291:14-20 (Cocozza), and is critical to the success of an individual MA plan, PX0412 at -735; *see also* PX0015 at -856 (dissatisfaction with provider network is one of the principal reasons seniors change MA plans). As Molina Senior Vice President Lisa Rubino observed, if Molina loses key providers, it "will lose members in droves." PX0102 at -449; *see also* PX0241 at -459 ("getting the aetna humana network on board with Molina will be key to retention and lead generation").

293. Molina is not acquiring either Aetna's or Humana's provider contracts. Tr. 380:5-9 (Cocozza); Tr. 2538:9-17 (Buckingham). Instead, Molina will be on its own to negotiate new contracts with providers and "put it on [their] own paper." Tr. 2466:24-2467:9 (Rubino).[18] Molina faces a large initial hurdle, however, as it currently has no presence in 89% of the Complaint counties and no Medicare presence in 95% of Complaint counties. Tr. 1243:15-19; 1244:3-7 (Burns); *see also* PX0560 (Burns Rebuttal Report) ¶ 5.

294. Although Defendants have introduced an "overlap analysis" that purports to show Molina's current provider network compared with the top handful of Aetna and Humana

[18] Prior to entering into the APA, Molina believed that a key part of the deal "was a provision relating to Aetna and Humana assigning provider contracts to Molina." Tr. 2466:18-23 (Rubino). However, Defendants have since abandoned plans to assign provider contracts. Tr. 380:5-9 (Cocozza); Tr. 2538:9-17(Buckingham). In any event, as few as [redacted] of Aetna's hospital contracts are assignable. PX606 at -730, Tab 2. Moreover, providers usually would be able to opt out of the contracts on short notice. Tr. 2539:24-2540:8 (Buckingham).

providers, this offers little support to Molina. For example, the overlap for Molina's physician/ancillary network is 0% in Pennsylvania, 3% in Virginia, and 6% in Nevada. DX0145. Except in Utah and Texas, no state has over 65% overlap in the physician/ancillary network, and in 12 states there is no overlap in provider network at all. DX0145; Tr. 2489:16-2491:10 (Rubino).

295. Even if Molina were to get contracts with the key providers in the divestiture counties, Molina would lack the scale necessary to negotiate comparable rate and non-rate terms to replicate the competitiveness of Defendants' provider networks. Non-rate terms are important and include value-based contracts, provisions requiring additional services that support star ratings, and provisions relating to care coordination, utilization management, and claims payment. Tr. 1255:20-1256:7 (Burns); PX0559 (Burns Report) ¶ 83.

296. Here, Molina is not acquiring either Aetna's or Humana's provider contracts. Tr. 380:5-9 (Cocozza); Tr. 2538:9-17 (Buckingham). Instead, Molina will be on its own to negotiate new contracts with providers and "put it on [their] own paper." Tr. 2466:24-2467:9 (Rubino). Molina faces a large initial hurdle, however, as it currently has no presence in 89% of the Complaint counties and no Medicare presence in 95% of Complaint counties. Tr. 1243:15-19, 1244:3-7 (Burns); *see also* PX0560 (Burns Rebuttal Report) ¶ 5.

297. In some metropolitan areas, the divestiture includes only "collar" counties and excludes the central city county that contains key academic medical centers.[19] Tr. 1257:17-

[19] Dr. Molina testified that he did not believe that scale is relevant in negotiating provider contracts. But he told his board in support of submitting a bid for the divested assets that "the acquisition . . . would provide additional negotiating leverage with respect to its provider contracts." PX0103 at -268. Dr. Molina's attempt to disavow this document at trial is not credible. *See* Tr. 2369:20-2370:3 (M. Molina).

1259:21 (Burns); Tr. 952:10-13 (J. Molina). For example, in Philadelphia and St. Louis, Aetna was able to leverage its scale across the entire metropolitan area when negotiating contracts with the medical centers in Philadelphia and St. Louis counties. After the divestiture, Molina will have a small fraction of the lives that Aetna currently uses in these negotiations. Tr. 1257:17-1259:21 (Burns).

298. Finally, because Molina does not currently operate in most of the Complaint counties, it does not have established, ongoing relationships with key providers, which are critical to value-based partnerships. Tr. 1254:2-1255:4 (Burns). According to Aetna, providers view "[t]rust," "[f]avorable financial terms," and "[p]lans' local market share" as among the most important criteria in deciding whether to enter into value-based contracts. PX0278 at -219. The greater the number of enrollees an insurer has in a given locality, the easier it is to "get the providers' attention" to collaborate on value-based programs. Tr. 543:11-544:4 (Wheatley). Similarly, as Humana's Bruce Broussard explained, value-based contracting requires a "partnership" and the "deep, rich ability to come together" with a provider. Tr. 1838:5-1840:23 (Broussard). Without a significant commercial or Medicare presence, it can take insurers a year or longer to negotiate a provider network. Tr. 342:9-17 (Cocozza) (agreeing that "[i]n areas where Aetna does not have any sort of commercial presence there with the providers, it could take up to 18 months just to develop that network to meet the CMS requirements from your experience"). For example, it took Aetna two years to develop its MA provider network in Georgia. Tr. 1260:10-20 (Burns). For contracts involving risk sharing, "those take much longer to negotiate" than other contracts and "clearly are more complex because of all of the financial ramifications associated with them." Tr. 2521:7-10 (Buckingham).

ii. Star Ratings Are an Important Barrier to Molina Replacing the Lost Competition

299. Star ratings are another barrier to Molina's replacing the competition lost through the merger. High star ratings allow insurers to offer low premiums and attractive benefits to MA enrollees. *See, e.g.*, PX0008 at -329 ("Aetna's star ratings are helping us to maintain our $0 premium Medicare Advantage plans as well as to preserve valuable supplemental benefits. . . . Through high star ratings, we are able to create and maintain solidly competitive MA plans."); Tr. 540:25-541:7 (Wheatley) ("If I lose star ratings on a plan where I had high star ratings before, that will absolutely impact my ability to keep premiums and benefits stable."). Star ratings also can be important to seniors when selecting a plan. *See, e.g.*, Tr. 1342:16-22 (Bertolini) (seniors "have plenty of time to [shop]" and, "all other things equal," will choose a plan with higher star ratings).

300. Star ratings are important enough that, at Molina's insistence, the closing of the deal is conditioned on the transfer of the star ratings. Tr. 986:22-987:3 (J. Molina) ("We put that in there because we wanted to protect the star ratings."); Tr. 2484:9-10 (Rubino) (Molina "repeatedly" asked for this term). According to Ms. Rubino, if Defendants' star ratings do not "come over" with the divestiture, Molina is "at risk of not being able to honor current benefits" in the divested plans. PX0102 at -449; Tr. 2484:11-14 (Rubino). But as noted above in Section IV.E.3.d, transferring Defendants' star ratings to Molina is contrary to current CMS practice.

301. Even if, contrary to CMS practice, CMS agrees to transfer Defendants' star ratings to Molina, Molina would have difficulty maintaining those ratings. Molina has never had an individual MA plan rated higher than 3.5 stars and lacks Defendants' resources and star-

related expertise.[20] Tr. 1263:6-16 (Burns). Molina's CFO stated that he is "most concerned about our ability to maintain the STAR ratings and the additional income that comes with those." Tr. 977:20-978:4; PX0084 at -515.

302. Molina would need to make significant investments to acquire the ability to match Aetna's and Humana's star ratings.[21] Molina is unlikely to replicate the star-related infrastructure and expertise of Aetna or Humana. *See, e.g.*, PX0213.

iii. Molina Has a Weak Brand

303. Brand is an important competitive asset in individual MA. Tr.3340:4-3341:1 (Orszag); Tr. 1267:4-17 (Burns) (Aetna continued to use the Coventry brand after the acquisition "because it apparently was stronger than the Aetna brand and had more salience to the enrollees in the market so Aetna wisely kept it"); Tr. 289:15-22 (Cocozza) (strong brand can offset other weaknesses).

304. Seniors "use brand to infer the quality of an individual [MA plan]." Tr. 1266:19-21 (Burns). A strong brand also helps an insurer attract brokers. Tr. 1266:22-1267:8 (Burns); PX0559 (Burns Report) ¶ 142. For example, Humana's brand and reputation for service in North Carolina are so strong that it was able to overcome a $19 premium differential. Tr. 794:25-795:12 (Farley).

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[20] Historically, Molina's D-SNP plans have rated around three stars. Tr. 1263:6-12 (Burns). Molina obtained its first and only four-star rating—for a D-SNP plan in New Mexico—for 2017. Tr. 1263:9-10 (Burns); PX0559 (Burns Report) ¶ 118.

[21] Aetna has a Vice President over stars (the "Star czar") and a team of people dedicated to star ratings; and 91% of its enrollees are in plans rated 4 stars or higher. Tr. 300:25-302:1, 357:11-25 (Cocozza). Humana's star ratings program is a company-wide focus. Tr. 538:12-13, 539:24-540:1 (Wheatley). Even with this strong focus on star ratings, Humana recently stumbled and saw many of its ratings downgraded. PX0505 at 2.

305. Molina would have trouble developing a competitive MA brand. Tr. 1267:18-22 (Burns); PX0560 (Burns Rebuttal Report) ¶¶ 24-29. Molina's "name recognition," its CFO John Molina stated, "is largely tied to a lower-income population and product." PX0082 at -265. Mr. Bertolini agrees that Molina "definitely has a weak brand in the Medicare Advantage space." Tr. 1350:3-9 (Bertolini); *see also* Tr. 3341:15-24 (Orszag). Renee Buckingham, who has over 18 years of experience in the health insurance industry, did not learn about Molina until this past summer, Tr. 2535:11-18 (Buckingham), and "didn't know that they had any experience in Medicare Advantage," Tr. 2506:25-2507:5 (Buckingham). Because the seniors divested to Molina would go from Aetna and Humana "to a relatively unknown Molina in the Medicare space," Molina anticipates losing membership. Tr. 980:12-17 (J. Molina); PX0499 at -382; PX0082 at -265.

306. Importantly, building an MA brand takes time and would require "a lot of spadework." Tr. 1268:6-7 (Burns). Molina would "have to develop credibility, staying power, commitment, reputation for quality, the stars ratings, the relationships with the providers, the relationships with the enrollees." Tr. 1267:23-1268:7 (Burns). Molina's plan—to increase its ordinary course marketing budget by "a bit"—is likely to be insufficient to successfully build that brand. Tr. 992:15-21 (J. Molina); *cf.* PX0241 at -459 (email to Rubino stating that "[i]n the states where we have zero brand awareness (GA, MO, KS) but large membership, we will need to spend large $ to get the awareness and cover for our brokers and to drive calls/lead cards quickly").

iv. Molina Would Lack Employees, Sales Infrastructure, and Experience with Managing PPO Plans

307. Unlike Aetna's acquisition of Coventry in 2013, where Aetna acquired the operations, employees, IT systems, "brick and mortar," and Coventry's brand, Tr. 380:13-381:4

(Cocozza), Molina is not acquiring any such assets or infrastructure as part of this proposed divestiture. Instead, it will need to hire all of its own employees to manage the divested membership. Tr. 952:14-953:17 (J. Molina); Tr. 2333:2-11 (M. Molina). This was a clear concern for Molina's board members prior to agreeing to the divestiture. *See* PX0083; PX0084 at -515. With only 200 employees in its Medicare division, Molina's resources would be a fraction of those of Aetna, which has 3,100 employees working in MA nationwide and over 30,000 licensed brokers selling its MA products. Tr. 2450:7-2451:1 (Rubino); Tr. 261:9-262:18 (Cocozza).

308. Molina is also not acquiring Aetna's or Humana's broker network. Brokers play a crucial role in selling MA plans to seniors, and are viewed by seniors as "trusted advisors." Tr. 439:17-18 (Cocozza); Tr. 1264:6-13 (Burns). Molina would face challenges in establishing a competitive broker network. Molina has no MA business in the Complaint counties, and, while it has brokers for its public exchange business, those brokers may not sell MA plans. Tr. 1265:20-1266:1 (Burns). Given Molina's weak brand, "Medicare Brokers for the most part do not know who Molina INC is." PX0101 at -087; *see also* Tr. 1045:1-3 (Gonzalez) (Molina does not have a brand presence in Texas); Tr. 1086:6-15 (Fitzgerald) (Atlanta broker had not heard about Molina prior to the divestiture announcement).

309. Finally, the majority of the plans being divested are PPO plans rather than HMO plans. Tr. 1270:23-24 (Burns). Until now, Molina has "studiously avoided" PPO plans. Tr. 1271:25-1272:3 (Burns); *see also* Tr. 983:14-17 (J. Molina) (Molina never offered a PPO plan). John Molina, the principal negotiator of the divestiture agreement, was surprised to learn that 60% of the divestiture involves PPO assets—a fact that he discovered two weeks after the agreement had been signed. Tr. 984:10-985:5 (J. Molina); PX0247 ("how did we miss this?!").

310. A benefit of narrow-network HMO plans—the type most frequently offered by Molina—is the ability to control costs. Molina's MA plans are not profitable. It is unlikely that Molina, which has no PPO experience, could profitably operate PPO plans, for which cost containment is more likely to be an issue. Tr. 1273:1-22 (Burns); PX0559 (Burns Report) ¶ 156; *see also* PX0248 at -445 (a "key task" is to "[u]nderstand any contract impacts for new landscape with PPO relationships and contracts").

g. The ASA Will Not Solve These Problems for Molina

311. The ASA is, essentially, a stop-gap measure "intended to permit the buyer to make operational arrangements to administer the membership on a stand-alone basis." PX0526 at -026. Under the ASA, Aetna and Humana will perform all the functions necessary to manage the divested membership on Molina's behalf for a period of time. Tr. 2460:13-2462:1 (Rubino).

312. The ASA, however, offers no material assistance to Molina for building provider networks, broker networks, or gaining the experience necessary to manage the MA plans. Defendants have no obligation—save for "facilitating discussions"—to ensure that providers enter into new contracts with Molina. Tr. 2541:9-14 (Buckingham); Tr. 2467:10-25 (Rubino); *see also* PX0095 at Schedule 2.02 at -718; PX0096 at Schedule 2.02 at -427.

313. Moreover, the combined Aetna-Humana company would compete against Molina's divested plans during and after the term of the ASA. Tr. 2542:23-2543:24 (Buckingham). Thus, the merged firm will have little incentive to do anything more to assist Molina than minimally fulfill its contractual requirements. Tr. 1275:4-1276:5 (Burns); PX0559 (Burns Report) ¶ 79; *see also Sysco*, 113 F. Supp. 3d at 77 (recognizing that it can be a "problem" if a proposed divestiture allows "'continuing relationships between the seller and buyer of divested assets after divestiture'") (quoting *CCC Holdings*, 605 F. Supp. 2d at 59).

h. Expert Analysis Shows that the Divestiture Is Unlikely to Preserve Competition

314. The academic literature casts further doubt on Molina's prospects. Academics have studied divestitures across a wide range of industries and identified two conditions associated with unsuccessful divestitures: (1) a weak buyer, and (2) the buyer receiving "partial or insufficient assets." Tr. 1664:22-1665:21 (Nevo). The proposed divestiture to Molina "suffers from both of these flaws." Tr. 1665:20-21 (Nevo).

315. Humana's 2013 acquisition of Arcadian presents a case study. Humana divested Arcadian assets in 45 counties, but these divestitures did not preserve competition in many counties. Tr. 1645:4-1646:1 (Nevo). By 2016, the buyers had exited almost 50% of the divestiture counties and rebate-adjusted premiums increased on average by $15 relative to appropriate control counties unaffected by the merger. Tr. 1645:13-1646:11 (Nevo). Further, buyers that had no prior MA presence in a county—like Molina—did even worse than the average buyer. Tr. 1646:12-1648:2 (Nevo).

316. Building on this analysis, Professor Nevo calculated market concentration measures assuming that (a) Molina retained the percentage of enrollment after the divestiture that is retained by the average divestiture buyer without local experience, and (b) the enrollees lost by Molina join MA plans on the basis of market share. PX0551 (Nevo Report) ¶ 249. Under those assumptions, 90% of Complaint counties still meet the market concentration and change in concentration thresholds in the Merger Guidelines such that the merger warrants significant concerns. PX0551 (Nevo Report) ¶ 249.

i. A "Screaming Good Price" for Molina But Not a Good Deal for Seniors

317. John Molina agreed that Molina would "only pursue [the deal] if we can get a clear bargain." Tr. 977:11-19 (J. Molina). And, in fact, Molina got "a screaming good price," as

a board member put it. Tr. 2328:24-2329:6 (M. Molina). The purchase price is $401 per enrollee, PX0095 at -796; PX0096 at -502, a significant discount from the typical purchase price of $3,000 to $10,000 per member, Tr. 2249:24-2250:13 (M. Molina); PX0100 ("Everyone acknowledges the bargain price paid - 400 per member vs normal px for these lives that seems to range from 3-5k.").

318. A low purchase price can indicate that the divestiture will not replace the lost competition. *See Franklin Elec.*, 130 F. Supp. 2d at 1033 (low purchase price creates "minimal incentive" to make divestiture work effectively). Skepticism is especially warranted in this case. Given the "bargain price," PX0100, Molina can lose most of the enrollees but still make money on the divestiture, PX0559 (Burns Report) ¶ 56.

319. Defendants contend that the purchase price for Molina is $400 million, and, with that much invested in this business, Molina will be motivated to compete effectively. But that figure includes $280 million in statutory capital, which remains with Molina and would become available to Molina if it withdraws from MA markets. *See* Tr. 988:2-21 (J. Molina).

320. The discount rate that Molina used in its valuation of the divestiture highlights its riskiness. Although Molina generally uses a 10% discount rate for its Medicaid transactions, Molina's CFO recommended a 15 or 16% discount rate for the divestiture purchase because of the higher risk of the transaction. Tr. 995:7-13, 996:1-16 (J. Molina). Moreover, the $75 million termination fee—representing more than 60% of the value of the transaction—that Aetna and Humana would pay to Molina if the deal is blocked, or approved without requiring a divestiture, also emphasizes the riskiness of this transaction. PX0095 at § 08.03; PX0096 at § 08.03.

321. Molina's CFO noted that the transaction would not be a "bargain [for Molina] if the whole thing blows up in our face a year later," recognizing that "buying is one thing.

Integrating and operating is something else." Tr. 990:5-14 (J. Molina).

322. Again, Molina's pre-litigation, ordinary course documents—created during the due diligence phase—affirm the riskiness of this deal. On July 14, Lisa Rubino was unequivocal: "I have been clear with Dr. Mario and John-key to success . . . Their Star ratings need to come over-4-4.5-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 . . . G[eneral]A[gents] and broker network . . . Then the basics in ops and C[are] M[anagement] . . . big fricken lift." PX0102 at -449. Should Molina be unable to accomplish any of these "key" tasks, Molina will likely lose members, be unable to operate competitive care management, and may need to reduce plan benefits to seniors. Tr. 2499:6-2502:9 (Rubino).

323. In short, the risk is high that Molina will not be able to succeed with the divestiture assets and effectively replace the competition that would be lost as a result of a merger between Aetna and Humana.

4. New Entry or Expansion in the Relevant Markets Will Not Replace Lost Competition

a. Applicable Legal Standards

324. Defendants argue that new entry by insurers selling MA plans in the relevant markets will prevent harm from the merger. To rebut the government's case, Defendants need to show that entry by new firms or expansion by existing firms will "'fill the competitive void that will result'" from the merger. *H&R Block*, 833 F. Supp. 2d at 73 (quoting *Swedish Match*, 131 F. Supp. 2d at 169). Specifically, the entry must be (1) timely, (2) likely, and (3) sufficient to replace the lost competition. *Cardinal Health*, 12 F. Supp. 2d at 55-58. Defendants cannot meet these criteria.

b. Barriers to Entry in Individual Medicare Advantage

325. Barriers to entry in the individual MA market make successful and timely entry unlikely. According to Humana CEO Bruce Broussard, "the barriers to entry into the business [have] considerably increased" and "the smaller players will continue to have troubles competing." PX0062 at 4. Barriers include the need for a competitive provider network, high star ratings, strong brand, and MA-related operational expertise and infrastructure. Tr. 631:13-16 (Wheatley) ("The hardest part about getting into this business is knowing how to build networks, knowing how to file products, knowing how to manage CMS compliance, [and] knowing how to think about star ratings."); Tr. 1139:2-4, 9-11 (Cavanaugh) (compliance with "minimum standards" set forth in MA regulations does not ensure a new entrant will be "a successful competitor"); PX0007 at -848 ("Medicare has unique aspects that require a clinical engagement approach, scorecard, stars element and coding/revenue attention that is different [from other forms of health insurance]."); DX0506-048 ("New market entry presents several challenges, including building local competitive intelligence, developing provider relationships, and understanding the nuances of local distribution.").

326. Mr. Cavanaugh explained that, due to such barriers, entrants "really operate on the margins." Tr. 1139:22-24 (Cavanaugh). "The vast majority of enrollment is in established plans and beneficiaries don't move around a lot." Tr. 1139:24-1140:1 (Cavanaugh). An exception would be "a company like Aetna that has more resources and can build a robust network might have an ability to be more competitive than a small regional provider." Tr. 1206:11-13 (Cavanaugh); DX0120-004 ("[s]maller plans continue to struggle and usually react slower to cuts than larger plans"); PX0552 (Nevo Rebuttal) ¶ 114 (finding that large insurers survive entry at a "markedly" higher rate than others).

327. Smaller entrants, therefore, are unlikely to timely replicate the competition lost from

the merger due to challenges in developing a competitive provider network, earning high star ratings, and lack of a strong brand to attract customers.

i. Provider Network

328. New entrants must have a local provider network that meets CMS standards before they can market an MA plan in a given county. PX0353 at -590 (insurers expanding to new counties "must document an adequate network" to CMS 11 months before entering); *supra* ¶ 223. This requirement can function as a barrier to entry for insurers seeking to enter new individual MA markets. Tr. 563:14-20 (Wheatley); *see also* Tr. 3295:22-3296:8 (Orszag); PX0534 at -752. Building out an MA presence in a local market requires a significant financial investment and can take more than a year. Tr. 342:9-17 (Cocozza); *supra* ¶ 298. Some providers may be unwilling to contract with certain insurers or they may already be in an exclusive relationship with Aetna, Humana, or another incumbent. Tr. 546:4-547:2 (Wheatley). CMS has rejected MA insurers for having an inadequate network. Tr. 1180:21-22 (Cavanaugh); *see also* PX0046 at -283 (CMS denied Aetna bids [redacted]).

329. Even when CMS's provider network requirements are met, the entrant's network may be inadequate to compete effectively with incumbents. *See, e.g.*, PX0013 at -337 (Humana was not competitive in Topeka because it lacked contracts with two area hospitals); PX0026 at -422 (Aetna/Coventry not competitive in Baton Rouge area against Humana [redacted]).

330. In addition to competitive networks, value-based contracts are increasingly important to MA plan viability and quality. Tr. 346:6-347:10 (Cocozza); *see supra* ¶¶ 53, 184. Experienced, successful MA insurers are better able to sign providers to value-based contracts than those with a small or no MA presence. Tr. 348:1-9, 344:21-345:23 (Cocozza); *supra* ¶¶ 295, 298; *see also* Tr. 1887:20-24 (Broussard) (now and "especially in the future," achieving

local scale requires value-based care arrangements with local providers). As established insurers are increasingly using value-based provider contracts, this also "[c]reates barriers to entry for other payers." PX0603 at -358.

ii. Star Ratings

331. Star ratings are important to insurers as higher star ratings allow insurers to offer more benefits for the same price or to lower the overall cost of an MA plan. *See, e.g.*, Tr. 302:2-17 (Cocozza); Tr. 1897:7-14 (Broussard) (stars have an important effect on an MA insurer's ability to compete because of rebates). As Ms. Cocozza explained, "[m]aintaining high star ratings is an essential element of a sustainable Med Advantage program. Through high star ratings, we are able to create and maintain solidly competitive MA plans." PX0008 at -329. As a result, new entrants must quickly gain and maintain high star ratings. [redacted].

332. Star ratings are also important in attracting enrollees because "[c]onsumers are attracted to plans with the highest STARS ratings; they consider them indicators of quality." DX0543-023 (MA plans with highest stars ratings experienced higher growth); DX0120-006 ("Stars act as a measure of quality for those unfamiliar with MAPD"); PX0019 at -401("High star ratings improve [Humana's] brand perception and . . . may increase our attractiveness to consumers.").

c. Provider-Sponsored Entry Will Not Prevent Harm to Competition

333. The difficulties experienced by large hospital systems in trying to enter MA markets underscore the significant barriers that new entrants face. Recent unsuccessful MA entry attempts by Catholic Health Initiatives (Catholic) and Piedmont-WellStar illustrate these difficulties.

334. Catholic is a very large hospital system—it operates 105 hospitals in 18 states, has approximately 100,000 employees, and earned $16 billion in revenue. Barto Dep. 22:1-3, 20-25,

23:1-5. After Catholic acquired a small MA insurer, it tried to expand its MA (and commercial insurance) offerings into six additional states. Barto Dep. 32:18-33:2. After two or so years of trying, Catholic had enrolled barely ten thousand members, Barto Dep. 28:3-7, and decided to exit the MA business with losses of over $50 million, Barto Dep. 26:23-27:2. Upon learning Catholic's intent to exit, Mr. Fernandez commented: "Turns out this insurance business is harder than they thought." PX0486 at -751.

335. Similarly, Piedmont and Wellstar, two of the four major health systems in Atlanta, began selling jointly MA plans in Atlanta-area counties. *See* Tr. 2090:18-22, 2102:6-13 (Follmer). Ms. Follmer testified that in the Atlanta area an MA insurer needs contracts with the four major hospital systems to have an adequate network; Piedmont-Wellstar had two upon entry. *See* Tr. 2090:18-2091:8 (Follmer). Nevertheless, Piedmont-Wellstar survived only two years in the MA business before announcing its exit. Tr. 1079:21-23 (Fitzgerald); Tr. 2102:14-18 (Follmer); Tr. 361:25-362:5 (Cocozza). Humana noted: "Piedmont/Wellstar is exiting the MA market after their '3 year' experiment. They had previously said they were in it for a minimum of 5 years, but heavy financial losses forced an earlier closure." PX0013 at -344.

d. Professor Nevo's Analysis Establishes that Entry Will Not Be Timely, Likely, or Sufficient

336. Professor Nevo's analysis of historical MA entry in the Complaint counties over a five-year period from 2012 through 2016 establishes that entry would not be timely, likely, or sufficient to offset the anticompetitive effects of the proposed merger. Tr. 1652:1-9 (Nevo).

337. Professor Nevo found that entry into the Complaint counties is unlikely. Tr. 1656:4-7 (Nevo). Only 13% of the Complaint counties experienced entry during any given year, and more than half of them did not experience *any* entry during that five-year period. Tr. 1656:8-18 (Nevo). When Professor Nevo revised his analysis to focus only on entrants that eventually

achieved at least 5% market share, he found that such entry is even less likely: only a quarter of the Complaint counties experienced entry over the five-year period. Tr. 1656:19-24 (Nevo).

338. Professor Nevo also concluded that whatever entry into the Complaint counties occurs is unlikely to be timely. Tr. 1657:18-20 (Nevo). Due to the challenges inherent in entering a new county, particularly constructing a provider network, he finds that entry is unlikely before 2019 at the earliest. Tr. 1657:21-1658:4 (Nevo).

339. Professor Nevo's analysis further showed that even if entry does occur, it is unlikely to be successful. Of the 66 entrants entering the Complaint counties in 2012, "73 percent of them, so three quarters of them were no longer offering plans in 2016." Tr. 1659:3-7 (Nevo). Of the entrants in 2013, which have had one year less to fail, "43 percent were no longer offering a plan." Tr. 1659:8-13 (Nevo). Moreover, the new entrants that remained in the market rarely captured enough share, either individually or as a group, to offset the share of the smaller of Aetna or Humana. Tr. 1662:7-14 (Nevo).

340. Based on these findings, Professor Nevo concluded that entry into the Complaint counties will not be sufficient to offset the effects of the merger. *See* Tr. 1662:7-14 (Nevo); PX0551 (Nevo Report) ¶¶ 253-56.

341. Mr. Fernandez's observations regarding entry in Texas are consistent with Professor Nevo's conclusion that entry is unlikely to offset the merger's anticompetitive effect. Mr. Fernandez testified that from 2014 to 2017, new entry occurred in only 15 of the 254 counties in Texas. Tr. 2161:10-24 (Fernandez). On a yearly basis, only about 1% to 2% of Texas counties experienced new entry. Tr. 2162:4-8 (Fernandez).

e. New Entry Did Not Prevent Price Increases Following Prior Medicare Advantage Mergers

342. Professor Nevo also addressed the issue of whether entry post-merger would be

sufficient to counter any harmful effects of the merger by examining past MA mergers. In particular, he considered whether entry following Humana's 2012 acquisition of Arcadian served to offset the transaction's presumed anticompetitive effect. Tr. 1643:24-1644:14 (Nevo). He found that neither entry nor any other potential mitigating factor was sufficient to prevent significant price increases in either presumption counties (i.e., counties in which the transaction was presumptively unlawful) or divestiture counties. Tr. 1644:15-1645:10 (Nevo).

343. Professor Nevo also investigated the quantity, quality, and sufficiency of entry in the 168 counties in which the Humana-Arcadian merger was presumptively unlawful. Tr. 1648:5-7 (Nevo). He found that entry was not likely: only a third of presumption counties saw any entry by 2016, three years after the merger, despite significant price increases. Tr. 1648:8-16 (Nevo). When he focused on entrants that eventually reached 5% market share, he found that only a fifth of the presumption counties saw any entry. Tr. 1648:17-23 (Nevo).

344. Professor Nevo also found that what entry did occur following the Humana-Arcadian merger was not timely. Tr. 1648:24-1649:1 (Nevo). Only 9% of the presumption counties saw entry within two years of the merger, again despite significant price increases. Tr. 1649:1-11 (Nevo). Nor was entry sufficient. Rebate-adjusted premiums increased after the merger, Tr. 1642:19-1643:4 (Nevo), and the rise in concentration was not fully mitigated in many counties, Tr. 1649:12-1650:6 (Nevo).

f. Mr. Orszag's Entry Analysis Is Flawed and Misleading

345. Mr. Orszag's entry analysis relied upon the same historical entry data as Professor Nevo, but Mr. Orszag arrived at opposite conclusions due to flaws in his definition of entry that led him to overestimate the likelihood, timeliness, and sufficiency of entry. Tr. 3529:1-3530:6 (Nevo). First, Mr. Orszag included entry by the merging parties. Tr. 3283:20-23 (Orszag). Professor Nevo properly excluded such entry because Aetna and Humana will not be available to

enter post-transaction (i.e., they cannot offset the anticompetitive effects of their own merger). Tr. 1653:4-19 (Nevo). This flaw in Mr. Orszag's definition of entry is important given that Aetna is by far the fastest growing MA insurer in the United States. Tr. 1634:23-1635:10 (Nevo). Indeed, of the 398 entrants Mr. Orszag identifies in the Complaint counties between 2012 and 2016, 191 of them are either Aetna or Humana. *See* PX0552 (Nevo Rebuttal Report) ¶ 93.

346. Second, Mr. Orszag incorrectly defines a firm as an entrant when it achieves a market share of 5% even if it has been in the market for years. *See* Tr. 3529:7-3530:6 (Nevo); PX0552 (Nevo Rebuttal Report) ¶¶ 92, 94 & n.108. In other words, he disregards the requirement that entry be timely. Professor Nevo, however, correctly counts an insurer as an entrant the first time it registers to sell MA plans in a county. Tr. 1652:15-1653:3, 1654:19-1655:20 (Nevo).

347. Mr. Orszag's entry analysis is also misleading. When analyzing the likelihood of entry, he uses data from 2012 to 2016. Tr. 3283:24-3285:11 (Orszag). When analyzing the success of entrants, however, he uses data from 2013 to 2016. Tr. 3285:12-3286:12 (Orszag). The effect of omitting 2012 when considering the success of entrants is important because entrants in 2012 failed at significantly higher rates than entrants in 2013. Tr. 3287:5-3288:14 (Orszag). Omitting 2012 entrants biases upward Mr. Orszag's evaluation of the success of entrants. Furthermore, the inclusion of 2012 when analyzing the likelihood of entry is not without consequence, given that more insurers entered in 2012 than in any other year except 2013. *See* DX0419 (Orszag Reply Report) ¶ 128, Table II-10.

V. THE MERGER LIKELY WOULD SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF INDIVIDUAL INSURANCE ON THE PUBLIC EXCHANGES IN THE COMPLAINT COUNTIES

A. Background on Individual Insurance Sold on the Public Exchanges

1. The Affordable Care Act and Public Exchanges

348. The ACA established public exchanges that would function as centralized, electronic marketplaces for consumers to select among available health plans. Tr. 2638:24-2639:14 (Counihan); PX0553 (Frank Report) ¶ 72. The ACA requires individuals who meet certain broad conditions to purchase health insurance or pay a penalty. PX0553 (Frank Report) ¶ 73. Individuals can purchase coverage through the public exchanges (on-exchange) or directly from an insurer or through a broker (off-exchange). PX0551 (Nevo Report) ¶ 271.

349. Plans are grouped in five different tiers according to the level of coverage they provide: catastrophic, or one of four "metal" tiers (bronze, silver, gold, and platinum). The metal tiers are assigned by the portion of an average individual's health care costs they cover: bronze plans cover 60% of expected medical costs; silver plans 70%; gold plans 80%; and platinum plans 90%. Tr. 142:11-13 (Frank); *see also* PX0553 (Frank Report) ¶ 74. The ACA defines the benefits that must be included in individual health plans and places limits on an enrollee's total out-of-pocket costs. PX0553 (Frank Report) ¶ 73. The ACA prohibits insurers from charging individuals different premiums depending on perceived health status and denying coverage due to pre-existing conditions. Tr. 141:6-8 (Frank); PX0553 (Frank Report) ¶ 73.

350. The ACA also provides financial assistance to aid lower-income individuals buying individual health insurance in the form of premium subsidies and cost-sharing reductions. PX0553 (Frank Report) ¶¶ 82-83. Individuals must purchase on-exchange plans to obtain this assistance. PX0553 (Frank Report) ¶¶ 82-83.

2. The Exchanges Rely on Competition to Make Low Cost, Attractive Plans Available to Individuals and to Lower Program Costs for Taxpayers

351. The ACA relies on competitive exchange markets to "ensure consumers have more choices and insurance companies face more competition." 155 Cong. Rec. S13, 890-91 (daily ed. Dec. 24, 2009) (statement of Senator Reid); Tr. 140:3-4 (Frank) (exchanges are "based on market principles"). Vigorous competition among insurers is needed to promote attractive and affordable health insurance options for individual consumers. *See* Tr. 140:8-10 (Frank); Tr. 2639:2-4 (Counihan) ("Exchanges are insurance stores. They are fundamentally about providing a[n] easy and simple experience for people to shop for competitive products.").

352. Competition is also important for maintaining sustainable program costs for taxpayers. Because the amount of the subsidy is tied to the price of on-exchange plans, higher premiums increase the subsidy that must be funded by taxpayers. *See* Tr. 140:23-141:1 (Frank) (taxpayers get a "better deal" where competition drives premiums lower).

3. The Merger Would Eliminate Competition between Aetna and Humana on the Public Exchanges

353. Insurers first began selling individual health plans on ACA exchanges in 2013 for coverage taking effect in 2014. PX0551 (Nevo Report) ¶ 273. The number of individuals enrolled in on-exchange plans has grown each year, from 8 million in 2014 to an estimated 12.7 million in 2016. PX0551 (Nevo Report) ¶ 272.

354. Aetna and Humana are among the most important insurers selling individual plans on the public exchanges. In 2016, Aetna and Humana each offered on-exchange plans in 15 states. Tr. 1500:15-17 (Mayhew); Humana Answer ¶ 42. Of the 9.6 million people enrolled in plans on federally administered exchanges in 2016 (i.e., not counting state-administered exchanges), almost one million (10.3%) are enrolled in Aetna plans, while approximately

650,000 (6.7%) are enrolled in Humana plans. PX0551 (Nevo Report) ¶ 266.

B. The Court Should Not Allow Aetna to Evade Antitrust Review by its Withdrawal from the Florida, Georgia, and Missouri Exchanges

355. The evidence establishes that Aetna's withdrawal decision was influenced by this litigation. Courts rightly disregard conduct plausibly intended to influence the outcome of an antitrust investigation or litigation, and the Court should not countenance Aetna's effort to evade review of the merger's effect on the 700,000 consumers in the 17 Complaint counties.

1. Applicable Legal Standards

356. The probative value of merging parties' manipulable post-complaint 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." *Gen. Dynamics*, 415 U.S. at 504-505. Post-complaint or post-investigation conduct should be given little to no weight not only when there is evidence of actual manipulation, but also "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); *see also United States v. Bazaarvoice*, No. 13-cv-00133-WHO, 2014 WL 203966, at *57 (N.D. Cal. Jan. 8, 2014) ("The post-acquisition evidence regarding pricing and the effect of the merger is reasonably viewed as manipulatable and is entitled to little weight.").

357. When a merging party takes an action plausibly intended to affect the outcome of an ongoing merger challenge, the Court properly may disregard the resulting change. *Hosp. Corp. of Am.*, 807 F.2d at 1384 ("We agree with the Commission that it was not required to take account of a post-acquisition transaction that may have been made to improve Hospital Corporation's litigating position."); *Alberta Gas Chems. Ltd. v. E.I. Du Pont de Nemours & Co.*, 826 F.2d 1235, 1244 (3d Cir. 1987) (analyzing merger without taking into account post-

acquisition divestiture or closure of operations and instead "view[ing] the acquisition at the time of its occurrence").

358. Defendants incorrectly argue that the authorities cited in the preceding paragraphs are "wholly irrelevant" because they arose in the context of post-merger litigation. Defs. Pretrial Br. at 36 n.34. To the contrary, the underlying rationale for the rule—that conduct by merging parties arguably intended to undermine a merger challenge should be given little or no weight—is the same for actions taken following the issuance of a complaint challenging a proposed merger as for actions taken following an already completed merger. The focus in these cases is on whether the conduct at issue was subject to manipulation—which could be the case after the merger was announced and the government opened an investigation, after a complaint seeking to block the merger was filed, or after the merger was consummated. *See Chicago Bridge*, 534 F.3d at 435 (price reductions that occurred "'well after the Complaint in this case issued [] are the type of evidence that is wholly manipulable'") (quoting the FTC); *Hosp. Corp. of Am.*, 807 F.2d at 1384 (agreeing that the FTC was entitled to give no weight to contract cancellation that occurred "after the Commission began investigating Hospital Corporation's acquisition" and noting that the defendant's acquiescence to contract cancellation was inconsistent with its prior practice of suing hospitals "that tried to get out of their management contracts"). The court in *Bazaarvoice* explained that the rule that manipulable evidence is entitled to little weight is "especially true when the parties are aware of the government's scrutiny and the potential for a court challenge." 2014 WL 203966 at *73. This rule should apply all the more here where the manipulated evidence followed an actual court challenge.

359. Contrary to Defendants' attempt to limit this rule to specific categories of conduct, the rule applies to any type of evidence that could be manipulated to improve the

merging parties' litigating position. This includes evidence about the extent of the defendants' participation in the relevant market, *see Alberta Gas*, 826 F.2d at 1243-44 (disregarding for purposes of analyzing the anticompetitive effects of a merger the fact that DuPont "had divested or shut down Conoco's methanol-consuming operations" after acquiring Conoco); *Hosp. Corp. of Am.*, 807 F.2d at 1384 (agreeing that the FTC could disregard cancellation of management contract that would have lowered defendant's market share), and evidence about the number of participants in the relevant market, *see Chicago Bridge*, 534 F.3d at 435 (finding "the existence of actual and potential entry" to be "arguably manipulable"). The fact that these authorities did not involve precisely the type of conduct engaged in by Aetna here is not surprising: few companies would brazenly withdraw—even temporarily—from a market immediately after a complaint was filed to avoid antitrust scrutiny of their merger.

360. Defendants also argue that Aetna's intent is irrelevant to the Court's analysis of Plaintiffs' exchange claims, citing *Libbey*. Defs. Pretrial Br. at 35-36. This argument cannot be squared with the cases discussed above, and it is also flatly contradicted by the court's analysis in *Libbey* on which Defendants purport to rely. In *Libbey*, the court concluded that the FTC's argument "that defendants have in some manner sought to evade FTC and judicial review" by proposing an amended merger agreement including a divestiture was "without merit," and the court therefore held that the FTC could not disregard the amended agreement in proving its case. 211 F. Supp. 2d at 46. The court explicitly distinguished the defendants' "good-faith effort to address the FTC's concerns" from an "unscrupulous[] attempt to avoid judicial and FTC review of an agreement by continuously amending it." *Id.* at 46-47 n.27. In short, the court in *Libbey* held that intent is relevant. And, here, of course, even Aetna does not contend that it withdrew from the Complaint counties in a good attempt to ameliorate the potential anticompetitive effects

of the merger.

361. Defendants posit that the only possible legal theory relevant to Plaintiffs' exchange claims is that Aetna should be treated as an "actual potential competitor"—a theory that, according to Defendants, is "legally invalid." Defs. Pretrial Br. at 37-40. This straw-man argument is incorrect for the reasons discussed in the preceding paragraphs—Plaintiffs' exchange claims are focused on the fact that Aetna is an *actual competitor* in the relevant markets in 2016. Whatever the merits of "actual potential competition" as a basis for Section 7 liability (and Plaintiffs see no need to address Defendants' characterization of that legal theory), Aetna is not in the same position as a firm that had contemplated possible entry into a market but decided to merge instead. Rather, Aetna withdrew from markets in which it was *already competing* in *direct response* to the Complaint.

362. Finally, Defendants argue that Plaintiffs—and, by implication, the Court—must accept Aetna's withdrawal as a *fait accompli* that resolves Plaintiffs' exchange claims. Defs. Pretrial Br. at 36-37. This argument is again inconsistent with the cases discussed above holding that manipulable evidence should be given little or no weight. *Cf. FTC v. Warner Commc'ns Inc.*, 742 F.2d 1156, 1165 (9th Cir. 1984) ("a company's stated intention to leave the market . . . does not in itself justify a merger").

363. Important public policy considerations undergird these cases. A firm should not be able to avoid judicial review by withdrawing from a market in an effort to undermine the government's case—particularly where it can reverse that decision. *Cf. United States v. W.T. Grant Co.*, 345 U.S. 629, 632 (1953) (courts have long guarded against efforts to "deprive the tribunal of power to hear and determine the case" and "rightly refused to grant defendants such a powerful weapon against public law enforcement"); *United States v. Trans-Missouri Freight*

Ass'n, 166 U.S. 290, 309 (1897) ("The defendants cannot foreclose [the rights of the public], nor prevent the assertion thereof by the government as substantial trustee for the public under [the Sherman Act], by any such action as has been taken in this case."). If Aetna's temporary withdrawal from the markets at issue absolves it of any antitrust responsibility, the Court risks creating a template for similarly situated firms in the future.

364. Defendants' argument also disregards the Supreme Court's admonition that it is a party's "future ability to compete" that counts for Section 7 purposes. *Gen. Dynamics*, 415 U.S. at 501. Here, the evidence shows that Aetna withdrew in such a way as to preserve its ability to compete going forward. *See* Merger Guidelines § 5.1; *United States v. El Paso Nat. Gas Co.*, 376 U.S. 651, 660-61 (1964) (acquisition of pipeline company selling only in Pacific Northwest by firm selling in California violated Section 7 because acquired firm could readily enter California market); *Polypore Int'l, Inc. v. FTC*, 686 F.3d 1208, 1214-16 (11th Cir. 2012) (FTC correctly treated acquired firm as actual competitor where acquired firm was already making similar product and only would need to "retool a production line" to sell in relevant market).

2. Aetna Withdrew from the 17 Markets Alleged in the Complaint in Response to This Lawsuit

365. Aetna has long viewed the ACA public exchanges as an important part of its business. However, in August 2016, after the filing of the Complaint, Aetna abruptly reversed its plans for its public exchange business in 2017, terminating its planned expansion to five new states and withdrawing from 11 of the 15 states in which it currently competes. Plaintiffs acknowledge that Aetna may have made some of these changes for business reasons independent of this litigation. But the evidence at trial made clear that Aetna's decision to withdraw from the public exchanges in Florida, Georgia, and Missouri—and, more particularly, the counties alleged in the Complaint—was influenced by the litigation.

a. Prior to the Threat of Litigation, Aetna Viewed the Public Exchanges as a "Big Opportunity"

366. Aetna has supported efforts to expand health insurance coverage for many years. Tr. 1350:13-19 (Bertolini). As early as 2005, Aetna "made a commitment that every American should be insured," Tr. 1386:21-25 (Bertolini), and the ACA, in the words of its CEO, "was a natural extension of what [Aetna was] trying to do," Tr. 1387:4-5 (Bertolini).

367. Aetna also has viewed the ACA public exchanges as a good business opportunity. For example, in October 2015, Mr. Bertolini told investors that the public exchanges have "long-term market potential" and are "a big opportunity" for the company. Tr. 1351:1-8 (Bertolini); PX0162 at 6. In April of this year, he reiterated that the public exchanges are "a good investment," and "a less expensive way of acquiring members than the alternatives." Tr. 1351:12-22 (Bertolini); *see also* PX0112 at 13. As of March 2016, Aetna predicted that, by 2018, its individual business would "grow revenue to $5.8B" and, by 2020, it would "be the recognized leader in the Individual Commercial market." PX0259 at -739 to -740.

368. Through the first half of 2016, Aetna considered ways to expand its public exchange business. In June, Aetna was compiling a "large" list of states for possible expansion in 2018. Tr. 1505:9-14 (Mayhew); PX0264 at -121; *see also* PX0259 at -733 (March 2016 Aetna strategy document noting, for 2018 "Consider expansion on Consumer Platform where deferred in 2017 (CO, CT, LA, MI, NV, TN, WA, WV)" and "Evaluate opportunity in CA and MD").

b. Aetna Maneuvered to Use its Public Exchange Participation to Win Regulatory Approval for the Proposed Merger

369. Once it became evident that the government might oppose the merger, Aetna tried to use its participation in the public exchanges as a bargaining chip to gain approval for the transaction. Aetna alternatively intimated that either it would expand its footprint if the government did not challenge the merger (the carrot) or it would reduce its footprint if the

government challenged the merger (the stick).

i. "We're Just Going to Pull Out of All the Exchanges"

370. In the months leading up to this lawsuit, Aetna representatives suggested to the government—both the U.S. Department of Justice (DOJ) and HHS—that it might exit public exchange markets if the DOJ sued to block the transaction. At a May 12, 2016, meeting attended by Mr. Bertolini, Steven Kelmar, Aetna's Executive Vice President and Mr. Bertolini's Chief of Staff, told HHS Secretary Burwell that, if the United States blocked the merger, Aetna "would likely have to revisit its plans for and presence on the public exchanges." Tr. 1354:2-6 (Bertolini); Tr. 1453:12-23 (Kelmar); PX0134 at 7. Mr. Bertolini did not disagree. Tr. 1354:9:11 (Bertolini).

371. Aetna's meeting with HHS occurred the day after Mr. Bertolini's deposition at which Aetna's counsel offered that if Aetna was not "happy" with the outcome of a meeting with DOJ lawyers about the merger, "we're just going to pull out of all the exchanges." Tr. 1353:6-10 (Bertolini). Mr. Bertolini seconded, "Nice." Tr. 1353:15-18 (Bertolini). In late June, Aetna's counsel had conversations with DOJ attorneys in which he suggested that "a lawsuit could have consequences for the company and its ability to continue participating in the public exchanges." PX0134 at 7; *see also* Tr. 1357:3-9 (Bertolini); PX0265 ("On exchange posture, if asked in the interviews . . . without a deal this will present significant challenges for us to remain committed to this market.").

372. Shortly thereafter, Mr. Bertolini made this threat explicit. In a letter to the DOJ, dated July 5, he wrote that "if the DOJ sues to enjoin the transaction, we will immediately take action to reduce our 2017 exchange footprint" and "we would also withdraw from at least five

additional states."[22] Tr. 1357:19-25, 1358:12-13 (Bertolini); PX0117 at 2. He further cautioned that, if the proposed merger is ultimately blocked, "we believe it is very likely that we would need to leave the public exchange business entirely." PX0117 at 2. In his letter, Mr. Bertolini noted that, if the merger were blocked, Aetna would need to recover the $1 billion breakup fee. Tr. 1358:20-24 (Bertolini); PX0117 at 2. Mr. Bertolini forwarded a copy of his letter to Secretary Burwell the next day. Tr. 1359:20-1360:1 (Bertolini); PX0118.

ii. "I Would Appreciate a Good Word"

373. Parallel to these threats, Aetna explored ways to trade an expansion of its public exchanges footprint for approval of the deal. In February 2016, Aetna entered into a consent order with the Florida Office of Insurance Regulation requiring it to expand to five new counties on the Florida public exchange by 2018. PX0476. On June 27, Mr. Soistman directed the head of Aetna's individual business, Jonathan Mayhew, to "dust off the 2017 IVL [Individual] Expansion Plan" because "we may need to consider ways to settle to get our [Aetna/Humana] transaction approved and one of those could be to agree to enter more states in the future (not 2017)." Tr. 1502:8-1503:18 (Mayhew); PX0115.

374. Mr. Bertolini himself sought to leverage Aetna's public exchange participation to get the deal approved. On a June 15 call, Bertolini told Secretary Burwell "if, by chance, you get a reach-out from the DOJ about us as a candidate for this merger, I would appreciate a good word for all that we've done with you." Tr. 1356:21-23 (Bertolini); *see also* PX0134 at 7. Mr. Bertolini made this request because he was "trying to find a way to get the deal done." Tr.

[22] The DOJ had issued a Civil Investigative Demand following Aetna's statements suggesting a link between Aetna's participation on the public exchanges and any action by the DOJ on its proposed merger. Tr. 1438:9-1440:14 (Bertolini); PX0702 at 3.

1396:19-20 (Bertolini). (Prior to the call, Mr. Kelmar had sent Mr. Bertolini talking points, including, "[b]y getting this deal done, I can make the commitment that we will expand our exchange footprint and continue to take a leadership position on expanding the value of exchanges to a greater part of the population," and, conversely, "[i]f we can't get to a good path forward on this deal the break-up fee of 1 billion dollars will significantly impact our business model and have some very tough consequences for us and the market." PX0113; *see also* Tr. 1454:18-1456:2 (Kelmar).) In his July 5 letter to the DOJ, which was forwarded to Secretary Burwell, Mr. Bertolini noted that, if the United States allowed the proposed merger to proceed, Aetna "would explore . . . supporting even more public exchange coverage over the next few years" than previously planned. Tr. 1359:7-19 (Bertolini); PX0117 at 2.

375. Mr. Bertolini felt betrayed that the government sued to block the merger given his prior support for the ACA. He wrote Ron Williams, Aetna's former CEO, that "the administration has a very short memory, absolutely no loyalty and a very thin skin." Tr. 1365:22-1366:1 (Bertolini); PX0131. When asked what he meant, Mr. Bertolini explained, "[i]t was about my involvement in helping them get the Affordable Care Act structured and properly done. And so that was our feeling was that we were doing good things for the administration and the administration is suing us." Tr. 1366:25-1367:4 (Bertolini).

c. "A Business Decision Except Where DOJ Has Been Explicit about the Exchange Markets"

376. Aetna reacted to the lawsuit—and the failure of its carrot and stick—by taking immediate steps to exit the markets alleged in the Complaint. Prior to the filing of the Complaint, Aetna already was studying what to do with its public exchange footprint in the event of litigation. On July 9, Mr. Bertolini received financial data indicating that Aetna had suffered losses for the second quarter of 2016. Tr. 1362:5-25 (Bertolini). At Mr. Bertolini's direction, a

team of Aetna executives immediately began examining Aetna's participation in the public exchanges. Tr. 1360:17-22, 1362:5-1363:17 (Bertolini). This team included Karen Lynch, Aetna's President, Mr. Mayhew, Mr. Soistman, Mr. Kelmar, and Tom Sabatino, Aetna's General Counsel. Tr. 1363:1-17 (Bertolini); Tr. 1476:13-1477:6 (Lynch).

377. Plaintiffs filed their Complaint on July 21. At that time, the team analyzing Aetna's public exchange participation had not yet finished its analysis or made a recommendation to Mr. Bertolini. Tr. 1478:18-1479:4 (Lynch); Tr. 1461:17-20 (Kelmar). But Aetna executives reacted immediately and unequivocally to the lawsuit. On that day, Aetna employees were instructed to gather information on the 17 Complaint counties. PX0220 at -290.

378. The following day, July 22, Mr. Soistman informed a colleague, "[b]y the way, all bets are off on Florida and every other state given the DOJ rejected our transaction." PX0121 at -106. Later that day, Mr. Soistman advised Mr. Kelmar, "I also need to share with you what I've learned about the 17 counties in the DOJ's complaint. We have a very narrow window of opportunity to affect changes in footprint particular with the off exchange business." PX0122 at -638. He later forwarded the message to Ms. Lynch, warning "it may get ugly." PX0122 at -638.

379. The next day, July 23, Mr. Kelmar asked Mr. Soistman whether "the counties in the [DOJ] suit overlap with Humana's recent announcement of withdraw [sic]." PX0124; *see also* Tr. 1460:10-21 (Kelmar). When Mr. Soistman responded the Aetna and Humana would continue to overlap in the Complaint counties, Mr. Kelmar replied, "[t]hen that makes it easy we need to withdraw from those." Tr. 1460:22-1461:6 (Kelmar); PX0124. Later that same day, Mr. Kelmar told Ms. Lynch that "[m]ost of this is a business decision except where DOJ has been explicit about the exchange markets [the 17 Complaint counties]. There we have no choice." Tr. 1462:4-13 (Kelmar); PX0125. Ms. Lynch responded definitively: "Agree." PX0125.

380. The team immediately took steps to implement this strategy. The weekend after the Complaint was filed, they worked feverishly to add the 17 Complaint counties to their analysis. On Sunday, July 24, at 6:42 a.m., Mr. Mayhew sent Ms. Lynch a document showing "Strategic Options for [Aetna's] 2017 Footprint." Tr. 1481:9-1483:1 (Lynch); Tr. 1505:15-22 (Mayhew); PX0126; PX0127. Less than an hour later, at 7:35 a.m., Ms. Lynch queried, "[d]oes this include the 17 places in the DOJ complaint"? Tr. 1483:2-11 (Lynch); PX0127. Mr. Mayhew then directed his team to update the Strategic Options document to incorporate an exit from the Complaint counties in its recommendation. Tr. 1509:12-1511:18 (Mayhew); PX0128 at -987. That evening, Mr. Mayhew sent the updated document—which now included the recommendation to "[e]xit targeted service areas (17 counties in total; 3 states)"—to Ms. Lynch and Mr. Soistman. Tr. 1484:2-1486:2 (Lynch); PX0129 at -243.

381. As late as August 2, Aetna was still analyzing the implications of an exit from various markets, including the Complaint counties. Tr. 1511:24-1515:1 (Mayhew); PX0130 at 4 (spreadsheet showing "Markets to remove" comprising Pennsylvania, Arizona, Kentucky, Texas, Northern Illinois, Southern Illinois, and "17 Counties").

382. Ultimately, the team recommended that Aetna withdraw from Florida, Georgia, and Missouri altogether. Tr. 1497:12-18 (Lynch). Given the timing of its decision, the team determined that Aetna could not reduce its footprint within a particular state by withdrawing only from certain counties. Tr. 1518:12-1519:2 (Mayhew). Instead, Aetna's only option for exiting the 17 Complaint counties was to withdraw from Florida, Georgia, and Missouri completely. Tr. 1518:25-1519:2 (Mayhew).

383. On August 2, Aetna reported that it had reversed its decision to enter the public exchanges in 5 new states in 2017, *see* PX0333 at 4, and, on August 15, it announced that it was

withdrawing from the public exchanges in 11 of the 15 states in which it had participated in 2016, including Florida, Georgia, and Missouri. *See* Tr. 1360:14-16 (Bertolini); Tr. 1514:23-1515:1 (Mayhew); PX0133; DX0031.

384. Mr. Bertolini testified that he made the final decision about Aetna's exchange footprint and that this lawsuit had no impact on Aetna's decision to exit public exchange markets, Tr. 1388:3-8, 1396:25-1397:3 (Bertolini). However, he also testified that he knew that the lawsuit "was going to influence the decision is some way." Tr. 1363:24-1364:7 (Bertolini). Ultimately, Mr. Bertolini adopted the recommendation of his team—including the recommendation to withdraw from the 17 Complaint counties—without any changes. Tr. 1449:21-1450:8 (Bertolini); Tr. 1473:23-1474:1 (Kelmar); Tr. 1497:19-24 (Lynch).[23]

385. Aetna executives took steps to conceal from discovery the non-business reasons for Aetna's decision to withdraw from the Complaint counties. For example, Mr. Mayhew was cautioned about discussing the counties in writing and directed to copy an attorney on e-mails discussing them in order to shield them from discovery in this lawsuit.[24] Tr. 1507:8-1508:7 (Mayhew); PX0127. Mr. Mayhew relayed those instructions to Ms. Lynch, telling her in a July 24 e-mail, "I was told to be careful about putting any of that in writing" and "I will have the attorney client privilege ccd by tomorrow." Ms. Lynch replied, "got it." Tr. 1492:25-1493:10 (Lynch); PX0127. In another e-mail, Ms. Lynch cautioned Mr. Soistman that blind-copying her

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[23] Mr. Guertin testified that he was not involved in deciding which particular states to leave, that the team considered criteria in addition to the financial criteria he proposed, that he cannot "speak definitively to what criteria they used to pick the individual markets," and that his meetings with the team began on July 25, after the team had incorporated the Complaint counties into the strategy document. Tr. 2750:3-8, 2751:20-2752:23 (Guertin).

[24] Mr. Mayhew could not recall who instructed him to be careful about discussing the 17 Complaint counties in writing. Tr. 1507:15-17 (Mayhew).

on e-mail (i.e., using the "bcc" feature when sending an e-mail) would not "protect" their e-mails from "the scan." PX0122 at -638. When Mr. Soistman asked her to what scan she was referring, Ms. Lynch replied, "[t]he one they do for discovery." Tr. 1489:24-1491:24 (Lynch); PX0122 at -638. Additionally, Aetna executives repeatedly directed one another to communicate via telephone rather than via email. Tr. 1509:7-11 (Mayhew) ("Q: You then write, 'I will provide you an update tomorrow verbally, not in writing.' And this is just another example of where you didn't want to put in writing how Aetna was handling its exchanges footprint, correct? A: Correct."); PX0122 at -638 ("Best we talk live."); PX0124 ("Can you take another quick call?").

386. The testimony of certain Aetna executives to the contrary should not be credited. The self-serving testimony about PX0122 and PX0125 is not credible given the witnesses' statements in the documents themselves or when read in the context of the other evidence showing Aetna planning for and implementing a withdrawal from the exchanges in the Complaint counties. For example:

- Ms. Lynch's testimony that she warned Mr. Soistman that "bcc" emails would be produced in discovery in this lawsuit because "I wanted to make sure everything was open," Tr. 1491:23-24 (Lynch), is inconsistent with her own statement that the "bcc doesn't protect it," PX0122 at -638, and other evidence showing that, rather than wanting to be "open" about the reasons for its withdrawal, Aetna sought to hide them from discovery.
- When testifying about his statement in PX0125 that "[m]ost of this is a business decision except where DOJ has been explicit about the exchange markets," Mr. Kelmar asserted that he was worried that regulators might be concerned if Aetna and Humana both withdrew from these counties. Tr. 1471:11-12 (Kelmar). But this

explanation is impossible to square with his statement earlier on the same day that the overlap in the Complaint counties made Aetna's decision to withdraw "easy" and his failure to ask about any other overlaps. PX0124.

- Ms. Lynch's self-serving testimony that she "agree[d]" only with the first half of Mr. Kelmar's statement that "[m]ost of this is a business decision except where DOJ has been explicit about the exchange markets," Tr. 1479:25-1480:10 (Lynch), is inconsistent with the plain language of PX0125.

d. Aetna's Rationales Are Inconsistent with its Prior Business Practices and Industry Norms

387. The timing and scope of Aetna's withdrawal is inconsistent with its prior business practices and with the actions of other large insurers like United and Humana. As an example, Aetna's withdrawal from Florida—a profitable state with "a good cost structure," PX0112 at 10—is explainable only in light of the Complaint. Finally, whatever the merits of Aetna's criticisms of the public exchanges, the regulatory issues predated Aetna's exit by months or years, and CMS is addressing many of Aetna's specific complaints.

i. Aetna Departed from Precedent by Withdrawing from Profitable Markets at the Eleventh Hour

388. Aetna executives testified that poor financial results for the second quarter of 2016 prompted Aetna's decision to reduce substantially its public exchanges footprint in 2017. But Aetna acted contrary to its prior practice (as well as that of other insurers) and seemingly to its business interests.

389. Aetna had lost money in previous years and still viewed its individual business as "a good investment." PX0112 at 13. As Mr. Bertolini explained in April 2016:

> We have 911,000 members on the public exchange as individual. We have 1.2 million members that are exchange or ACA compliant. If we were to go out and buy those members, it would cost us somewhere around $1.2 billion to acquire

> them. If we were to build out 15 markets, it would cost us somewhere between $600 million to $750 million to enter those markets and build out the capabilities necessary to grow that membership. So in the broad scheme of things, we are well, well below any of those numbers from the standpoint of losses we've incurred in the first two-and-a-half years of this program.

PX0112 at 13.

390. On the eve of litigation, Aetna "Remained Committed to a Measured Multi-Year Approach to our Participation on Public Exchanges." PX0116 at -198 (circulated on June 29, 2016). A July 6 draft of a presentation for Aetna's Audit Committee detailed "The Value We Will Deliver" and "What We Can Achieve" with the business, including "$6B in revenue by 2018" and capitalizing on any future "'sea change' in group benefits." PX0221 at -433, -435.

391. Aetna continued to view the business positively even after Mr. Bertolini learned of its second-quarter losses on July 9. *See* Tr. 1362:5-25 (Bertolini). As late as July 19, two days before the Complaint was filed, Aetna still held open the possibility of entering additional public exchange markets, Tr. 1437:21-24 (Bertolini), and viewed its public exchange business as having "significant potential under the right conditions," PX0120 at -746. In July 19 notes for a presentation to Aetna's board, Mr. Soistman wrote that Aetna "will pursue a disciplined market participation strategy" and that the individual business "will grow from $68B to $99B in revenue by 2020." PX0120 at -745, -746, -749. His notes also indicate that Aetna still planned to expand to 20 states in 2017. PX0120 at -756.

392. Aetna's purported rationale for its withdrawal also departed from its prior practices. Previously, when Aetna determined its footprint for the 2016 plan year, it based its decision in part on the profitability of the business. Tr. 2691:10-21, 2743:8-13 (Guertin) (Aetna withdrew from its most unprofitable state, Kansas). However, in preparing its recommendation for Aetna's 2017 footprint, the team appears to have disregarded profitability. Indeed, for 2017, Aetna is withdrawing from states in which its on-exchange or total individual business is forecast

to be profitable for 2016. DX0009-002. In contrast, the four states where Aetna will remain on-exchange in 2017—Delaware, Iowa, Nebraska, and Virginia—are all forecast to be unprofitable in 2016, both for the on-exchange business and the total individual business. DX0009-002. Tellingly, Ms. Lynch testified that the team never assessed the profitability of Aetna's individual business in the 17 Complaint counties. Tr. 1498:1-9 (Lynch). Additionally, Aetna decided to withdraw from Florida, Georgia, and North Carolina, states where, Ms. Lynch and Mr. Guertin, respectively, told investors in April 2016, Aetna has a "very good" and "solid cost structure." PX0112 at 10. In fact, in late June 2016, Aetna's Operating Committee considered additional investment in Florida and Georgia. Tr. 2748:23:2749:2 (Guertin); *see also* PX0208 at -029.

393. Aetna decided to withdraw from the most profitable segment of its individual business. In 2016, Aetna's losses for its off-exchange business have been larger than for its on-exchange business. DX0009-002. Despite this, Aetna decided to withdraw from its on-exchange business in 11 states, while remaining off-exchange in those states. Thus, Aetna remains exposed to off-exchange losses without its more profitable on-exchange business to buffer the losses. In contrast, in the four states in which it will compete on-exchange in 2017, Aetna adopted a different strategy of remaining on-exchange while minimizing its off-exchange enrollment. DX0019-008 ("Partial On-Exchange market exits and go dormant in Off-Exchange markets including in markets where we remain On-Exchange.").

394. Additionally, Aetna undertook its withdrawal notwithstanding the potential negative consequences for its other lines of business. Aetna executives understood that exiting public exchanges might damage Aetna's relationships with health care providers. *See, e.g.*, Tr. 1516:16-1517:3 (Mayhew). Withdrawals also would eliminate synergies with other lines of business. *See, e.g.*, PX0260 at -206 (withdrawal in Carolinas could have a "potential catastrophic

impact to our multi-segment business interests in our 3 most important NC markets"); PX0217 at -405 (discussing the individual business's "Strategic Intersections" with Small Group, Medicare, and Medicaid businesses). Indeed, Aetna executives not involved in the decision expressed surprise and concern upon learning of the decision. *See*, *e.g.*, PX0132 at -565 ("Really disappointed we are pulling the plug on Florida"); PX0260 at -206 (expressing "grave concerns").

395. Aetna highlights exits by other insurers to justify its decision. But the actions of other insurers cannot erase the documents and other evidence discussed *supra* in Section V.B.2.c tying Aetna's withdrawal to this litigation. Moreover, other insurers like Humana and United announced their decisions to withdraw from certain markets much earlier in the year, before their second quarter 2016 results. Tr. 1875:1-19 (Broussard); Tr. 2744:19-2745:5 (Guertin); Tr. 2652:22-2653:10 (Counihan). Aetna's decision was not typical for a large insurer and "curiously timed." Tr. 2652:22-2653:10 (Counihan). Aetna's timing was "very awkward" for CMS because it left some markets without insurers just weeks before a September deadline for finalizing participation for the 2017 plan year. Tr. 2652:13-21 (Counihan).

396. Aetna's actions stand in contrast with those of its merger partner. Humana also has experienced losses in its individual business. Tr. 1873:18-23 (Broussard). However, Humana is withdrawing from only 4 of the 15 states in which it participated in 2016. PX0407 at 12. Instead of a mass withdrawal, Humana has taken "corrective actions," as discussed *infra* ¶ 430. Tr. 1876:7-12 (Broussard). Additionally, in the 11 states where it will sell individual insurance for 2017, Humana is attempting to minimize its off-exchange enrollment. *See* Tr. 1879:2-17 (Broussard); PX0407 at 12. In fact, Humana's CEO was "surprised" when he learned that Aetna was exiting the exchanges but remaining off-exchange in some states. Tr. 1880:1-12 (Broussard).

ii. "I Just Can't Make Sense of the Florida Decision"

397. Aetna's decision to exit Florida's public exchange is illustrative. In Florida, Aetna's on-exchange and total individual (on-exchange and off-exchange combined) businesses were profitable in 2015 and the first half of 2016, and were forecast to be profitable for full year 2016. Tr. 2756:14-2757:18, 2758:6-22 (Guertin); DX0009. In fact, Florida was Aetna's third most profitable state (as measured by before-federal-income-tax margins) for its on-exchange business in 2015 and the first half of 2016. Tr. 2756:14-2757:18 (Guertin); DX0009-002. Conversely, Aetna's off-exchange business in the state was unprofitable in 2015 and the first half of 2016, and was forecast to be unprofitable for full year 2016. Tr. 2758:1-5 (Guertin); DX0009-002. Thus, Aetna's individual business in Florida has been profitable overall only because its on-exchange profits compensated for off-exchange losses. Tr. 2758:6-2759:1 (Guertin).

398. Additional facts cast further doubt on Aetna's explanation for its decision to withdraw from Florida. In an April 2016 call, Ms. Lynch informed investors that Aetna has a "very good cost structure" in Florida and Mr. Guertin agreed. Tr. 2747:19-2748:15 (Guertin); PX0112 at 10, and, in late June 2016, Aetna discussed the possibility of additional investments in Florida, Tr. 2748:23:2749:2 (Guertin); *see also* PX0208 at -029. Aetna executives shared the concern that pulling out of the Florida public exchange "would severely damage the provider relationships in that market." Tr. 1516:21-24 (Mayhew). Aetna has entered into a consent order with Florida's Office of Insurance Regulation requiring it to expand to new counties by 2018. Tr. 1518:8-11 (Mayhew); PX0476.

399. An email written by Aetna's President of the Florida Market to Mr. Mayhew shortly after learning of the decision encapsulates the questions about Aetna's withdrawal from the Florida public exchange. He noted that "we are making money from the on-exchange business" and "thought we would limit our off-exchange participation (which has incurred

losses) and maybe pull back on several weaker performing counties. Never thought we would pull the plug all together [sic]." PX0132 at -565. "Was Florida's performance ever debated?" he queried. PX0132 at -565. He feared that the decision "is going to severely damage our provider relationships in the market and impede our ability to bring the HPNs up market into large group" and worried that "we will never get back to the Broward county position that we worked so hard to achieve." PX0132 at -565. In short, after having "had two days to think about our Exchange decision," he pressed, "I just can't make sense out of the Florida decision." PX0132 at -565.

iii. Regulatory Issues Do Not Explain Aetna's Exit Decision

400. Aetna executives testified that various regulatory issues contributed to its withdrawal decision. However, the issues long predated Aetna's decision. Moreover, CMS has addressed many of the issues. Only after the filing of the Complaint did these issues appear to unsettle Aetna's commitment to its public exchange business.

401. Aetna executives raised concerns about the risk adjustment program, including its zero-sum nature and the time lag in receiving final results.[25] Tr. 1375:9-21, 1377:18-25 (Bertolini); Tr. 2676:10-2677:9 (Guertin). But the program was zero-sum from its inception. Tr. 1433:25-1434:5 (Bertolini). As to the time lag issue, Aetna purchases data from a vendor to estimate its risk adjustment results in advance of its rate filings, Tr. 2676:10-2676:9 (Guertin). Moreover, some states permitted insurers to refile their rates after receiving the 2016 risk adjustment results, and Aetna, in fact, did so in a number of states. Tr. 1546:10-20 (Mayhew); Tr. 2623:12-18 (Counihan); *see* DX0158-013. Additionally, CMS has acted on suggestions from

[25] The risk adjustment program transfers funds from insurers with relatively healthy populations to insurers with relatively unhealthy populations. It is a zero-sum program, meaning payments from insurers with healthier populations equal payments to insurers with unhealthier populations. PX0553 (Frank Report) ¶ 81.

Aetna, including proposals to include prescription drugs and partial-year enrollees in the risk adjustment formula. Tr. 1434:13-1435:11 (Bertolini).

402. Aetna executives also raised concerns about Special Enrollment Periods (SEPs).[26] Tr. 1373:9-1374:16 (Bertolini). CMS has made changes to SEPs, including changes specifically recommended by Aetna like requiring documentation to confirm eligibility and reducing the number of SEPs. Tr. 1433:2-22 (Bertolini); Tr. 2650:9-2651:1 (Counihan). Aetna has already seen improvements in SEP enrollment as a result of these changes. DX0158-002 ("Internal initiatives and CMS actions continue to result in improvement in SEP membership volume over 2015[.]").

403. Aetna executives complained about the underfunding of the risk corridor program.[27] Tr. 1378:15-1379:10 (Bertolini); Tr. 2681:19-2683:15 (Guertin). But Aetna learned in 2015 that it would not receive full payment under the program. Tr. 2681:24-2682:11 (Guertin). And "[u]nlike many competitors, Aetna showed early and prudent caution regarding the [risk corridor] program and never booked an accrual." DX0003-007 (emphasis omitted); *see also* Tr. 2742:7-13 (Guertin).

404. Aetna executives testified that it was "particularly frustrating" that Aetna received a $90 million risk corridor assessment in June 2016. Tr. 2685:14 (Guertin). But this assessment was only "a one-timer" that related to the 2014 plan year. Tr. 2685:18 (Guertin); *accord* Tr.

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[26] SEPs allow an individual who has experienced certain life events to enroll in an individual health insurance plan outside of the annual enrollment period. Tr. 1373:21-25 (Bertolini).

[27] The risk corridor program is a temporary program (expiring at the end of 2016) that requires insurers serving populations having lower than expected medical costs to pay into the program and provides payments to insurers serving populations having higher than expected costs. PX0553 (Frank Report) ¶ 80.

2643:1-7 (Counihan). Moreover, regulatory guidance issued by CMS a year earlier made clear in advance that Aetna was subject to a potential assessment. Tr. 2643:8-19 (Counihan). Aetna ultimately was required to pay approximately $60 million. Tr. 2683:19-2684:17 (Guertin); Tr. 2643:20-24 (Counihan). Moreover, this payment was offset by additional payments to Aetna for prior years' cost-sharing reductions. Tr. 2742:23-2743:7 (Guertin).

405. Aetna executives raised concerns that "keep what you have" (KWYH) plans have kept healthy individuals off the public exchanges.[28] Tr. 1379:11-1380:10 (Bertolini); Tr. 2673:24-2674:10 (Guertin). But the KWYH plans date from the start of the program, and one class of KWYH plans is expiring at the end of 2017. Tr. 2740:25-2741:17 (Guertin); Tr. 1436:1-5 (Bertolini).

3. Aetna's Future Ability to Compete Is Not Jeopardized by its Withdrawal from the Exchanges in 2017

406. Aetna's future ability to compete is not jeopardized by its decision to stop selling on the public exchanges in the Complaint counties in 2017. Aetna consciously withdrew from the exchanges in Florida, Georgia, Missouri, and other states in a way that allows it to compete on those exchanges in 2018—the next competitive episode—and beyond. Tr. 1467:11-13 (Kelmar); Tr. 1489:21-23 (Lynch).

407. State laws prohibit an insurer from selling in the state for five years if the insurer stops selling individual commercial insurance in the state altogether. Tr. 1364:20-25 (Bertolini). But Aetna will continue to sell off-exchange policies for the 2017 policy year in Florida, Georgia, Missouri, and other states, avoiding this rule. Tr. 1364:8-11 (Bertolini).

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[28] KWYH refers to the decision made in 2013 to permit individuals who had health insurance prior to 2014 to keep their plans. Tr. 2674:11-2675:6 (Guertin).

408. Aetna chose to maintain a presence in the individual market because it "needed to remain in the game." Tr. 1387:11-12 (Bertolini). Mr. Bertolini rejected his team's recommendation that Aetna exit the public exchanges completely because, in his words, Aetna wants "to remain at the table to have influence over where exchanges [go] in the future." Tr. 1412:6-7 (Bertolini). Mr. Bertolini conceded that, if there is a reasonable possibility to operate profitably, Aetna will want to sell health insurance to individuals of low-to-moderate income. Tr. 1365:7-13 (Bertolini); *cf.* Tr. 1676:4-16 (Nevo) (explaining that basic economic theory teaches that firms operate in markets where they expect to be profitable in the future).

409. Additionally, Aetna has retained key management and assets needed to compete on the exchanges in the Complaint counties. For example, the day after announcing its withdrawal, Aetna authorized a six-figure retention bonus for Mr. Mayhew, payable only if he remains with the company for two years. Tr. 1488:22-1489:10 (Kelmar); PX0215. Aetna will maintain an off-exchange presence in all of the states where it participated in 2016 and have systems to process premiums and claims. Tr. 1520:7-16 (Mayhew). Aetna will continue to sell on the public exchanges in four states and have the IT necessary to interface with the public exchanges. Tr. 1520:17-19 (Mayhew). In addition to Mr. Mayhew, Aetna will retain other experienced employees. Tr. 1520:23-25 (Mayhew).

410. It is not too late for Aetna to compete in the public exchanges in the Complaint counties in 2018. Tr. 2656:9-21 (Counihan). Aetna has substantial advantages over a new entrant, including state licenses, the ability to meet state solvency requirements, and relationships with state regulators. *See* Tr. 2656:9-21 (Counihan). Aetna already plans to expand to a new state exchange in 2018. Tr. 1521:1-3 (Mayhew). Moreover, the Florida consent order requires Aetna to participate on the public exchanges in 2018. Tr. 1518:8-11 (Mayhew); PX0476. Further, Ms.

Lynch recently expressed interest in meeting with CMS to discuss ways of retooling its individual business. Tr. 2655:15-2656:8 (Counihan); *cf.* PX0262 (August 13, 2016, email stating that, in [redacted], Aetna plans to "file place-holders for off-exchange and to reassess options in early 2017 for 2018").

411. Aetna executives testified that Aetna has no plans to compete in the Complaint counties in 2018. But this testimony, subject to manipulation and advantageous to Aetna's litigating position, is entitled to little to no weight. *Hosp. Corp. of Am.*, 807 F.2d at 1384. Moreover, any lack of planning to date may reflect Aetna's hope that it will consummate this merger and thus gain Humana's public exchange business in the Complaint counties.

412. Aetna withdrew from the Complaint counties for the 2017 plan year late in the competitive cycle, after submitting its plans and later re-filing its rates after receiving the June 30 risk adjustment results. Tr. 1546:10-20 (Mayhew). Thus, while Aetna's withdrawal has denied consumers in the Complaint counties (and other markets) the choice of Aetna plans in 2017, those consumers at least benefitted from competition among Aetna and other insurers on price and other plan characteristics prior to the withdrawal. And Aetna is poised to participate in the next competitive episode—the 2018 plan year—and beyond. *See* Merger Guidelines § 5.1 (firms "that are not current producers in a relevant market, but that would very likely provide rapid supply responses with direct competitive impact in the event of a SSNIP, without incurring significant sunk costs, are also considered market participants").

C. Individual Insurance Sold on the Public Exchanges in Each of the 17 Complaint Counties Constitutes a Separate Relevant Market

413. Defendants have not presented any expert testimony or other significant evidence challenging Plaintiffs' market definition, effectively conceding that the sale of individual commercial health insurance on the ACA public exchanges in each of the 17 Complaint counties

constitutes a relevant antitrust market.

1. The Complaint Counties Are Relevant Geographic Markets

414. Individual counties are relevant geographic markets. Tr. 1677:8-1678:3 (Nevo). Under the ACA, states define geographic areas known as rating areas, which can be broader than a county. PX0551 (Nevo Report) ¶ 290. However, for each on-exchange plan, an insurer must propose a service area, which can be smaller that the rating area, but which must be no smaller than a county (with certain limited exceptions). PX0551 (Nevo Report) ¶¶ 289-290.

415. Insurers can determine prices and other plan characteristics on a county-by-county basis in Florida, Georgia, and Missouri, and, therefore, compete on a county-by-county basis. PX0551 (Nevo Report) ¶ 290. Though insurers cannot charge different premiums for the same plan within a rating area, insurers effectively can price and design plans on a county-by-county basis by offering a plan in only a single county in a rating area. PX0551 (Nevo Report) ¶ 290.

416. In the geographic areas at issue, a consumer can purchase only those on-exchange plans offered in the service area in which she resides. Tr. 1677:8-1678:3 (Nevo); PX0551 (Nevo Report) ¶ 289. Thus, a hypothetical monopolist of all individual health insurance plans sold on a public exchange in a county could impose a SSNIP on those plans. Consumers cannot switch to an on-exchange plan not available in their county of residence, so the hypothetical monopolist would not lose customers to plans outside the county. Tr. 1678:4-17 (Nevo); PX0551 (Nevo Report) ¶ 291. Therefore, the counties alleged in the Complaint are relevant geographic markets.

2. On-Exchange Individual Insurance Is a Relevant Product Market

417. Individual plans offered to individuals on the ACA public exchanges constitute a relevant product market. A critical distinction between on-exchange and off-exchange plans is that, because of the availability of subsidies, on-exchange plans are significantly cheaper for many consumers. Therefore, most individuals with on-exchange plans are not likely to substitute

to an off-exchange plan in the face of a price increase, and a hypothetical monopolist of on-exchange plans likely would impose a 5% to 10% SSNIP.

a. On-Exchange Plans Are Not Reasonably Interchangeable with Off-Exchange Plans

418. Individuals (with certain exceptions) whose incomes are between 100% and 400% of the Federal Poverty Level (FPL) are eligible for premium subsidies in the form of an Advanced Premium Tax Credit (APTC). However, individuals must purchase a metal-level plan on a public exchange in order to receive the APTC. PX0551 (Nevo Report) ¶¶ 279-281. The amount of the APTC is the difference between the premium of the second-lowest-price silver plan available to the individual and a percentage of the individual's household income, with the percentage varying by income (between 2% and 9.5%). PX0551 (Nevo Report) ¶ 279.

419. Additionally, individuals (with certain exceptions) whose incomes are between 100 and 250% of the FPL are eligible for cost-sharing reductions that lower out-of-pocket costs for deductibles, coinsurance, and copayments. However, individuals receive the cost-sharing reductions only if they purchase a silver plan on a public exchange. PX0553 (Frank Report) ¶ 83.

420. These subsidies significantly reduce the cost of health insurance for most on-exchange consumers. In 2016, an estimated 85% of on-exchange enrollees—and 88% of on-exchange enrollees in the Complaint counties—receive the APTC. PX0553 (Frank Report) ¶ 84; PX0551 (Nevo Report) ¶¶ 281 n.358, 295. In 2016, the average APTC covered 74% of premiums—77% of premiums for consumers in the Complaint counties. PX0553 (Frank Report) ¶ 84; PX0551 (Nevo Report) ¶ 295. The cost-sharing reductions provide additional financial assistance for eligible consumers. Thus, on-exchange plans are uniquely appealing to subsidy-eligible individuals.

b. Economic Analysis Shows That On-Exchange Plans Are a Relevant Product Market

421. The structure of these subsidies means that the hypothetical monopolist test is easily satisfied. If a hypothetical monopolist raised the prices of all on-exchange plans in a Complaint county by the same amount, the second-lowest-price silver plan would retain that position. Because the APTC increases dollar-for-dollar with the second-lowest-price silver plan for all eligible consumers, the APTC would increase by the same amount as the price increase, and the 88% of consumers receiving the APTC would not experience any price increase. A hypothetical monopolist of all on-exchange plans in a Complaint county therefore would likely impose a SSNIP. Tr. 1679:4-24 (Nevo); PX0551 (Nevo Report) ¶ 294.

422. Professor Nevo's analysis confirms that on-exchange plans constitute a relevant product market. Professor Nevo conducted a hypothetical monopolist test for every Aetna and Humana plan in the Complaint counties. Professor Nevo assumed conservatively that the price of the second-lowest-price silver plan is fixed—i.e., that the amount of the subsidy does not vary and consumers experience a dollar-for-dollar price increase—used a wide range of margins and diversion ratios. PX0551 (Nevo Report) ¶¶ 306 n.399, 310. His analysis shows that a 10% SSNIP would be profitable for at least one Aetna or Humana plan in 100% of the Complaint counties, meaning that the hypothetical monopolist likely would impose at least a 5% SSNIP. Tr. 1683:7-21 (Nevo); PX0551 (Nevo Report) ¶ 310. Professor Nevo also examined evidence on consumer substitution and reviewed the academic literature, which confirmed his analysis. Tr. 1679:25-1683:6 (Nevo); PX0551 (Nevo Report) ¶¶ 297-303.

D. The Transaction Is Presumptively Unlawful in All 17 Counties.

423. The proposed merger would significantly increase concentration in already concentrated markets. Tr. 1690:9-12 (Nevo). Using 2016 data, Professor Nevo calculated market

shares, post-merger HHI, and change in HHI for each Complaint county. The post-merger HHI would exceed 2,500 for each county, with a minimum of 3,408 and a weighted average of 4,871. Tr. 1690:13-25 (Nevo); PX0551 (Nevo Report) ¶ 313 & App. M. The change in HHI would exceed 200 for each county, with a minimum of 690 and a weighted average of 1,037. PX0551 (Nevo Report) ¶ 313; App. M. Aetna and Humana's combined market share in each Complaint county exceeds 40%, ranging from 43% to 81%. PX0551 (Nevo Report), App. M. These concentration measures greatly exceed the thresholds under which a transaction presumptively violates Section 7.

E. The Elimination of All Direct Competition between Aetna and Humana Is Likely to Increase Prices and/or Decrease Benefits

1. Economic Analysis Shows that Consumers Are Likely to be Harmed by the Proposed Merger

424. In order to evaluate the likely effect of the proposed merger on prices, Professor Nevo studied the relationship between market concentration and premiums. Specifically, he conducted a regression analysis of the relationship between market concentration and premiums for three plans—lowest-price silver, second-lowest-price silver, and average-price silver—for more than 2,500 counties in states with federally facilitated exchanges. Tr. 1692:18-1693:8 (Nevo); PX0551 (Nevo Report) ¶¶ 317, 320. He found that all these premiums increase as market concentration (i.e., HHI) increases and that the relationship is statistically significant. Tr. 1692:18-1693:8 (Nevo); PX0551 (Nevo Report) ¶ 322-23, Ex. 35.

425. Professor Nevo's analysis indicated that, on average, a 10% increase in HHI is associated with a 0.5% increase in average silver plan premiums. PX0551 (Nevo Report) ¶ 323, Ex. 35. Using his results, Professor Nevo predicted the likely impact of the proposed merger on the second-lowest-price silver plan's premium in the 17 Complaint counties. He found that the merger would cause an average enrollment-weighted premium increase of 2.1%, with a low of

1.1% and a high of 4.7%. Tr. 1692:18-1693:8 (Nevo); PX0551 (Nevo Report) ¶ 323, Ex. 35. The predicted increases in average premiums would lead to approximately $38 million per year in additional payments by consumers and taxpayers. PX0551 (Nevo Report) ¶ 324. Professor Nevo also reviewed the academic literature, which confirmed that the merger would lessen competition in the relevant markets. Tr. 1691:12-1692:7 (Nevo); PX0551 (Nevo Report) ¶¶ 318-319.

2. Consumers Have Benefited from Head-to-Head Competition between Aetna and Humana

426. Aetna and Humana are close competitors on the public exchanges. For example, on hearing rumors of the merger, his CFO informed Mr. Mayhew that Humana is "a big competitor" in Florida, Georgia, Utah, and Texas. Tr. 1524:3-1525:11 (Mayhew); PX0108. Similarly, a March 2016 Aetna presentation listed Humana as one of four "Selected Competitors" and noted that Humana has "[s]trong brand recognition and community-type culture" and was in the midst of "a pilot 'Bold Moves' market initiative." PX0259 at -743; *see also* PX0210 at -707, -709 (June 1, 2016, draft of presentation for Audit Committee showing Humana as one of four competitors and noting that Humana has a "significant presence" in Florida and Georgia); PX0267 at -542 (email from head of Humana's individual business identifying Aetna, Blue Cross and Blue Shield plans, United, and Centene as "[o]ur major competitors").

427. Aetna and Humana track each other's pricing, product offerings, and performance. *See, e.g.*, PX0266 at -341 (President of Humana's Retail Segment wants "to see where Aetna's footprint is a match and what they're [sic] pricing looks like by metal tier and how their high level benefit design compares to ours"); PX0116 at -201 (June 28, 2016, slides comparing Aetna's footprint to Humana's footprint); PX0351 at -001 (2016 Georgia Market Presentation observing that Humana has a "[s]trong brand" and "[n]ot enough price separation

for them to be uncompetitive"); PX0110 at -650 (Aetna "benefiting from Humana's rate action" in Georgia). Aetna and Humana target each other's customers. PX0518 (Aetna email stating that "Humana will have a strong hold on their current population" in Georgia and Aetna "will need to come up w/ a creative distribution strategy to attract membership to leave"); PX0218 at -078 (Aetna email noting that Humana's 2016 commission schedules "will help us target brokers and GA by geography").

428. Aetna and Humana have competed vigorously in the Complaint counties. For example, in an email discussing Aetna's pricing for 2016 in Broward County, the Florida president stated that he was "concerned that we have dropped to #2 behind Humana" and recommended that Aetna lower its rates by 4% to "maintain #1 in Broward." Tr. 1528:5-1529:24 (Mayhew); PX0263 at -987. Similarly, a 2016 Missouri market presentation stated that Humana is Aetna's "Biggest Competitor in Joplin and also very well priced in Kansas City" and that "[w]e are neck and neck with Humana in Joplin." Tr. 1525:12-1528:4 (Mayhew); PX0351 at -977; PX0268 at -495 (Aetna is Humana's "biggest competitor" in Broward County); PX0521 at -999 (2015 Atlanta Case Study showing Aetna and Humana as "Leading the Market," with other competitors "Lagging the Market").

F. The Defendants Cannot Rebut the Government's Case

1. Defendants' Weakened Competitor Defense Fails

429. Mr. Orszag cast Humana as "an ineffective competitor." Tr. 3036:11 (Orszag). But courts credit this type of "weakened competitor" or "weakened division" argument only when the acquiring firm "makes a substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's prima facie case." *Univ. Health, Inc.*, 938 F.2d at 1221. The weakened competitor argument has been described as the "weakest ground of all for

justifying a merger," *Arch Coal*, 329 F. Supp. 2d at 154 (quoting *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339 (7th Cir. 1981)), and "the Hail-Mary pass of presumptively doomed mergers," *ProMedica*, 749 F.3d at 572. This rule recognizes that "while a merger is a relatively 'permanent' arrangement having long-lasting competitive effects, financial difficulties not raising a significant threat of failure are typically remedied in a moderate length of time." 4A PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 963a3 (4th ed. 2016).

430. Defendants have failed to rebut Plaintiffs prima facie case given, *inter alia*, the evidence that Humana is resolving any weakness by competitive means. Humana will maintain its on-exchange business in 2017 in 11 states, including Florida, Georgia, and Missouri. Tr. 3224:20-25 (Orszag). Humana is taking "corrective actions" to improve its business. Tr. 1876:7-1878:6, 1880:21-1881:3 (Broussard); *see also* PX0407 at 12. For example, Humana has adopted "a more insurance focused approach," is using narrower networks, and is featuring "leaner product design." Tr. 1876:19-1877:6, 1879:8-12 (Broussard). In the states in which Humana remains, it expects to offer "a high-quality and ultimately stable individual commercial health plan." Tr. 1880:21-1881:3 (Broussard); *see also* PX0407 at 12. About six weeks ago, CMS, at the request of Humana's CEO, met with Humana executives to discuss ways to improve Humana's individual business going forward. Tr. 2653:14-2655:23 (Counihan).

431. Mr. Orszag criticized Professor Nevo's market share calculations, focusing singularly on Humana's 2017 prices. This line of attack runs counter to case law establishing that, while future market shares may be affected by entry and exit, Plaintiffs need present only the "closest available approximation" of market shares and HHIs. *FTC v. PPG Indus., Inc.*, 798 F.2d 1500, 1505 (D.C. Cir. 1986); *see also Brown Shoe*, 370 U.S. at 343 n.70 ("we recognize that this share need not remain stable in the future"); *H&R Block*, 833 F. Supp. 2d at 72 ("[a]

reliable, reasonable, close approximation of relevant market share data is sufficient"); *Sysco*, 113 F. Supp. 3d at 54 (government "need not present market shares and HHI estimates with the precision of a NASA scientist").

432. Additionally, Mr. Orszag's analysis has several flaws. Mr. Orszag based his predictions regarding Humana's 2017 share on his analysis of the correlation between the lowest premium an insurer sets on its silver plans and the resulting membership gained by the insurer across all of its offered plans in the market, averaging across counties and years. Tr. 3029:13-3031:23 (Orszag); DX0418 (Orszag Reply Report) ¶ 174, Figure III-1. Despite having access to plan-level enrollment data, Mr. Orszag did not test the intended takeaway from his analysis, namely, whether each insurer's enrollment is, in fact, concentrated in the lowest priced silver plan offered. *See* PX0551 (Nevo Report) App. C at 31 (listing DOJ Request 20160901.xlsx). Furthermore, Mr. Orszag did not make any attempt to control for the year, geography, number of competing insurers, or diversity of plan options available, nor did he purport to establish a statistically significant link between price and enrollment. DX0418 (Orszag Reply Report) ¶ 174.

433. Finally, Mr. Orszag ignored crucial facts. He did not address the fact that, due to the exits of other insurers, in six of the Complaint counties in 2017, Humana will be a duopolist on the public exchange, Tr. 3220:1-15 (Orszag); PX0711, a fact indicating that Professor Nevo's analysis understates the competitive harm. Nor did Mr. Orszag acknowledge that Humana increased its prices only for the 2017 plan year—not for future competitive episodes. Humana has efforts to underway to improve its competitiveness, and these efforts are likely to affect its pricing when it next competes (for the 2018 plan year). Finally, Mr. Orszag ignored the evidence that Aetna and Humana are particularly close competitors. *See supra* Section IV.D.2.

2. New Entry Will Not Offset the Effects of the Proposed Merger

434. Entry by other insurers is unlikely to forestall the competitive harm given the

substantial barriers to entry. Tr. 1694:16-1695:2 (Nevo) (concluding that entry "would be insufficient to restore lost competition"). To enter and compete successfully on a public exchange, a party would need to hire experienced personnel; build a cost-effective provider network; build the necessary IT infrastructure for enrollment, billing, and interfacing with the exchanges; obtain a license, meet solvency standards, and satisfy other regulatory requirements; build a brand; and develop experience pricing the business, among other hurdles. *See, e.g.*, Tr. 1521:4-1522:10, 1523:14-1524:2 (Mayhew); Tr. 1693:20-1694:3 (Nevo); Tr. 2663:19-2664:7 (Counihan); PX0551 (Nevo Report) ¶¶ 327-35; *see also* Tr. 2644:8-16 (Counihan) ("One is that this is a very difficult business to enter. Over half of new entrants typically fail.").

435. Aetna's experience illustrates the barriers to entry in the exchange markets. Aetna spent around $150 to $200 million preparing to enter the public exchanges in 2014, and, depending on the time of year, has 500 to 800 employees focused on its individual business. Tr. 1521:11-1521:23 (Mayhew); *see also* Tr. 1522:7-10 (Mayhew) (agreeing that "the technology build that Aetna had to do to enter the exchanges took closer to a year to build than a month").

3. Conjecture about a Market Collapse or the Future Regulatory Landscape Cannot Foreclose Enforcement of the Antitrust Laws

436. Defendants invite the court to consider the prospect of a "death spiral"[29] on the public exchanges and the possibility of future changes to the ACA. However, this conjecture cannot forestall enforcement of the antitrust laws.

437. Witnesses explained that "the advance premium tax credits of reimbursement, of which 85 percent of enrollees receive, make it essentially impossible for there to be a death spiral

[29] A death spiral describes a scenario in which the cost of insurance would rise, healthier people would increasingly leave the market, and premiums would continue to rise, with the process continuing until no enrollees are left in the market. PX0554 (Frank Rebuttal Report) ¶¶ 53-54.

on the exchange." Tr. 2619:8-14 (Counihan); *see also* Tr. 144:9-145:8 (Frank). Generally, "premium increases won't impact most of the people who are buying insurance through the marketplace, because even when premiums go up, the tax credits go up to offset the increases." PX0709 at 10.

438. Finding a lack of competitive harm due to potential changes to the public exchanges and the ACA would necessitate speculation on the particulars of future legislative, administrative, or judicial actions. Courts "lack 'sufficient confidence in [their] powers of imagination'" to assess potential future conduct by governmental actors. *Worth v. Jackson*, 451 F.3d 854, 862 (D.C. Cir. 2006) (quoting *Texas v. United States*, 523 U.S. 296, 301 (1998)); *see also Williams v. Lew*, 77 F. Supp. 3d 129, 132 (D.D.C. 2015) (declining to act on "the hypothetical premise that the United States government will, at some unknown future date, fail to pay on plaintiff's Treasury securities because of the debt limit statute"). Importantly, the fact that the competitive field might change in the future "does not appreciably alter our mission in assessing the alleged antitrust violations in the present case." *United States v. Microsoft Corp.*, 253 F.3d 34, 50 (D.C. Cir. 2001).

439. Moreover, competition will continue to be important for individuals purchasing health insurance because "[i]t's a critical component for shopping for any consumer product." Tr. 2640:5-12 (Counihan). Whatever the particulars of the competitive landscape in the future, the 700,000 individuals purchasing health insurance on the public exchanges in the Complaint counties, [30] Tr. 1675:3-8 (Nevo), and consumers across the country, will lose competition as a result of the merger of two of the most important suppliers of individual health insurance.

[30] There are nearly 430,000 enrollees in the three Florida counties alone, ranging from 40,000 in Volusia County to 240,000 in Broward County. PX0551 (Nevo Report) Apps. M & L.

VI. THE PARTIES' CLAIMED EFFICIENCIES CANNOT JUSTIFY THE LIKELY HARM TO COMPETITION IN THE RELEVANT MARKETS

440. Defendants seek to rebut Plaintiffs' prima facie case with over $2 billion of claimed efficiencies. Tr. 2852:17-2853:2 (Gokhale). However, to justify this otherwise anticompetitive merger, the efficiencies would have to be verifiable, merger-specific, likely to benefit consumers, and specific to the markets at issue. Defendants fail on all of these issues.

A. Applicable Legal Standards

441. "The Supreme Court has never expressly approved an efficiencies defense to a § 7 claim," *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 788-89 (9th Cir. 2015), and lower courts "have rarely, if ever" held that efficiencies successfully rebutted the government's prima facie case, *CCC Holdings*, 605 F. Supp. 2d at 72; *see also Sysco*, 113 F. Supp. 3d at 82 (finding no such case).

442. Defendants bear the burden of verifying and quantifying their efficiency claims. *See H&R Block*, 833 F. Supp. at 89 ("it is incumbent upon the merging firms to substantiate efficiency claims") (quoting Merger Guidelines § 10). To rebut Plaintiffs' case, Defendants would need to "show that the prediction of anticompetitive effects from the prima facie case is inaccurate." *St. Luke's*, 778 F.3d at 791; *see also, e.g., Sysco*, 113 F. Supp. 3d at 86 (efficiencies must outweigh the competitive harm from merger). The hurdle for Defendants is especially high here, as "high market concentration levels" require "proof of extraordinary efficiencies." *Heinz*, 246 F.3d at 720; *see also Sysco*, 113 F. Supp. 3d at 81. In considering Defendants' claims, "[t]he court must 'undertake a rigorous analysis of the kinds of efficiencies being urged by the parties in order to ensure that those 'efficiencies' represent more than mere speculation and promises about post-merger behavior.'" *Sysco*, 113 F. Supp. 3d at 82 (quoting *Heinz*, 246 F.3d at 721).

443. To be considered at all, efficiencies must be (i) "reasonably verifiable by an

independent party," *H&R Block*, 833 F. Supp. 2d at 89, and not "mere speculation and promises about post-merger behavior," *Heinz,* 246 F.3d at 721; (ii) "merger-specific," meaning "efficiencies that cannot be achieved by either company alone," *id.* at 722; and (iii) likely to benefit consumers, *Sysco*, 113 F. Supp. 3d at 82. Additionally, the efficiencies must relate specifically to the markets at issue, which are the "locus of competition[] within which the anti-competitive effects . . . [are] to be judged." *Brown Shoe*, 370 U.S. at 320-21; *see also St. Luke's*, 778 F.3d at 789.

B. The Defendants Have Not Claimed Any Post-Merger Efficiencies Attributable to the Markets at Issue

444. To meet their burden, Defendants must show efficiencies specific to the markets at issue after accounting for divestitures and withdrawals. The law does not allow "anticompetitive effects in one market" to be offset by "pro-competitive consequences in another." *Phila. Nat'l Bank*, 374 U.S. at 370.

445. Rajiv Gokhale, Defendants' efficiencies expert, did not attempt to calculate the efficiencies that Aetna will retain in the challenged markets post-divestiture. Tr. 3435:14-24 (Hammer); *see also* Tr. 3465:20-3466:16 (Hammer). Instead, he appears to have attempted to calculate the efficiencies *lost* in the markets at issue due to divestitures and individual commercial withdrawals, a number that is irrelevant to the efficiencies case because it is conceptually distinct from the efficiencies that *remain* in the markets at issue after accounting for the divestitures and withdrawals. *See* DX0577 (Gokhale Rebuttal Report) Ex. 15. For this reason alone, Defendants' efficiencies defense fails.

C. The Claimed Efficiencies Have Not Been Verified

446. Defendants also have failed to verify the claimed efficiencies. Mr. Gokhale relies heavily on the work of others, making his analysis inadequate to substantiate the claimed

efficiencies. *See Sysco*, 113 F. Supp. 3d at 83-85 (rejecting claimed efficiencies where testifying expert relied extensively on work done by third-party consultants and conducted little or no "independent analysis").

447. In particular, Mr. Gokhale relied on models developed by clean-room consultants and, in some cases, Aetna employees. *See* DX0420 (Gokhale Report) ¶¶ 34-36, 53-54; Tr. 2863:23-2864:2, Tr. 2904:2-14 (Gokhale). Nothing in the record establishes the reasonableness of the many assumptions underlying the models, nor the accuracy of the data measurement and collection process used. Tr. 3400:4-18 (Hammer). Rather than check the substantive bases of the work, Mr. Gokhale merely "replicat[ed]" the models by checking the arithmetic. PX0562 (Hammer Rebuttal Report) ¶ 21; *see also, e.g.*, DX0420 (Gokhale Report) ¶¶ 141, 179 (instances where Mr. Gokhale claims to have replicated the models of others). Moreover, he did not provide the underlying data and documents to enable a third party to verify his estimates. PX0562 (Hammer Rebuttal Report) ¶¶ 17-20, 40-42. Mr. Gokhale also relied on second-hand information he gathered from undocumented interviews with third-party consultants or Aetna and Humana personnel. Tr. 2860:15-2863:18 (Gokhale); DX0577 (Gokhale Rebuttal Report) App. C (listing individuals interviewed); *see also* PX0562 (Hammer Rebuttal Report) ¶ 79.

448. In addition, Mr. Gokhale relied on estimates of total efficiencies developed by Aetna employees—estimates that are clearly unreliable. Shortly before the Defendants began their synergy calculations, Aetna developed a "stretch target" of $3.3 billion in efficiencies by 2020 for its synergy teams. Tr. 1428:6-8, 12-15 (Bertolini); Tr. 2831:14-20 (Horst); DX0420 (Gokhale Report) ¶ 28; PX0180, at -970; PX0140 at -555 ("Mark [Bertolini] has honed in on $3.3 so let's make sure that is our recommendation."). This target has not changed through four rounds of "bottoms up" estimates. Tr. 2812:19-2813:9, 2832:14-18 (Horst); *see also* PX0158 at -

979 ("Reminder: Synergies are zero-sum—a reduction in one team means an increase elsewhere"). Moreover, Aetna is not confident that it will achieve these targets. At its July 2016 meeting, Aetna's board received financial projections applying a "confidence weighting" of 50% to all pharmacy, medical cost, and revenue synergies (i.e., discounting the targeted amounts by 50%), underscoring that Aetna views its targets in these major categories as unreliable. Tr. 3422:8-25 (Hammer); PX0562 (Hammer Rebuttal Report) ¶¶ 44-46; PX0324 at -453 (pretax synergies); PX0320 at tab "Synergies by line item," at AC11, W11, E11, AK4, and AK16; *see also* PX0139 at -018.

449. The limited analysis that Mr. Gokhale performed is inadequate to verify the claimed efficiencies. Two large categories of claims are illustrative. First, Defendants claim $202.8 million in pharmacy efficiencies in the form of rebate maximization. DX0577 (Gokhale Rebuttal Report) Ex. 5-1. These efficiencies were calculated by comparing the drug rebate rates of the two merging companies and assuming that the combined company will receive the higher of the two rates going forward. Tr. 2898:23-2899:17 (Gokhale); PX0562 (Hammer Rebuttal Report) ¶ 116. This calculation assumes that the difference in the rates the two companies received on a given drug at the time the synergies were calculated will continue in perpetuity absent the merger. *See* Tr. 2903:8-2904:6 (Gokhale) (using the fourth quarter of 2015 "as a representative time period"); Tr. 3402:23-3403:12 (Hammer). That assumption is erroneous, as demonstrated by counterexamples found in the data of the Defendants' own consultants but not included in Mr. Gokhale's calculations. Tr. 3410:12-3412:15, 3417:19-3419:9 (Hammer). Had Defendants used a longitudinal study as their consultant Deloitte had suggested, they might have found that some or all of the difference in rates in the baseline period arose from random fluctuations. Tr. 3419:10-3420:14 (Hammer); *see also* Tr. 3405:11-3406:22 (Hammer); PX0137

at -546. Deloitte believed that such a study was necessary to verify the claimed efficiencies, but Aetna disagreed and dropped Deloitte in favor of another consultant. Tr. 2964:8-17, 2960:25-2961:6 (Gokhale). Mr. Gokhale knew of this disagreement, but never examined Deloitte's concerns in detail. Tr. 2965:12-16 (Gokhale); *see also* PX0137 at -546 (longitudinal analysis); *see generally* PX0562 (Hammer Rebuttal Report) ¶¶ 123-125.

450. Second, Defendants claim $258.6 million in network medical cost savings. DX0577 (Gokhale Rebuttal Report) Ex. 1.1. Most of these savings are based on the assumption that the combined company will be able to pay the lower of the rates that the two merging companies currently pay to in-network health care providers. Tr. 2917:16-2918:12 (Gokhale); PX0562 (Hammer Rebuttal Report) ¶¶ 205-07. But Mr. Gokhale testified that he did not "independently review the provider rates." Tr. 2936:5-7 (Gokhale). Mr. Gokhale also ignored evidence that some providers might be unwilling to accept the lower rate currently paid by the two companies, or already are in the process of renegotiating their contracts to avoid that result. Tr. 3430:22-3432:5 (Hammer); *see also* PX0138 at -203; PX0146 at -826; PX0192 at -176 to -177; PX0141 at -154. Nor did Mr. Gokhale take into account evidence that Aetna in fact encountered such problems in attempting to realize network synergies after it purchased Coventry.[31] PX0143 at -921; PX0141 at -154; PX0377 at -371. Moreover, he ignored the concern of one Aetna synergy consultant that the merged company might not be able to pursue simultaneously the network synergies and the concurrent review synergies discussed below. DX0209-011; s*ee also* Tr. 3432:6-17, 3429:15-3430:8 (Hammer); PX0147 at -267 (PwC

[31] The calculation of network efficiencies also shows how Mr. Gokhale dealt with uncertainty, by accepting an arbitrary "haircut," or discount factor, *see* DX0420 (Gokhale Report) ¶¶ 197-98, a practice that is methodologically flawed for reasons described by Ms. Hammer, Tr. 3400:15-3401:25; 3420:25-3422:7 (Hammer), and pervades the work relied upon by Mr. Gokhale.

recommended a provider-by-provider analysis of whether to lead with one synergy or the other).

451. Finally, Mr. Gokhale has not claimed any efficiencies for 2017, 2018, or 2019. Tr.3399:21-3400:3 (Hammer); PX0562 (Hammer Rebuttal Report) ¶¶ 22-23; *see also* Tr. 2923:5-7 (Gokhale). Rather, he confined his analysis to efficiencies that might be achieved in 2020, four years after the merger. Tr. 3399:21-3400:3 (Hammer). This renders Defendants' efficiencies claims even more difficult to verify, and entitled to even less weight. *CCC Holdings*, 605 F. Supp. 2d at 73 ("delayed benefits from efficiencies . . . will be given less weight because they are less proximate and more difficult to predict") (quoting 1997 Merger Guidelines); *see also* Merger Guidelines § 10 n.15.

452. The only efficiency category that Ms. Hammer found adequately verified by the Defendants is $72.3 million in savings from the elimination of duplicative full-time-equivalent employees from the commercial group business. Tr. 3387:22-3389:17 (Hammer). That business is outside the product markets alleged in this case. Tr. 3389:9-17 (Hammer).

D. The Claimed Efficiencies Are Not Merger-Specific or Likely to Benefit Consumers

453. Defendants also failed to show that significant claimed efficiencies are merger-specific or likely to benefit consumers. For example, Defendants claim $221.2 million in clinical services savings, $169.2 million of which represents concurrent review efficiencies. DX0577 (Gokhale Rebuttal Report) Ex. 6-1. Concurrent review is a "form of utilization management" that involves denying or downgrading care recommended by a treating physician when the insurer deems the care inappropriate. Tr. 2827:5-2828:5 (Horst); *see also* Tr. 2910:22-2911:18 (Gokhale); Tr. 3426:14-18 (Hammer).

454. These efficiencies were calculated by comparing the two companies' rates of denying certain services and assuming that the lower-denial-rate company will achieve the denial

rates of the higher-denial-rate company post-merger. Tr. 2911:19-2912:9 (Gokhale); Tr. 3426:19-3427:16 (Hammer); PX0562 (Hammer Rebuttal Report) ¶¶ 172, 187, 193; PX0561 (Hammer Report) ¶¶ 38-39. Mr. Gokhale did not identify particular concurrent review policies that the merged company will follow or explain why the merger is necessary to simply increase denial rates. Tr. 3428:1-3429:14 (Hammer); *see also* PX0137 at -546.

455. Defendants' claimed efficiencies are also not merger-specific because Aetna and Humana are large, sophisticated companies that can independently achieve efficiencies. Mr. Bertolini testified that Aetna is not gaining any capabilities from Humana that it could not build on its own over time. Tr. 1426:7-11 (Bertolini). Ms. Cocozza testified that, without the merger, Aetna would continue to improve operating efficiencies. Tr. 404:4-7, 404:17-19, 405:7-11 (Cocozza). Before contemplating a merger with Humana, Aetna adopted enterprise-wide initiatives to reduce costs, including one that seeks to reduce medical costs by 3% per year, which Mr. Bertolini testified the company had achieved. Tr. 1427:1-10 (Bertolini). Another initiative targets $4 billion in SG&A savings between 2014 and 2020. PX0575 at -302; DX0287-002, -003.

456. In addition, several categories of claimed efficiencies are likely to lead to a reduction in service and therefore are unlikely to benefit consumers. *See, e.g., Penn State Hershey Med. Ctr.*, 838 F.3d at 349 (citing Merger Guidelines § 10) ("[E]fficiencies must not arise from anticompetitive reductions in output or service."). For example, approximately 60% of the pharmacy rebate maximization efficiencies require one of the companies to change its drug formulary to that of the other. Tr. 3423:5-14 (Hammer); *see also* Tr. 2899:12-17 (Gokhale). This will constrain consumers' medication choices and potentially force them to either switch to a less-preferred drug, or pay higher out-of-pocket costs. Tr. 3423:9-3425:1 (Hammer). Another

example is the concurrent review efficiencies, which would increase the combined firm's rate of denying or downgrading care and reduce benefits to consumers. PX0562 ¶¶ 168, 171, 181 (Hammer Rebuttal Report); PX0561 ¶¶ 38-39 (Hammer Report); *see also* Tr. 2827:5-2828:5 (Horst).

E. Evidence from the Coventry Acquisition Undercuts Defendants' Efficiencies Defense

457. Defendants contend that Aetna's 2013 acquisition of Coventry Health Care is a useful guide to the efficiencies they will achieve from the Humana transaction. But the efficiencies would be relevant, if at all, only if they were cognizable and the mergers are similar enough that one could serve as a reliable guide for the other. Defendants have failed to establish either point.

458. Mr. Gokhale admitted that he did not examine whether the synergies claimed from the Aetna–Coventry transaction were cognizable. Tr. 2984:12-18 (Gokhale). He simply "took at face value" the synergies provided to him by Aetna. Tr. 2876:17-2877:22 (Gokhale); *see also* Tr. 2982:1-4 (Gokhale). And the reliability of those synergies is questionable. David Horst, an Aetna manager who worked on the Coventry integration, testified that Aetna stopped tracking synergies from that acquisition in January 2015 and that reported 2015 synergies are therefore extrapolations from 2014 data. Tr. 2837:7-15 (Horst). Mr. Horst also testified that the final determination as to whether a synergy was merger-specific was a "judgment call" and that synergy scoring was agnostic as to whether savings would be passed on to consumers. Tr. 2840:25-2841:5, 2841:12-21 (Horst).

459. Moreover, Mr. Gokhale has not offered any specific reasons for believing the two transactions are similar in ways that would make the efficiencies achieved in one a good predictor of those that could be achieved in the other. *See* Tr. 3395:20-3397:2 (Hammer).

Further, Mr. Gokhale compared his estimate of efficiencies in this transaction to the company's unverified synergies in Aetna-Coventry, a comparison that cast his Aetna-Humana efficiencies claims in an unduly favorable light because the Coventry synergies had not been subjected to Mr. Gokhale's discounting. Tr. 2992:13-2993:10 (Gokhale). Similarly, Mr. Gokhale attempted to use Aetna–Coventry synergies as a benchmark for administrative and medical cost savings, but not for pharmacy savings. *See* Tr. 2876:3-13, Tr. 2898:2-9 (Gokhale). This also biased his results because relatively few pharmacy synergies were asserted in the Aetna-Coventry merger. *See* Tr. 2993:11-2994:11 (Gokhale).

460. Even if the Aetna-Coventry transaction were sufficiently analogous to the current one to provide a benchmark for the calculation of efficiencies, the prior transaction would, if anything, undermine Defendants' claims. Professor Nevo found that the rebate-adjusted rates of Aetna and Coventry MA plans increased relative to those of competing plans in the years following the Aetna–Coventry merger. PX0551 (Nevo Report) ¶¶ 239-41, Ex. 23. Thus, even if that merger generated efficiencies, Aetna did not pass them on to consumers. PX0551 (Nevo Report) ¶ 241; *see also* Tr. 2982:1-4 (Gokhale) (Mr. Gokhale did not examine whether Aetna passed through to consumers any efficiencies allegedly resulting from the Coventry transaction).

CONCLUSION

The evidence shows that the proposed merger likely would substantially lessen competition in the markets for the sale of individual MA plans in 364 counties and for the sale of individual health plans on the public exchanges in 17 counties. The Court therefore should permanently enjoin Aetna from merging with Humana.

Dated: December 29, 2016

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