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

~~FILED UNDER SEAL~~

REDACTED

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES

STATUTES

OTHER AUTHORITIES

INTRODUCTION

The merger of Aetna Inc. and Humana Inc. will generate enormous benefits for healthcare consumers, including millions of senior citizens. Ignoring those benefits and focusing only on a narrow band of overlapping businesses, the United States, joined by eight States and the District of Columbia (collectively, the "Government"), contends that the merger must be enjoined to protect competition in certain counties for the sale of Medicare Advantage plans and individual insurance policies sold on Affordable Care Act ("ACA") exchanges. But agreeing with the Government on its Medicare Advantage claim would require the Court to:

- adopt a product-market definition inconsistent with the Government's everyday description of Medicare as a single insurance program that includes fee-for-service original Medicare ("Original Medicare" or "OM") and managed-care Medicare Advantage ("MA");
- disregard basic marketplace characteristics, such as the presence of other Medicare Advantage Organizations ("MAOs") that have responded and will respond to competitive opportunity;
- ignore the Government's three-fold role as Medicare market creator, ultimate payor, and industry regulator; and
- reject a divestiture package that would remedy any competitive concerns about MA.

Similarly, acceding to the Government's ACA-exchange claim would oblige the Court to:

- overlook the fact that Aetna and Humana no longer compete with one another on the challenged ACA exchanges because Aetna has withdrawn from them effective January 1, 2017; and
- assume that Aetna would re-enter those exchanges in 2018 but for the merger—a highly speculative proposition, since Aetna has accumulated substantial exchange-related losses and Congress appears more inclined to repeal the ACA than to fix the flaws that led to those losses.

The Government will not be able to satisfy its burden on either claim of showing that the merger, which will improve the delivery of high-quality and affordable healthcare, should be enjoined.

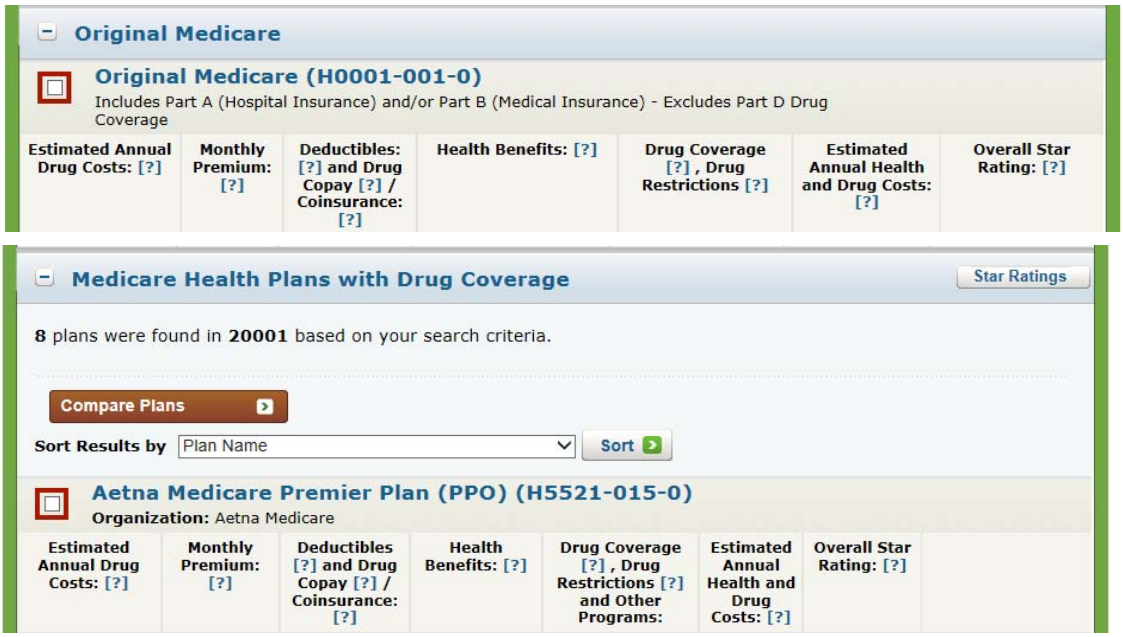
First, the Government is not entitled to a presumption that the merger will harm competition for the sale of Medicare Advantage plans, because the relevant product market (and corresponding market-share calculations) would have to include both Original Medicare and Medicare Advantage plans. The evidence will show that Congress has created—and the federal

government pays for and regulates—two ways for senior citizens to obtain Medicare coverage: OM and MA. The Centers for Medicare and Medicaid Service ("CMS") explains Medicare program choices this way:[1]

The website then directs seniors to take the following steps to decide what kind of Medicare coverage they want, and whether to add prescription-drug or other supplemental coverage:[2]

[1] *Your Medicare Coverage Choices*, Medicare.gov, https://goo.gl/gJKCBE.
[2] *Id.*

Moreover, CMS' "Plan Finder" tool includes Original Medicare as the first option against which it compares all Medicare products, including Medicare Advantage plans:[3]



In short, Original Medicare provides the conceptual and financial foundation for all Medicare Advantage plans. The evidence will demonstrate that CMS sets the prices it will pay providers under Original Medicare and uses those prices to calculate the benchmarks against which MAOs design, build, and price Medicare Advantage plans. [redacted] The documents and testimony will show that CMS regulates nearly every aspect of MA pricing—from MAO margins, to co-pay and out-of-pocket maximums, to caps on annual benefit cost changes—to protect Medicare beneficiaries from

[3] *Medicare Plan Finder*, https://goo.gl/VHV5iY (General Search; Zip Code: 20001; Step 1: "I don't know" for both questions; Step 2: "I don't want to add drugs now" (skipping Step 3); Step 4: "Medicare Health Plans with drug coverage"; sort results by Plan Name).

significant cost changes over time. CMS also regulates MA benefit thresholds, MA plan compliance, MA plan networks, and MA plan quality to ensure that private insurers provide the benefits and quality of care to which all Medicare beneficiaries are entitled. The Government's abstract economic model (which, as its own economic expert acknowledges, may be useful in some cases but "fail in others")[4] cannot account for any of these real-world facts, let alone predict the future.

Second, three key marketplace characteristics explain why the merger will not increase MA prices or decrease benefit quality. Most importantly, CMS will serve as a potent check on the post-merger entity. [redacted] Further, other MAOs have historically (and rapidly) entered into counties where they perceive competitive opportunity, and the evidence will show that they will continue to do so after the merger. And the evidence will show that there is no correlation between the number of MAOs in a county (or their shares) and Medicare Advantage pricing—a fundamental fact that the Government's theories of harm cannot overcome.

Third, should the Court find that any remedial action is warranted, Defendants have entered into binding agreements to divest certain Medicare Advantage assets to Molina Healthcare ("Molina"), a Fortune 500 healthcare company. The Government has dismissed the prospect of any divestitures out of hand, attacking them in its Complaint—even before Defendants had selected a

[4] Aviv Nevo, *Taking the Dogma Out of Econometrics: Structural Modeling and Credible Inference* at 9, Center for the Study of Industrial Organization (Feb. 25, 2010), https://goo.gl/YUaOQC.

winning bidder and finalized the agreements. The evidence will show, however, that the agreements will support a seamless transition from plans administered by Aetna and Humana to plans administered by Molina, and that Molina will be a formidable competitor that will supplant any competition lessened (at least in the Government's eyes) by the merger.

Nor can the Government secure a presumption—or otherwise prove—that the merger will harm competition for the sale of individual insurance plans sold on any ACA exchange. It is beyond dispute that Defendants no longer compete with one another in *any* of the counties challenged in the Complaint. That is because Aetna (which had incurred more than $200 million in exchange-related losses from the inception of the exchanges through the end of 2015; received and reviewed substantial risk-adjustment and claims data in late June and early July indicating that conditions on the exchanges were worse than expected; and, on the basis of that data, projected $300 million in additional exchange-related losses this year) decided to withdraw from ACA exchanges in more than 500 counties, including the 17 counties in the Complaint, effective January 1, 2017. Accordingly, the Government bears the burden of proving that Aetna would re-enter the exchanges in the short-term but for the merger—a highly speculative (and even less likely) proposition given Aetna's exchange-related losses and its inability to recoup them in light of the ACA's structural flaws.

It is also beyond dispute that the ACA exchanges are threatening to collapse under their own weight. The evidence will demonstrate that:

- ACA-compliant policies sold on- and off-exchange failed to attract enough young and healthy individuals to balance the risk of insuring old and sick individuals who signed up for policies in droves.
- Risk-adjustment mechanisms intended to incentivize insurers to sell those policies failed to mitigate this risk and to protect participating insurers from large financial losses from 2014 to 2016—and from the prospect of even larger losses in 2017.
- The implosion of federally-funded co-ops and dozens of other insurer withdrawals from ACA exchanges (including the high-profile departures of Humana and UnitedHealth Group in the first half of 2016) only increased risk for insurers remaining on the exchanges.

The facts will also show that these economic realities—and the difficulty of setting prices, forecasting profits and losses, and assessing risk in such a volatile marketplace—have not been lost on the federal government. [redacted]

The Government nonetheless continues to pursue an argument that Aetna's decision to withdraw from a number of ACA exchanges was motivated by litigation. But this case is about effects on competition, not intent, and those effects must be assessed in light of actual market facts and current competitive conditions. Here, those facts include Aetna's previous and projected exchange-related losses of more than $500 million, Humana's uncertain presence on the exchanges (since it has been forced to raise rates to levels unlikely to attract all but the sickest of patients), and the reality that dozens of insurers have left the exchanges altogether. Aetna has repeatedly told its investors that the exchanges' viability was uncertain absent fundamental regulatory and legislative reforms. Current competitive conditions on the exchanges are uncertain at best. Lacking any business documents or testimony indicating that Aetna is planning to enter any of the challenged counties anew, the Government is left asking the Court to look into the fog of the future, and to divine who will be competing on the exchanges, where they will be competing, and all of the other market conditions that would be necessary to assess competitive impact. That is a speculative request indeed, since there are real questions whether the exchanges will exist *at all* after ACA opponents assume control of the Executive and Legislative Branches early next year.

For all of these reasons, the Government's Medicare Advantage and ACA Exchange claims must fail. Aetna's acquisition of Humana should be permitted to proceed so that consumers can realize its myriad benefits.

BACKGROUND

Aetna Inc. is a Connecticut-based company that offers a wide variety of health insurance products and services to a broad range of consumers, including employer groups, individuals, health plans, providers, and the Government. Aetna Inc., *2015 Annual Report, Financial Report to Shareholders* at 2 (Apr. 2016), https://goo.gl/BGrMKL. In 2015, Aetna had an annual operating revenue of approximately $60 billion. *Id.* Its business principally concerns commercial products, such as benefit plans sold to employers providing health insurance to their employees. These commercial plans comprise over 82% of Aetna's membership base for medical insurance, with more than 19 million members. *Id.* at 10. Less than 8% of Aetna's business involves Medicare, and only about 3% (or under 1.3 million) of its medical members are enrolled in the individual Medicare Advantage plans at issue in this action. *Id.*

Humana Inc. is a Kentucky-based company that, like Aetna, offers a wide range of health-insurance products and services. Humana Inc., Form 10-K for 2015 at 5, https://goo.gl/o86UXO. In 2015, Humana reported revenues of $54 billion. *Id.* at 40. Humana's business focuses on Medicare, with nearly 55% (7.8 million) of its members enrolled in a Medicare-based plan, including over 3 million members in Medicare Advantage plans. *Id.* at 12. Only about 16% (2.2 million) of Humana's members have a commercial plan. *Id.*

The merger of Aetna and Humana will benefit consumers across the nation. Defendants' experts will show that the merger will generate more than $2 billion in cognizable, annualized run-rate efficiencies, including hundreds of millions of dollars that will flow through to consumers.

LEGAL STANDARDS

Section 7 of the Clayton Act forbids an acquisition only if its effect "may be substantially to lessen competition" in a "line of commerce." 15 U.S.C. § 18. The overriding question in a Section 7 case is "whether the challenged acquisition is likely to hurt consumers." *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 991 n.12 (D.C. Cir. 1990). As the D.C. Circuit has recognized, "the Supreme Court, echoed by the lower courts, has said repeatedly that the economic concept of competition, rather than any desire to preserve rivals as such, is the lodestar that shall guide the contemporary application of the antitrust laws." *Id.* at 990-91 n.12; *see also, e.g.*, *Cargill, Inc. v. Monfort of Colo., Inc.*, 479 U.S. 104, 110 (1986) (the Clayton Act "protect[s] competition, not competitors" (internal quotation marks omitted)).

A Section 7 analysis considers the impact of the transaction on consumers by looking to the "future competitive conditions in a given market." *Baker Hughes*, 908 F.2d at 988. It is "critical to maintain a dynamic view of the relevant market" (*FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 58 (D.D.C. 1998)), because "[e]vidence of past production does not, as a matter of logic, necessarily give a proper picture of a company's future ability to compete" (*United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 501 (1974)).

To prove a Clayton Act § 7 violation, the Government first "must show" that there is a "relevant market" for antitrust purposes. *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001). Next, the Government must prove that the acquisition would cause a "significant" and "undue" increase in concentration in the market. *Id.* If the Government can make that showing, typically through the use of statistics or HHI data (DOJ & FTC, Horizontal Merger Guidelines § 5.3 (2010)

("Guidelines")),[5] it "establishes a 'presumption' that the merger will substantially lessen competition" (*Heinz*, 246 F.3d at 715). The burden then shifts to the defendants to produce evidence that "the market-share statistics [give] an inaccurate account of the [merger's] probable effects on competition." *Id.* The defendants may use a wide range of evidence that "casts doubt on the persuasive quality of the statistics to predict future anticompetitive consequences." *Id.* at 715 n.7. After the defendants produce such evidence, "the burden of producing additional evidence of anticompetitive effects shifts to the government." *Id.* at 715.

The Government bears the burden on every element of its Section 7 challenge. *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 618, 622-23 (1974); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 114 (D.D.C. 2004); *Baker Hughes*, 908 F.2d at 985. The "ultimate burden of persuasion … remains with the government" to prove that a substantial lessening of competition is "probable." *Baker Hughes*, 908 F.2d at 983, 984 n.5. The Government must show loss of competition that is "sufficiently probable and imminent," not based on "ephemeral possibilities." *Arch Coal*, 329 F. Supp. 2d at 115.

ARGUMENT

I. The Government Cannot Prove Anticompetitive Effects In Any Market That Includes Medicare Advantage.

A. The Government Cannot Establish A Prima Facie Case Because The Relevant Product Market Must Include Original Medicare Options In Addition To Medicare Advantage Plans.

The first step in a Section 7 case is "[d]etermination of the relevant market," which "is a necessary predicate to a finding of a violation of the Clayton Act because the threatened monopoly must be one which will substantially lessen competition 'within the area of effective competition.'" *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 592-93 (1957). "[T]he 'relevant product

[5] "HHI" stands for Herfindahl-Hirschman Index, a commonly used metric for determining concentration in a market. The index number is computed by adding the squares of each firm's market share. *Heinz*, 246 F.3d at 716.

market' identifies the product and services with which the defendants' products compete." *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 24 (D.D.C. 2015). The Government erroneously contends that the relevant product market is limited to Medicare Advantage plans, and excludes Original Medicare options from the market (including OM alone; OM + Part D; OM + Part D + Med Supp; and OM + Med Supp).[6]

"The general question" in determining the scope of the product market "is '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 will generally include producers who, given product similarity, have the ability to take significant business from each other." *Id.* Courts defining a product market assess "[i]nterchangeability of use and cross-elasticity of demand"—*i.e.*, "whether there are other products offered to consumers which are similar in character or use to the product or products in question, as well as how far buyers will go to substitute one commodity for another." *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1074 (D.D.C. 1997). Analysis of these factors typically includes economic analysis "augment[ed]" by various "practical indicia" of market inclusion, like "industry or public recognition" or "the product's peculiar characteristics." *Arch Coal*, 329 F. Supp. 2d at 120; *see also Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962).

1. Congress Created Medicare Advantage As A Competitive Alternative To Original Medicare.

The Social Security Act entitles every Medicare-eligible individual "to elect to receive benefits … (A) through the original medicare fee-for-service program under parts A and B of this

[6] The parties agree that the county is the relevant geographic market, which is the second prong of the market analysis. *Sysco*, 113 F. Supp. 3d at 24.

subchapter, or (B) through enrollment in a [Medicare Advantage][7] plan under this part." 42 U.S.C. § 1395w-21(a)(1); *see also id.* § 1395w-21(a)(3)(A).[8] A Medicare-eligible consumer who fails to make a timely election "is deemed to have chosen the original medicare fee-for-service program option." *Id.* § 1395w-21(c)(3)(A)(i). This provision reflects a congressional determination—contrary to the Government's position in this case—that Original Medicare is an appropriate and adequate substitute for Medicare Advantage for *every* Medicare-eligible consumer. By itself this statutory language resolves the question of the interchangeability of OM and MA and is binding on the Court. *See, e.g.*, *Fund for Animals v. Norton*, 374 F. Supp. 2d 91, 102 (D.D.C. 2005) (noting that "if the text of the … statute is unambiguous, that statute is legally binding" as to the underlying policy determination), *aff'd*, 472 F.3d 872 (D.C. Cir. 2006).[9]

When it is not trying to prosecute a Section 7 claim, the Government recognizes that OM options and MA plans compete with and can be substituted for one another, such that Original Medicare constrains Medicare Advantage plan prices. [redacted]

[7] The bracketed language replaces the phrase "a Medicare+Choice plan," which is now known as Medicare Advantage. 42 U.S.C. § 1395w-21(a)(1).

[8] Accordingly, CMS' Medicare publications emphasize that an eligible individual's first choice is to decide whether to elect "Original Medicare or a Medicare Advantage Plan." *Your Medicare Coverage Choices*, Medicare.gov, https://goo.gl/gJKCBE; *see also* CMS, *Medicare & You 2017* at 16-17, https://goo.gl/bkzNrn.

[9] Thus, it is hardly surprising that many courts have recognized that Medicare Advantage is simply a species of Medicare. *See, e.g.*, *Exley v. Burwell*, No. 3:14-cv-1230, 2015 WL 3649632, at *1 (D. Conn. June 10, 2015); *Walkwell Int'l Labs. v. Nordian Admin. Servs., LLC*, No. 1:13-cv-0199, 2014 WL 174948, at *1 (D. Idaho Jan. 13, 2014); *Zanecki v. Health Alliance Plan of Detroit*, No. 12-13234, 2013 WL 2626717, at *4 (E.D. Mich. June 11, 2013), *aff'd*, 577 Fed. App'x 394 (2014); *United HealthCare Ins. Co. v. Sebelius*, 774 F. Supp. 2d 1014, 1019 (D. Minn. 2011).

[redacted] The trial record will be replete with similar evidence showing that the Government and the healthcare industry have long viewed OM options and MA plans within the same product market.[15]

To be sure, there may be differences among Original Medicare options and Medicare Advantage products—but such differences are not sufficient to support separate markets. "[A] product market includes all goods that are reasonable substitutes, even though the products themselves are not entirely the same." *Sysco Corp.*, 113 F. Supp. 3d at 25. And the traditional

[redacted]

[15] One of the Plaintiff States has similarly acknowledged that "Medicare Advantage, the private market product, competes directly with Traditional Medicare. Accordingly, when considering the impact of the acquisition, the private market is only a portion of the Medicare market." Florida Office of Ins. Reg., Consent Order Approving Aetna Acquisition of Humana at ¶ 20(e) (Feb. 15, 2016) ("Florida Consent Order"), https://goo.gl/jzv6CI.

doctrinal analysis of a market's boundaries—focusing on (1) functional interchangeability and (2) cross-elasticity of demand—confirms that OM and MA options compete within the same market, just as Congress intended and the Government itself has repeatedly recognized.

2. Original Medicare And Medicare Advantage Are Functional Substitutes, And CMS Treats—And Regulates—Both Kinds Of Medicare That Way.

"If consumers can substitute the use of one [product] for the other, then the products in question will be deemed 'functionally interchangeable,'" and "in the same product market" absent an affirmative showing to the contrary. *Arch Coal*, 329 F. Supp. 2d at 119. Original Medicare and Medicare Advantage options are functionally interchangeable because under each option, the Government ultimately pays for the same fundamental insurance benefits. *See* 42 C.F.R. § 422 (obligation of MAOs to provide basic Medicare benefits to members). While coverage and costs may vary both within and between OM and MA, any variations at the margins do not change the functional substitutability of the two. Indeed, courts have long held that managed and non-managed care plans should be considered part of the same market for antitrust purposes. *See, e.g., Doctor's Hosp. of Jefferson, Inc. v. SE Med. All., Inc.,* 123 F.3d 301, 308 n.15 (5th Cir. 1997) ("Competition among PPOs may not be considered in isolation from HMOs or other traditional or non-traditional vehicles for delivery of health services; all of which are substitutable."); *Ball Mem'l Hosp. v. Mutual Hosp. Ins., Inc.,* 784 F.2d 1325, 1331 (7th Cir. 1986) (rejecting PPO-only market, finding that the appropriate product market was instead that for "health care financing"); *see also Blue Cross & Blue Shield United of Wisc. v. Marshfield Clinic*, 65 F.3d 1406, 1411 (7th Cir. 1995) ("We thus do not believe

that a reasonable jury, confronting the record compiled in the district court, could find that HMOs constitute a separate market" from PPOs).[16]

The evidence will show that roughly two-thirds of Medicare beneficiaries choose an OM option instead of an MA plan, demonstrating that the Government's product-market definition excludes the option chosen by the vast majority of seniors in the Medicare program. Moreover, the evidence will show that when seniors age into Medicare at 65, and every year thereafter, they can and do reassess their coverage needs based on highly-individualized considerations that may point to one product—or combination of products—over others.[17] This is precisely the sort of decisionmaking process the Court described in *Arch Coal*: while consumer preferences may vary, the fact that Medicare beneficiaries consider both products when deciding which form of healthcare to choose means that OM and MA should be part of the same product market. *See Arch Coal*, 329 F. Supp. 2d at 121-22 (including two types of coal within same market in light of substantial evidence showing that coal consumers' preferences may vary and that consumers consider both when deciding what to purchase, "regardless of the economics").

Moreover, the evidence will demonstrate that CMS is charged with ensuring that Original Medicare options and Medicare Advantage plans are and remain close functional substitutes for one another. CMS has many levers for doing so. It comprehensively regulates MA plan types and benefits, MA plan compliance, MA plan provider networks, customer service (including member appeals and grievances), and MA plan quality—all to ensure that beneficiaries receive benefits that are at least equal to the basic Medicare benefits to which they are entitled. *E.g.*, 42 C.F.R.

[16] *See also* Florida Consent Order ¶ 20(b) ("The market dynamic that exists between Medicare Advantage and Traditional Medicare is similar in nature to the dynamic between a commercial market HMO and PPO, which clearly operate and function as direct competitors.").

[17] Because OM does not limit the network of healthcare providers, some Medicare beneficiaries may value the ability to see any healthcare provider that accepts Medicare nationwide over the limited provider networks of Medicare Advantage plans. Other Medicare beneficiaries may value the limit on beneficiary out-of-pocket costs that CMS requires for Medicare Advantage plans.

§§ 422.100(f), 422.112(a)(1).Further (as discussed in Section I.B.1, below), CMS regulates nearly every aspect of MA plan pricing—from MAO margins, to plan premiums, cost sharing, and out-of-pocket maximums, to caps on annual benefit cost changes—to ensure that Medicare beneficiaries are protected from significant cost changes during the year and over time. *E.g.*, 42 C.F.R. § 422.100(f).

3. Original Medicare And Medicare Advantage Are Competitive Substitutes For One Another.

An analysis of the cross-elasticity of demand will confirm that Original Medicare options and Medicare Advantage products are competitive substitutes. The evidence will show what *actually* happens when Medicare beneficiaries switch to or away from Medicare Advantage plans. It is a fact that some two-thirds of Medicare enrollees choose an OM option over an MA plan. Orszag Rpt. ¶ 46. It is also a fact that roughly a third of new enrollees in Aetna and Humana Medicare Advantage plans have switched to those plans *from* Original Medicare. Orszag Rpt. ¶ 103. Other evidence shows substantial diversions from MA to OM. Orszag Rpt. ¶¶ 98-99, 103. Such substantial movement between Original Medicare options and Medicare Advantage plans underscores that the market must include both kinds of Medicare.

Defendants' economic expert, Jonathan Orszag, will explain that his regression analysis shows that Medicare Advantage prices do not respond significantly to changes in Medicare Advantage concentration levels—a fact consistent with price constraints imposed by OM, the dominant supplier in the markets at issue. *See., e.g.,* Orszag Rpt. ¶ 111. This data-driven analysis confirms that consumers see OM options and MA plans as practical alternatives, and leaves no room for the Government to argue that one kind of Medicare should be segregated from the other.

Indeed, the Merger Guidelines determine the scope of a product market by applying the hypothetical monopolist test ("HMT"), which asks whether a hypothetical monopolist of all products in an alleged market could profitably impose a small but significant and non-transitory increase in price (a "SSNIP"). Guidelines § 4.1.1; *Arch Coal*, 329 F. Supp. 2d at 120. Mr. Orszag's

regressions show (with real-world data) why the HMT is not met here. Orszag Rpt. ¶ 111. And the Government's approach ignores a key part of the Guidelines: if Products A and B compete in the same market, but a price increase for Product A causes greater revenues to shift from Product A to Product C than to Product B, then Products A, B, and C are *all* in the relevant product market. Guidelines § 4.1.1, Example 6. Mr. Orszag will show that if Aetna or Humana were to raise Medicare Advantage prices enough to drive consumers to other alternatives, more of those consumers would switch to Original Medicare options than to other Medicare Advantage plans, confirming that both belong in the same product market.

The Government's expert, Dr. Aviv Nevo, purports to apply the HMT as well. But the evidence will show that Dr. Nevo's HMT analysis, which relies on a diversion ratio derived from one economic model multiplied by implied margins derived from another, fails to account for actual market facts, including the role of CMS in regulating the plans and prices that MAOs offer.

In short, the traditional legal tests and economic indicators used to define a market confirm that the relevant product market must include both OM options and MA plans. Excluding Original Medicare options from the market would be factually and legally erroneous.

4. Practical Indicia Demonstrate That Original Medicare Must Be Included In The Relevant Product Market.

In *Arch Coal*, this Court explained that an examination of certain practical factors may be "helpful to augment the assessment of interchangeability and cross-elasticity of demand when determining the relevant product market." 329 F. Supp. 2d at 120 (citing *Brown Shoe*, 370 U.S. at 325). None of the applicable factors set forth in *Brown Shoe* support a finding that MA belongs in a market of its own.[18] Specifically, the evidence will show that:

[18] The third of seven factors—"unique production facilities"—would not apply to services provided by health insurance providers.

- The "industry or public" does not recognize Medicare Advantage plans as a "separate economic entity." *Brown Shoe*, 370 U.S. at 325. Aetna and Humana's MAO competitors frame Medicare beneficiary choices in just the same way as Defendants and the Government do: between OM options and MA plans.
- The "product's peculiar characteristics and uses" (*id.*)—providing health insurance to senior citizens—does not require distinguishing between *types* of insurance, and doing so would eliminate an option elected by the vast majority of Medicare beneficiaries.
- Original Medicare products and Medicare Advantage plans do not attract "distinct customers." *Id.* It is impracticable to generalize about the kinds or types of Medicare beneficiaries who will select one product over the other, as the decisionmaking process is highly-individualized and may (along with a beneficiary's physical and financial circumstances) change over time.
- Original Medicare options and Medicare Advantage plans do not have "distinct prices." *Id.* The *total* cost (including premiums, co-pays, and deductibles) of individual MA plans to beneficiaries can be lower or higher than that of OM options (including supplemental coverage). This underscores the interchangeability of the products.
- Any Medicare beneficiaries who are "sensitiv[e] to price changes" (*id.*) can and will switch between Original Medicare options and Medicare Advantage plans in the event of a price increase.
- Original Medicare options and Medicare Advantage plans are not sold by "specialized vendors." *Id.* Part D and Med Supp plans are sold by many of the same private insurers that sell Medicare Advantage plans, and the only other "vendor" of Medicare benefits is the federal government.

While no one factor is dispositive (and courts have recognized product markets where some but not all of these factors are present (*Staples*, 970 F. Supp. at 1075)), together they compel the conclusion that Original Medicare products and Medicare Advantage plans belong in a single market for Medicare insurance.

For these reasons, the Government cannot satisfy its burden of proving the relevant product market. Defendants are entitled to judgment on the MA claim for that reason alone. *See, e.g.*, *United States v. SunGard Data Sys., Inc.*, 172 F. Supp. 2d 172, 184-93 (D.D.C. 2001); *United States v. Engelhard*, 126 F.3d 1302, 1308 (11th Cir. 1997).

5. With Original Medicare Properly Included In The Market, The Government Cannot Establish A Presumption Of Anticompetitive Effects.

The Government seeks to exclude OM from the relevant market in order to tilt its market-share calculations so that it may obtain a "presumption" of anticompetitive harm under *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963). However, even if the Court does not outright dismiss the Government's case for failure to properly define a relevant product market, once OM is included in the market, the Government's attempt to obtain an HHI-driven presumption must fail for the following reasons.

First, the Government has not attempted to establish an HHI-based presumption in a market properly defined to include Original Medicare products. HHI calculations are "meaningless" if they rest on share-based figures that "do not reflect market reality." *FTC v. PPG Indus., Inc.*, 798 F.2d 1500, 1503 (D.C. Cir. 1986). The Government's HHI calculations here, which are based on shares of a market that *excludes* Original Medicare options, do not reflect *any* reality. Thus, there is no basis to draw any inferences from the Government's HHI numbers about observable variables.[19]

Second, it would not be feasible to calculate HHI shares accounting for the wide variety of Original Medicare products available to Medicare beneficiaries. The evidence will show that senior citizens may choose from a menu of Original Medicare options and packages, including Original Medicare (Part A and B benefits) supplied by the Government alone; Original Medicare in conjunction with a privately issued MedSupp plan (for which there are different sellers); Original Medicare accompanied by a privately issued Part D prescription drug plan (for which there are also

[19] The Government's reliance on HHI calculations is also inappropriate because the ease of entry into the relevant markets (*see infra* at I.B.2) undermines any conclusion that purportedly high concentration would trigger a presumption of unlawfulness. *See* 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.").

different sellers); or combinations including all three of those components from as many as three different sources. Given these various options, which sometimes entail different suppliers, the Government would not be able to calculate—and the Court could not credit—HHI shares giving rise to a credible presumption of anticompetitive harm. *See, e.g.*, *PPG Industries*, 798 F.2d at 1505 (explaining that the district court "was, of course, unable to calculate an HHI for" a market in which determining market shares was not feasible).

Third, an HHI-based presumption would still be meaningless *even if* the Government had included Original Medicare in the relevant product market and *even if* a single share were assigned to the variety of OM options in that market. The dominant supplier in the properly defined OM/MA market is OM, which is provided by the federal government and serves two-thirds of all Medicare beneficiaries. Orszag Rpt. ¶ 46. An HHI calculation would take that dominant market share, square it, and add it to the squared market shares of its competitors, in order to determine whether market concentration is likely to lead to anticompetitive behavior like tacit collusion or price increases among the rival firms. But the HHI calculation's focus on "profit maximizing" private firms is the central concern of the Merger Guidelines, which analyze "how the merger affects conduct that would be most profitable for the firm." Guidelines § 1; *see also* Guidelines § 4.1 (hypothetical monopolist test assumes "profit-maximizing firms not subject to price regulation").

By definition, this entire "profit maximizing" premise of the HHI calculations—and of *Philadelphia National Bank*'s concentration-driven presumption of anticompetitive impact—has no application here, because the federal government is not a profit-maximizing entity. To the contrary, the federal government strives—both as payor and regulator—to *reduce* prices for OM and MA. The market share of OM thus bears no relationship to the risk of competitive harm, because CMS does not seek to maximize its own profits or to raise prices. To the contrary, CMS constrains them.

B. Competitive Conditions For The Sale Of Medicare Advantage Plans Will Prevent Competitive Harm From The Merger.

Even if the Government could show an entitlement to a presumption of harm relating to the sale of Medicare Advantage plans—which, for the many reasons set forth above, it cannot—the Government's showing would be rebutted by ample evidence demonstrating that the merger will not give rise to anticompetitive effects. "[A]lthough significant, statistics concerning market share and concentration are 'not conclusive indicators of anticompetitive effects.'" *Arch Coal,* 329 F. Supp. 2d at 130 (quoting *Gen. Dynamics*, 415 U.S. at 498). Similarly, "this Circuit has cautioned against relying too heavily on a statistical case of market concentration alone, and that instead a broad analysis of the market to determine any effects on competition is required." *Id.* A broader analysis in this case confirms that the merger will not yield any anticompetitive effects.

The federal government pays for Medicare Advantage plans, dictates the prices it is willing to pay for those plans, and otherwise constrains MAO margins, prices, and beneficiary costs. The evidence will show that competition among MAOs is robust, that there is no correlation between prices and measures of concentration, and that entry by new MAOs is easy and increasingly frequent, foreclosing the possibility of anticompetitive effects as a result of the merger.

1. The Regulatory Scheme Governing Medicare Advantage Plans Precludes The Possibility Of Anticompetitive Behavior.

The federal government is enmeshed in the Medicare market to a degree unmatched in any other industry. The government's three-fold role as market creator, ultimate payor, and industry regulator will figure prominently in the Court's analysis. These roles would prevent any imaginable harm to consumers post-merger.

Because a merger must be "viewed[] in the context of its particular industry," only a close "examination of the particular market—its structure, history and probable future—can provide the appropriate setting for judging the probable anticompetitive effect of the merger." *Brown Shoe,* 370 U.S. at 321-22 & n.38. A key consideration is the relative sophistication of the purchaser. *Baker*

Hughes, 908 F.2d at 986. Here, while consumers select among OM and MA options, the ultimate payor is the federal government—not only an undeniably sophisticated entity, but also the sovereign with the power to mandate the terms of payment. *See, e.g.*, *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 145 (E.D.N.Y. 1997) (declining to enjoin hospital merger where roughly 50% of revenues would come from Medicare/Medicaid patients for whom "the Government will set [] prices"). Further, the sale of Medicare Advantage plans is subject to substantial government regulation that "endow[s] the industry with special characteristics" relevant to the antitrust analysis. *United States v. Nat'l Ass'n of Broadcasters*, 536 F. Supp. 149, 156 (D.D.C. 1982); *see also, e.g.*, *United States v. F.C.C.*, 652 F.2d 72, 106 (D.C. Cir. 1980) (en banc) (concluding that "continuing supervision by a regulatory agency may accomplish the same end" as Section 7 of the Clayton Act, which can "make[] the antitrust problems in [a] case less immediate, and more controllable").

Here, the federal government's roles as market creator, ultimate payor, and industry regulator must inform the antitrust analysis. *First*, the federal government sets the reimbursement rates it will pay providers for Original Medicare services, from which it calculates the benchmark rates to reimburse MAOs (typically between 95 and 115% of Original Medicare rates). Orszag Rpt. ¶¶ 34, 37; 42 U.S.C. § 1395w-23(n). If an MAO's CMS-approved bid exceeds the benchmark, the MAO must charge any difference to beneficiaries in the form of premiums, making the plan correspondingly less marketable. If, by contrast, the MAO underbids the benchmark, its beneficiaries pay no premium and the MAO is required to use the difference to add additional plan benefits or reduce out-of-pocket costs to members of the plan. Orszag Rpt. ¶ 34; MedPAC, *Medicare Advantage Program Payment System* at 2 (Fig. 1) (Oct. 2015), https://goo.gl/bu3re3. The ACA has reduced those benchmarks, thereby diminishing reimbursements to MAOs and increasing pressure to maintain low prices in competition with Original Medicare. *See* 42 U.S.C. § 1395w-23(n) (explaining the phase-in of new benchmarks); MedPAC, *A Data Book: Health Care Spending and the*

Medicare Program at 136 (June 2016), https://goo.gl/Q97iUL (projecting that Medicare Advantage payments "will decline further over the next year as benchmarks are reduced relative to FFS levels to complete the transition to the requirements under the [ACA]"); Orszag Rpt. ¶¶ 35-37.

Second, CMS limits the amount by which MAOs can increase beneficiaries' total benefit costs (premium plus cost-sharing) from one year to the next. 42 U.S.C. § 1395w-24(a)(5)(C)(ii). The maximum increase for 2016 and 2017 is $32 per member per month. CMS, *Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter* at 165 (Apr. 4, 2016), https://goo.gl/lzVAMb. CMS has the discretion to reject any attempt to increase rates in excess of the cap. *Id.*; Orszag Rpt. ¶ 40.

Third, CMS restricts MAO margins and profits. Insurers must spend at least 85% of premium revenue on medical expenses—including reinvestments in quality—or remit the difference to the federal government. 42 U.S.C. § 1395w-27(e)(4); Orszag Rpt. ¶ 39. This leaves no more than 15% of revenues to cover administrative expenses and profits. And within that range, CMS imposes additional—and onerous—restrictions: an MAO's aggregate margins across plans must align with its long-term margins, its bid margins must align with its actual margins, and its MA margins must align with its *non*-MA margins. Orszag Rpt. ¶ 42 (citing Milliman Report, *Regulatory Oversight in Medicare Advantage* at 11 (June 24, 2016), https://goo.gl/Iu1UEj).

Fourth, CMS strictly regulates the substance of MAO offerings. MAOs cannot differentiate their plans based on members' individual characteristics, and instead must offer the same benefits, at the same premium, to all beneficiaries within a plan's service area. Orszag Rpt. ¶ 38; 42 U.S.C. § 1395w-24(c); CMS, *Medicare Managed Care Manual* at Ch. 1, https://goo.gl/4EDlFE.

Fifth, CMS continues to drive innovation as it requires more and more of its contractors—including both OM providers and MAOs—to invest in models of care that reward value rather than volume, and that deliver better patient outcomes. The evidence will show that CMS has already met

its goal of moving 30% of Medicare reimbursements into value-based contracts, and is working toward another goal of moving 50% of reimbursements into similar contracts by 2018. CMS, *Report to Congress: Alternative Payment Models & Medicare Advantage* at 44, https://goo.gl/iosH78. These reforms—including the advent of Accountable Care Organizations (ACOs) to coordinate the care of Original Medicare patients—will have the effect of reducing the benchmarks against which MAOs build and price their plans, making OM look more like MA in its care-coordination features, and requiring MAOs to serve Medicare beneficiaries in more effective and innovative ways in order to survive. Indeed, in just six years, the number of seniors participating in Original Medicare and receiving care coordination from an ACO has grown from zero to nine million, compared to 12 million seniors participating in individual Medicare Advantage plans today. Orszag Rpt. ¶¶ 68-69, 237. This intensifying regulatory control, combined with the federal government's extensive involvement in this market, will prevent the merger from yielding anticompetitive effects.

2. Ease Of Entry And Other Characteristics Of The Medicare Advantage Market Will Further Prevent Any Anticompetitive Effects.

The characteristics of this market and this transaction further ensure that the merger will not give rise to anticompetitive effects.

First, entry into the Medicare Advantage market is easy and common. This will lead to rapid entry by other MAOs that must be considered market participants for purposes of market definition. Guidelines § 5.1. It also bears on the competitive-effects analysis, since entry will be "timely, likely, and sufficient in its magnitude, character, and scope to deter or counteract the competitive effects of concern." Guidelines § 9.

Entry will be timely. As the evidence will show, the cost of entering into Medicare Advantage in a county is low, and the pace of entry matches the timetable on which any competitive concerns could be manifested.[20] Orszag Rpt. ¶ 132.

Entry is also likely, which is the applicable standard. *See Baker Hughes*, 908 F.2d at 987-89 (rejecting Government's proposed "quick and effective" standard for entry, and holding that it is not defendants' burden to show that entry *will* occur). Recent history, which serves as "the starting point" for assessing market participants as well as entry (Guidelines §§ 5.1, 9), shows that entry into Medicare Advantage is exceedingly common. The parties' experts agree that 14-15% of counties see at least one new entrant each year, accounting for nearly half of all counties since 2012. Orszag Supp. ¶ 85; Nevo Rpt. ¶ 253. Mr. Orszag will show that entry is geographically dispersed throughout the country and has occurred in 263 of the 364 counties challenged in the Complaint (without even considering entry data for 2017). Orszag Rpt. ¶ 129. The challenged counties have, on average, five potential entrants (*id.* ¶ 149), and many insurers have already committed to enter in 2017 (Orszag Supp. ¶ 88). Indeed, at least 78 of the challenged counties (21.4%) will see a net increase in MAOs in 2017 (*id.* ¶¶ 88, 98), and many insurers are actively planning entry into challenged counties beyond 2017 (*id.* ¶ 99).

Actual and potential entry will also be sufficient to safeguard competition. As Mr. Orszag will explain, new entrants have achieved meaningful shares and have grown roots where they sell Medicare Advantage plans. Since 2013, 88.3% of entrants have returned in Year 2, with an average 26.9% market share. In Year 3, 82.6% have remained (with a 29.3% market share), and 74.3% are

[20] Because Defendants have already had to submit their bids for 2017, the merger could not cause any harm during that period. Orszag Rpt. ¶ 131.

still selling Medicare Advantage plans (with 32.9% share) in Year 4. Orszag Supp. ¶ 93; Orszag Rpt., Table II-11.[21]

Second, the cumulative effect of the design and pervasive regulation of the Medicare market means that it functions differently than other markets in at least one key respect. In other markets, prices rise when the number of competitors falls. Not so here. Mr. Orszag will show that a reduction in the number of significant rivals has close to zero effect on beneficiary cost, and that the merger will not alter the state of play in any way that affects pricing. Orszag Rpt. ¶¶ 117-18.[22]

Third, the merger will not eliminate close competition. As Mr. Orszag will explain, there is no robust relationship between either Defendant's presence in a county and the prices consumers pay for the other Defendant's plan—a fact that refutes the Government's claim that head-to-head competition will be lost after the merger. Orszag Rpt. ¶¶ 122-24; *see also, e.g.*, *Sysco Corp.*, 113 F. Supp. 3d at 62 ("[E]ven if the merging parties had large market shares, if they were not particularly close competitors, then the market shares might overstate the extent to which the merger would harm competition.").

For all of these reasons, the merger will not have any anticompetitive effects with respect to the sale of Medicare Advantage plans. Thus, even if the Government could establish a presumption of harm, that presumption would be rebutted.

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[21] Mr. Orszag will also explain that the timeliness, likelihood, and sufficiency of new entry are borne out by the regression analysis that he conducted, which accounts for characteristics of counties to determine the equilibrium number of MAOs a county can support and then "evaluate[s] whether and how quickly the number of MAOs adjusts in response to changes in market conditions within a county." Orszag Rpt. ¶¶ 138, 140. And this analysis confirms that the market will quickly fill any competitive void the merger could create: if the number of MAOs in a county falls below equilibrium, 67-76% of the adjustment to equilibrium will occur within 2 years, and 87% within 3 years. *Id.* ¶¶ 139, 145. Thus, "if the Transaction creates a deficit in the number of MAOs relative to the equilibrium, then entry by other MAOs would be likely, timely, and sufficient." *Id.* ¶ 145.

[22] Further, any divestitures that the Court might order would mean that the number of competitors in any counties requiring divestitures would not decrease at all. *Infra* at I.C.

C. The Proposed Divestitures Would Remedy Any Competitive Concerns.

Though Aetna and Humana do not believe that the Government has defined a valid product market or demonstrated that the merger will have anticompetitive effects, Defendants are committed to their merger and have entered into binding agreements with Molina that would permit the divestiture of Medicare Advantage assets in any or all of the counties at issue, should the Court find that any such remedial action is warranted. Defendants need not show that any divestitures will perfectly replicate competition in existence prior to the merger; rather, the pertinent question is whether the transaction as a whole, including the divestitures, would violate Section 7. Any divestitures to Molina would ensure that the merger will give rise to no anticompetitive effects.

1. The Government Bears The Burden Of Showing That The Merger—Including Any Divestitures—Will Unlawfully Restrict Competition.

Contrary to the Government's contention (Status Hearing Tr. 37:1-6 (Oct. 20, 2016)), it bears the burden of establishing that the merger *as a whole*—including any divestitures the Court might order—will unlawfully restrict competition. This Court so held in *Arch Coal,* explaining that "the transaction that is the subject of the FTC's challenge is properly viewed as the set of two transactions involving the acquisition of Triton by Arch and the immediate divestiture of the Buckskin mine to Kiewit." Mem. Op. at 5, *FTC v. Arch Coal, Inc.*, No. 1:04-cv-534 (D.D.C. July 7, 2004) (Bates, J.), ECF No. 67; *see also United States v. Atl. Richfield Co.*, 297 F. Supp. 1061, 1067-69 (S.D.N.Y. 1969) (considering the merging parties' proposed sale of certain assets in assessing the Government's prima facie case). Indeed, it would be irrational to "turn[] a blind eye to the elephant in the room" during the Government's case-in-chief. Mem. Op. at 7-8, *Arch Coal.*[23]

[23] Although a few decisions in this District have considered proposed divestitures as part of the merging parties' rebuttal case (*Sysco Corp.*, 113 F. Supp. 3d at 72-73; *FTC v. CCC Holdings Inc.*, 605 F. Supp. 2d 26, 56-59 (D.D.C. 2009)), neither the parties nor the Court specifically addressed this issue in either case—unlike *Arch Coal*, which speaks directly to the question.

2. The Divestiture Agreements Provide The Support Necessary To Stand Up A Robust New Competitor For Medicare Advantage Plans.

The divestiture agreements—an Asset Purchase Agreement ("APA") and an Administrative Service Agreement ("ASA") between each Defendant and Molina—ensure that no competition will be lost through the merger.[24] Under the APAs, Defendants will transfer to Molina individual Medicare Advantage contracts [redacted] Orszag Rpt. ¶ 11; [redacted]. The agreements provide that Molina will acquire approximately 290,000 Medicare Advantage members. Aetna Inc., *Aetna and Humana Agree to Sell Certain Medicare Advantage Assets to Molina Healthcare, Inc.* (Aug. 2, 2016), https://goo.gl/6kgUXl.

[redacted]

[24] The agreements that each Defendant executed with Molina are substantially similar, and so all citations refer to the same provisions of each Defendant's agreements. [redacted]

[redacted]

3. Molina Is Poised And Ready To Address The Government's Concerns And Minimize Member Disruptions In The Transition.

The evidence will show that Molina has a proven track record, with 36 years' experience administering government-sponsored insurance. It ranks 201st on the Fortune 500 list, with $14.2 billion in revenue in 2015. Molina Healthcare, Fortune 500, https://goo.gl/RR4WAm. Molina's more than 20,000 employees serve roughly 4.2 million members in government-sponsored insurance programs. Molina Healthcare, Form 10-Q for Quarterly Period Ended Sept. 30, 2016, at 6, https://goo.gl/wWc1Js. These members primarily consist of Medicaid beneficiaries, but also include roughly 51,000 members in Medicare Advantage Special Needs Plans ("SNPs," which are designed for people who are institutionalized, dual-eligible for Medicare *and* Medicaid, or afflicted by certain severe or chronic conditions), and another roughly 42,000 people in Medicare Advantage-Medicaid Plans ("MMPs," which are for dual-eligible people in certain counties). Orszag Rpt. ¶ 12. SNP and MMP plans are more complicated to administer than Medicare Advantage plans, and Molina has a proven record of success in serving members in these plans.

Molina is also well qualified to take on the divested contracts because the company has substantial experience with acquisitions and expansions similar to—but much larger than—the divestitures. [redacted]

[redacted]

[redacted] As these examples show, and as Molina executives will testify at trial, Molina has the know-how to effectively manage this acquisition and integrate new members and services.

Reflecting their commitment to a seamless divestiture process, Defendants and Molina have already undertaken substantial preparations for transferring the divestiture assets with joint working groups that have been meeting regularly to ensure that all applicable deadlines are met. DX0248-003. The evidence will also show that Molina is well underway in analyzing its provider needs and developing its networks [redacted] In short, Molina will be ready and able to serve the divested members, and the divestitures will ensure that the merger will not result in any change in concentration in the relevant markets.

4. The Government's "Concerns" About The Divestitures Elevate Form Over Substance.

The Government's criticisms of the divestitures—aired in the Complaint before the divestitures were even finalized—miss the mark.

First, the Government wrongly contends that Molina will have trouble building strong provider networks. Compl. ¶ 58; Burns Rpt. ¶¶ 69-70. [redacted]

[redacted]

Moreover, witnesses with years of provider-contracting experience will explain how insurers build provider networks, and why Molina does not face insurmountable obstacles in establishing CMS-compliant and effective provider networks. They will explain that those providers who are caring for beneficiaries who receive services pursuant to a divested contract will want to continue caring for those members rather than lose a portion of their business just because the logo on an insurance card has changed.[25] These witnesses will also explain that Molina can build its network in less than a year, as evidenced by its successful experience quickly building larger networks for other Medicare Advantage, public-exchange, and Medicaid products. Finally, these witnesses and Defendants' economist, Mr. Orszag, will explain that, because the range of provider reimbursement rates paid by insurers is extremely narrow (typically between 98 and 102 percent of Medicare rates),[26] there is nothing to the Government's claims that differences in scope and scale will prevent Molina from negotiating competitive rates. Orszag Rpt. ¶¶ 169-70, Orszag Supp. ¶ 104 & n.216. Moreover,

[25] [redacted]

[26] Rates cluster around 100% of Medicare rates because, by law, providers outside the network are paid based on 100% of the Medicare rate.

the Court will hear that some providers prize high member volume while others do not, and some actually prefer to contract with *smaller* MAOs.

Second, the evidence will show that there is no basis for the Government's claim that Molina will struggle to maintain strong quality ratings (known as "star ratings") for the divested plans. *See* Burns Rpt. ¶ 106. Stars are awarded at the contract level and have principally depended on membership, network, plan design, and benefits.[27] Orszag Rpt. ¶¶ 187-88. All of those elements will remain the same.

Nor will Molina face particular challenges in maintaining the existing star ratings. [redacted] the Molina plans will be able to keep the same key attributes (including plan design and benefits) that supported their existing ratings. Molina is positioned to offer the same high-quality service as Defendants, and already has years of successful experience with star ratings for its SNP and MMP plans.[28]

Third, Mr. Orszag will explain that the Government's concern that Molina lacks sufficient brand recognition is misplaced. Compl. ¶ 58; Burns Rpt. ¶¶ 139-45. Molina's brand is already well known in the areas it serves, and the evidence will show that it plans to spend as much as it needs to attain even greater brand recognition. The Molina witnesses will explain how Molina has built recognition in the past and how it will use that experience to build its brand in the divested counties.

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[27] CMS issues star ratings each year based on data from two years prior.

[28] In any event, Orszag will explain that star ratings are not a statistically significant predictor of consumer demand, and any relationship between these ratings and demand likely reflects the desirability of factors underlying the rating rather than the rating itself. Orszag Rpt. ¶ 188; *see also, e.g.*, G. Jacobson *et al.*, *Medicare Advantage 2016 Spotlight: Enrolling Market Update* at 13, Henry J. Kaiser Family Foundation (May 2016), https://goo.gl/wO8b8F ("[W]hile a larger share of beneficiaries is in a Medicare Advantage plan with relatively high star ratings, seniors have said in focus groups that they do not use the star ratings to select their plan."). Those underlying factors, moreover, will not change as a result of the divestitures. So even if star ratings do impact consumer choice, there is no reason to think that the ratings here will suffer.

Mr. Orszag will also explain that branding—like star ratings—is not a predictor of an MAO's success. Orszag Rpt. ¶¶ 179-80; Orszag Supp. ¶ 110. MAO entry is exceedingly common and competition is inherently local (not national), undercutting any notion that only established national brands can succeed. And Mr. Orszag's analyses confirm that brand strength is not correlated with higher enrollment share or growth after entry. Orszag Rpt. ¶¶ 178-85. Rather, consumers in any given county care about the underlying quality of the plan being offered in that county, and Molina is well positioned to continue offering members the high level of quality they currently receive from Aetna or Humana.

* * * * *

In sum, there will not be *any* change in market concentration in *any* of the relevant markets following any divestitures that the Court might order. For this reason, in addition to the Government's failure to define a valid product market or to demonstrate that the merger will have anticompetitive effects (both of which serve as independent reasons for rejecting its claim), the Government's Medicare Advantage claim must fail.

II. The Merger Will Not Have Any Adverse Effect On Competition In The Public Exchanges.

The evidence will demonstrate a fundamental, dispositive error in the Government's ACA exchange claim: the consummation of the merger will not have any competitive impact because Aetna no longer competes with Humana in the 17 exchange counties identified in the Complaint.

A. There Is No Competitive Overlap Between Aetna And Humana In The Challenged Exchange Counties.

On August 15, 2016, Aetna announced that it would withdraw from exchanges in more than 500 counties after incurring significant losses and facing ongoing financial exposure in its individual

commercial business.[29] Consequently, Aetna will not be competing with Humana (or any other insurer, for that matter) to serve new or existing members in these counties for 2017.[30] Lacking any "competitive overlap," these counties cannot comprise "relevant geographic market[s]" for antitrust purposes. *United States v. Phillipsburg Nat. Bank & Trust Co.*, 399 U.S. 350, 362 (1970).

Instead of acknowledging that there is no longer a competition issue relating to the exchange counties in its Complaint, the Government now appears to be arguing that Aetna's decision to withdraw from the exchanges was litigation-driven, and that Aetna might re-enter the exchanges once the cloud of litigation has passed.[31] Though other courts have overwhelmingly rejected such speculative claims (which would require the Government to prove that Aetna would likely re-enter a market but for the merger) the Government appears intent on punishing Aetna for refusing to continue to participate in a deeply flawed program—a conclusion bolstered by the fact that the Government has elected not to pursue its exchange claim against Anthem and Cigna, notwithstanding that those companies compete against one another in 22 counties where the Government alleged that their merger would substantially lessen competition.[32]

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[29] Aetna Inc., *Aetna to Narrow Individual Public Exchange Participation* (Aug. 15, 2016), https://goo.gl/koCEDG. Aetna's commercial individual business includes products sold "on-exchange" and "off-exchange" to individuals. Company witnesses will explain that on- *and* off-exchange products are included in risk-adjustment mechanisms that were intended to incentivize insurers to participate in the exchanges, and that Aetna took steps to reduce its exposure to both kinds of products as a result.

[30] The annual enrollment period for 2017 is underway now and will close on December 15. HealthCare.gov, *Dates & Deadlines for 2017 Health Insurance*, https://goo.gl/GsQVPp.

[31] The Government will no doubt point to a July 5, 2016, letter that Aetna CEO Mark Bertolini sent the Department of Justice in response to a June 30, 2016, Civil Investigative Demand (the "CID"). The CID asked the company to explain how, if the merger were not completed, costs and fees associated with it would affect Aetna's business strategy and operations, including its participation on the ACA exchanges. The Court will hear from Mr. Bertolini that the concerns expressed in his letter were subsequently overtaken by events having nothing to do with litigation.

[32] Stipulation, *United States v. Anthem, Inc.*, No. 1:16-cv-1493 (D.D.C. Sept. 26, 2016), Dkt. No. 163. The Government evidently agreed not to pursue its public exchange claim against Anthem and Cigna in order to "narrow the issues for trial." *Id.* at 1.

1. Aetna Withdrew From The Exchanges In Light Of Substantial Losses And Unrelenting Risk, Not Because Of The Threat Of Litigation.

The public exchanges have been a study in volatility since their inception. Enrollment is far smaller than expected, members are older and sicker than anticipated, consumers buy coverage when they need medical care but drop that coverage (and stop paying premiums) after receiving the care they need, regulatory risk-adjustment mechanisms have not been funded or functioned as expected, and effective pricing is difficult because insurers must make pricing decisions long before relevant data are available to inform those decisions. Orszag Rpt. ¶¶ 198-203, 212 n.426. The Court will hear from the businesspeople who wrestled with these issues every day, and who watched while other insurers withdrew from the exchanges long before Aetna decided to exit more than 500 counties across fifteen States.

For 2017 alone, at least 32 insurers will reduce or eliminate their public-exchange footprint, with most citing financial reasons for their departures. *Id.* ¶¶ 206-08 and Table III-2. In April 2016, for instance, UnitedHealth Group announced that it will reduce its 2017 public exchange footprint by over 75% due to losses of $475 million in 2015 and anticipated losses of $650 million in 2016. *Id.* ¶ 207 & n.414. Humana reduced its 2017 footprint from 309 counties down to 156 counties, and substantially increased its rates on those exchanges where it remains. *Id.* ¶¶ 209, 218.

Although Aetna executives, along with numerous industry observers, had longstanding concerns about the viability of the exchanges, and although Aetna had sustained significant exchange-related losses, the company had been optimistic that the situation would stabilize this year. But the evidence will show that by early July, Aetna's individual commercial team realized that the exchanges were failing to improve, that the company's risks were increasing as other insurers left the exchanges, and that Aetna's 2016 losses would be far higher than originally projected. In mid-July—*before* the DOJ filed suit on July 21—the team began to evaluate a number of options and

determined that the company needed to book a $65 million premium-deficiency reserve against its projected losses and reduce its exposure to exchange-related risk.

Aetna's decision to reduce its presence on the public exchanges was neither a response to this litigation nor some other form of litigation-related gamesmanship. To be sure, Mr. Bertolini's July 5 letter said that if DOJ sued to enjoin the merger, Aetna would be forced to re-evaluate its 2017 exchange footprint.[33] But any link between litigation and Aetna's participation on the exchanges was quickly broken by the realization that the exchanges were much sicker—and the business was much worse—than previously thought.

2. Whatever Its Motivation, Aetna Is No Longer Competing With Humana On The Challenged Public Exchanges.

In any event, Aetna's motivation for withdrawing from the exchanges is legally irrelevant to the question whether the merger will have an anticompetitive effect on those exchanges. Because Aetna no longer operates in the challenged counties, the merger will have no effect on market concentration or competition. There is no "competitive overlap," so these counties are not "relevant geographic market[s]" on which the Government can rest a Section 7 claim. *Phillipsburg*, 399 U.S. at 362.

The Supreme Court long ago recognized the "[o]bvious[]" reality that "an acquisition will not produce the forbidden result [of substantially lessened competition] if there [is] no pre-existing substantial competition to be affected." *Int'l Shoe Co. v. FTC*, 280 U.S. 291, 298 (1930). Moreover, this Court has recognized that "[m]arket concentration is a function of the number of firms in a market and their respective market shares." *Arch Coal*, 329 F. Supp. 2d at 123. That rule and many other antitrust principles presuppose that both the seller and buyer operate in the market at issue,

[33] While the DOJ evidently viewed this as a "threat," it is hardly surprising that the company would have responded to the CID by suggesting that a lawsuit could affect the business relationship between CMS and the company and dampen Aetna's enthusiasm for continuing to participate on the public exchanges.

whatever their motive for doing (or not doing) so. In *FTC v. Libbey, Inc.*, 211 F. Supp. 2d 34 (D.D.C. 2002), the parties admitted that they had modified their merger agreement in response to the FTC's complaint. The Court rejected the FTC's argument that, because the modification was "not for business reasons, but as the predicate for a defense to the … challenge," it should be rejected as an effort to "evade FTC and judicial review," recognizing instead that the parties' intention for modifying the deal was irrelevant. *Id.* at 43 & n.21 45-46 ("The FTC's argument that defendants have in some manner sought to evade FTC and judicial review by proposing the amended agreement is without merit.").[34]

The Government's effort to create a sideshow about Aetna's intent does not change the fact that Aetna's exit from the challenged counties forecloses the possibility of any anticompetitive effects in those counties.

B. The Theory That The Merger Is Anticompetitive Because Aetna *Might* Return To The Exchanges In The Merger's Absence Is Legally Invalid And Factually Implausible.

Oddly, the Government seems to be suggesting that if it can show that Aetna's withdrawal was a reaction to litigation, the Court can then analyze previous competition in the exchange markets as if it still existed today. But Aetna's withdrawal was neither a threat nor a mere possibility.

[34] The Government has elsewhere cited cases suggesting that the Court should assign limited weight to certain "post-acquisition" evidence because it can be "manipulate[ed]." *See, e.g.*, *Chicago Bridge & Iron Co. N.V. v. Fed. Trade Comm'n*, 534 F.3d 410, 435 (5th Cir. 2008). But those cases are wholly irrelevant because they address the opposite situation from what occurred here, where Aetna's exchange withdrawal was not "post-acquisition." In those cases, parties to *already-consummated* mergers attempted to use evidence of their post-acquisition lack of anticompetitive conduct as a rebuttal to the Government's prima facie case. Courts often give such evidence little weight because the already-merged entity may simply refrain from acting anticompetitively for the duration of the litigation, but then change their policies and reduce competition later. *E.g., id.* In other words, those cases are predicated on the fact that the party *remains* in the market and therefore could act to hinder competition in the near term. But Aetna's withdrawal *removed* Aetna from the challenged markets, so it can do nothing anticompetitive in these markets now or in the future. That is, Aetna's withdrawal is not evidence for a rebuttal case: it is a changed condition that eradicates the predicate of competitive overlap essential to the Government's case in the first place.

It has already happened, and it is a fact with which the Government must contend. The exchanges' annual enrollment period is well underway, and individuals are currently selecting from a variety of coverage options for 2017. In over 500 counties (including the 17 in the Complaint), those options do not include Aetna plans. As a result, the only legal theory the Government could conceivably pursue relates to the prospect of Aetna's future entry, and a claim based on the discredited "actual potential competition" theory. Under that theory, a merger can violate Section 7, even where there the parties do not currently operate in the same market, *if* (but for the merger) one of the parties would have entered the market. This is a legally invalid theory, and the Government could not satisfy its burden of proof even if the Court were to credit it. The Government has no evidence that Aetna likely would enter *de novo* any of the counties from which it has withdrawn, whether in 2018 or any year thereafter.

1. The "Actual Potential Competition" Theory Is Legally Invalid.

As an initial matter, the "actual potential competition" theory fails both as a textual matter and under the case law. Textually, Section 7 is unambiguous, as it prohibits only transactions that "substantially … lessen competition." 15 U.S.C. § 18. Indeed, the statute refers four times to "lessen[ing]" "competition" but it does not reference foregone "potential" competition or anything like it. *Id.* The statutory text is fundamentally incompatible with an "actual potential competition" theory.

Affirming the plain statutory language, the Supreme Court has long held that only a reduction in "pre-existing substantial competition" can render a merger unlawful. *Int'l Shoe Co.*, 280 U.S. at 298. By itself this precedent forecloses an "actual potential competition" theory, which is predicated on speculative, unsubstantiated competitive effects stemming from hypothetical future competition. Indeed, when the Supreme Court was presented with the opportunity to revisit its precedent and endorse the "actual potential competition" theory, the Court declined to do so, twice

reserving the question whether it should expand its precedents to embrace such a cause of action. *United States v. Marine Bancorporation*, 418 U.S. 602, 625-26 (1974); *United States v. Falstaff Brewing Corp.*, 410 U.S. 526, 537 (1973). The Supreme Court's refusal to embrace the "actual potential competition" cause of action makes perfect sense: as the Court noted, the theory would prohibit mergers that "leave competition in the marketplace exactly as it was, neither hurt nor helped." *Falstaff Brewing*, 410 U.S. at 537. The antitrust laws do not mandate the creation of new competition.

Given the statute's unambiguous text and applicable Supreme Court precedent, it is unsurprising that those courts of appeals to consider the "actual potential competition" theory have overwhelmingly refused to adopt it. *See Tenneco, Inc. v. FTC*, 689 F.2d 346, 347-50 (2d Cir. 1982) (noting that the Second Circuit has not adopted this theory and analyzing it only to explain that it would not apply anyway); *United States v. Siemens Corp.*, 621 F.2d 499, 506 (2d Cir. 1980) (same); *F.T.C. v. Atl. Richfield Co.*, 549 F.2d 289, 294-95 (4th Cir. 1977) (same); *Fraser v. Major League Soccer, L.L.C.*, 284 F.3d 47, 70 (1st Cir. 2002) (same).[35] Indeed, even the Federal Trade Commission, which shares responsibility with DOJ for enforcing antitrust laws, has remarked that the theory is "rather peculiar" because it "postulates that a merger or acquisition may prevent the relevant market from *becoming* as competitive as it might otherwise become." *In re B.A.T. Indus., Ltd.*, No. 9135, 1984 WL 565384, at *3 (FTC Dec. 17, 1984).[36]

[35] Commentators, too, have rejected the theory. *See, e.g.*, Lewis A. Kaplan, *Potential Competition and Section 7 of the Clayton Act*, 25 Antitrust Bull. 297, 314-17 (1980) ("[T]he actual potential entrant doctrine should be rejected as inconsistent with the language and the congressional purpose of [S]ection 7"); Richard A. Posner, *Antitrust Policy and the Supreme Court: An Analysis of the Restricted Distribution, Horizontal Merger and Potential Competition Decisions*, 75 Colum. L. Rev. 282, 323 (1975) (criticizing the theory on various grounds).

[36] Only the Eighth Circuit has accepted the theory in a single case 35 years ago. *Yamaha Motor Co. v. FTC*, 657 F.2d 971, 977 (8th Cir. 1981). Even then, the Eighth Circuit performed no textual analysis and discussed no contrary authorities. One 35-year-old outlier is hardly sufficient to resurrect a discredited theory that is inconsistent with the statutory text.

2. The Evidence Here Would Not Support An "Actual Potential Competition" Claim In Any Event.

Assuming *arguendo* that "actual potential competition" were a valid theory, the Government's burden of proof would be heavy. The Supreme Court explained its reticence to adopt an "actual potential competition" theory by noting, among other reasons, that "[u]nequivocal proof that an acquiring firm actually would have entered de novo but for a merger is rarely available." *Marine Bancorporation*, 418 U.S. at 624. In the years since, courts discussing the theory (even while refusing to adopt it) have stated that a stringent burden of proof would have to apply. For instance, the Fourth Circuit has cited *Marine Bancorporation* and opined that the Supreme Court "impl[ied] that the standard is one of 'unequivocal proof.'" *Atl. Richfield Co.*, 549 F.2d at 294. Likewise, in *Tenneco*, the Second Circuit rejected an "actual potential competition" theory even though there was "abundant evidence that [the party] had both the interest and the incentive to enter the market," because the record was "deficient in evidence … that [the party] *would have* entered the market de novo." 689 F.2d at 353 (emphasis added). Accordingly, the Government must offer unequivocal proof, or at the very least "clear proof that entry would occur." *Siemens*, 621 F.2d at 506-07.

The Government has no such proof, and even its expert does not offer an opinion that Aetna would enter the challenged exchange counties in 2018 or any year thereafter. Indeed, the evidence will prove the contrary. The Court will hear that, without significant legislative and regulatory changes, Aetna will not enter any of the exchange counties it exited. The Court will also hear that any planning for 2018 would have to begin immediately to satisfy relevant CMS deadlines—a practical reality that would preclude Aetna's return to the exchanges in the short term.

Aetna has already lost hundreds of millions of dollars on its individual commercial market products. Without regulatory and legislative fixes, there is no reason to believe that competitive conditions on the public exchanges will improve. And even if HHS and Congress were to address the fundamental flaws underlying the exchanges (rather than repeal the ACA altogether), any

changes would be sure to alter the market in such unpredictable ways that the Government's current theory would no longer fit the facts.

C. Even Assuming That The Government Established A Presumption Of Anticompetitive Effects, The Unique Volatility Of These New Markets Rebuts Any Such Presumption.

Because Aetna is not present on the challenged public exchanges, any analysis of concentration or competitive effects is fruitless. But even ignoring reality and *pretending* that Aetna is still on the exchanges—as the Government's expert does (Nevo Rpt. ¶ 268)—Defendants can rebut any presumption of competitive harm. "[E]vidence on a variety of factors" is relevant to rebuttal (*Baker Hughes*, 908 F.2d at 985), and the evidence will show that two factors in particular rebut the presumption here. *First*, the public exchanges are new, volatile markets, where past concentration statistics provide little evidence of future likely concentration. *Second*, entry and withdrawal in these markets is common and ubiquitous.

Where a market is "new [and] volatile," the "bare market concentration ratios or percentages may not … 'accurately depict the economic characteristics' of the market.'" *Siemens*, 621 F.2d at 506 (citation omitted); *see also Gen. Dynamics*, 415 U.S. at 501 ("Evidence of past production does not … necessarily give a proper picture of a company's future ability to compete."). In *Baker Hughes*, for instance, the D.C. Circuit approved the district court's finding that, because the relevant market was small, market share statistics were "volatile and shifting and easily skewed." 908 F.2d at 986 (citation omitted). Because of the size of the market, the sale of even a few products could "catapult a firm from last to first place." *Id.* (citation omitted). And in *Siemens*, the Second Circuit recognized the volatility of a new market in which companies experienced large swings in market share over a five-year period. *Siemens*, 621 F.2d at 506; *see also McCaw Pers. Commc'ns, Inc. v. Pac. Telesis Grp.*, 645 F. Supp. 1166, 1173 (N.D. Cal. 1986) (where government increased number of available frequencies for paging services, "present market concentration statistics reflect the prior scarcity" and "do not

provide an accurate prediction of … future market power"). The Government's own Guidelines similarly recognize the relevance of "ongoing changes in market conditions," such that "current market share[s]" can be of little value. Guidelines § 5.2.[37]

Likewise, the ease of entry and exit is a "crucial consideration[] in a rebuttal analysis," because where entry and exit are easy, "a company probably cannot maintain supra-competitive pricing for any length of time." *Baker Hughes*, 908 F.2d at 987. Courts have not hesitated to uphold mergers against governmental challenges where entry is "easy" and "any anti-competitive impact of the merger … would be eliminated more quickly by such competition than by litigation." *United States v. Waste Mgmt., Inc.*, 743 F.2d 976, 983 (2d Cir. 1984); *see also Arch Coal*, 329 F. Supp. 2d at 148 (recognizing that competitors' ability to "expand production" would mitigate any attempts to restrain production by merged entity).

The evidence will show that these factors preclude a finding of anticompetitive effects here.

III. The Merger Will Produce Substantial Procompetitive Efficiencies.

The merger will create large efficiencies. *See Heinz*, 246 F.3d at 720 (courts must consider "potential to generate efficiencies"). As this Court has previously recognized, efficiencies are "relevant to … whether the proposed transaction will substantially lessen competition," and in some cases can "support an outright defense." *Arch Coal*, 329 F. Supp. 2d at 151; *see also FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054-55 (8th Cir. 1999) (reversing district court where it failed to "consider[] evidence of enhanced efficiency in the context of the competitive effects of the merger"). Even the Government acknowledges the importance of efficiencies, which can "enhance

[redacted]

the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products." Guidelines § 10.

Accordingly, where efficiencies are "merger-specific and verifiable by reasonable means" (*Arch Coal*, 329 F. Supp. 2d at 150), they can rebut a presumption of anticompetitive effects. And, particularly relevant here, "efficiency claims substantiated by analogous past experience are those most likely to be credited." Guidelines § 10. Indeed, "[t]he best way to substantiate an efficiency claim is to demonstrate that similar efficiencies were achieved in the recent past from similar actions." DOJ & FTC, Commentary on Horizontal Merger Guidelines at 53 (2006) ("HMG Commentary").

As Defendants' experts will demonstrate, the merger will produce over $2 billion in cognizable, annualized run-rate efficiencies, which are highly likely to pass through to consumers in the form of lower premiums and better service.[38] And those efficiency gains are verifiable in the most direct way possible: they track the gains achieved in Aetna's own recent merger with Coventry Health Care, Inc. That is, they are "similar" to "efficiencies … achieved in the recent past from similar actions." HMG Commentary at 53.

The evidence will show that Aetna performed a thorough review of potential efficiencies, devoting an "entire team of financial executives" to full-time roles and creating 28 work teams with distinct areas of expertise. Gokhale Rpt. ¶¶ 5, 25-28. Aetna used a sophisticated process to identify only those efficiencies that were merger specific. *Id.* ¶¶ 31-32. Moreover, where the efficiencies analysis required the investigation of confidential information, Aetna and Humana retained numerous third-party consultants (such as Boston Consulting Group, PricewaterhouseCoopers, Pharma Strategy Group, and Information Services Group) to conduct "clean room" analyses. *Id.* ¶¶ 35-36.

[38] Efficiencies are "cognizable" if they are merger-specific, verifiable, and not the result of anticompetitive reductions in output or service. Guidelines § 10.

Accounting for the costs of the transaction, as well as the reduced efficiencies due to the Molina divestiture and Aetna's greatly reduced public-exchange presence, Defendants currently estimate $2.8 billion in efficiencies. Of that number, Defendants' expert Rajiv Gohkale confirms that at least $2 billion are of the type recognized as merger-specific and verifiable. *Id.* ¶ 49; Gohkale Supp. ¶ 9. Moreover, Mr. Gokhale identifies additional efficiencies that would accrue directly to the consumer, ranging as high as $330 million in directly accrued consumer benefits. Gokhale Supp. ¶ 9.

Mr. Gokhale will explain that these efficiencies derive from numerous sources, including: (1) the elimination of duplicative personnel; (2) savings associated with moving Aetna's relatively cost-inefficient Medicare business onto Humana's relatively cost-efficient Medicare business; (3) IT reductions, such as moving to a single email server system; (4) procurement savings, based on the merged entity's ability to move its procurement costs onto more favorable existing contracts; (5) pharmacy cost reductions through consolidating contracts and moving Aetna's outsourced pharmacy to Humana's in-house pharmacy; and (6) clinical cost savings, including the benefits of moving Humana's claims-review process to Aetna's proprietary technology.

Mr. Gokhale will further explain that these efficiencies are merger-specific and verifiable. For instance, savings from reducing the number of executive officers are merger-specific because the combined company will need only one CEO or COO and neither Defendant could eliminate "half" of a CEO or COO on its own. And such savings are verifiable because the savings are based on ordinary-course compensation data. Gokhale Rpt. ¶ 58, Ex. 2.

Underlying all of this analysis is Aetna's experience acquiring Coventry, a medical insurance company with large commercial and Medicare/Medicaid portfolios, in 2012. *Id.* ¶¶ 14-15. Mr. Gokhale will show that the Coventry transaction was similar to the current transaction in every relevant aspect. Gokhale Supp. § II. At the time of the Coventry transaction, Aetna internally estimated $615.4 million in savings by 2017. Gokhale Rpt. ¶ 17. Instead, Aetna achieved *$1.13*

billion in efficiencies from the transaction, outpacing its own internal target by almost double. *Id.* ¶ 18. In the Coventry transaction, Aetna used the same process to identify efficiencies that it has used to identify efficiencies in the Humana transaction. *Id.* ¶ 32; Gokhale Supp. ¶¶ 14-15. Aetna's directly "analogous past experience" (Guidelines § 10) will provide powerful evidence that Aetna's current estimates, as assessed by Mr. Gokhale, are merger-specific and verifiable.

Finally, as Mr. Orszag explains in his expert report, the merged entity "will have an incentive to pass these efficiencies through to consumers." Orszag Rpt. ¶ 226. This conclusion "follows from both economic theory and empirical evidence." *Id.* ¶ 227. Theoretically, profit-maximizing firms balance the lower revenue per customer from a price decrease against the greater number of customers that a lower price would attract. *Id.* By reducing costs, the merger makes consumer price decreases more attractive. *Id.* The empirical literature on this point confirms that pass-through rates are positive, ranging from 40 to 100 percent. *Id.* ¶ 228 & n.458. Orszag's own analysis confirms these points. *Id.* ¶ 228.

The magnitude of the cognizable efficiencies will be sufficient to rebut the Government's argument even if the Government were able to demonstrate anticompetitive effects in every single challenged county. But the efficiencies overwhelm the Government's argument even more when, at best, the Government is hanging its hat on a small minority of counties where the parties compete for Medicare customers and a tiny handful of counties in which they *previously* competed for public-exchange customers.

CONCLUSION

For all of the foregoing reasons, and based on the evidence to be adduced at trial, Defendants respectfully submit that this Court should deny the Government's claims that the acquisition violates § 7 of the Clayton Act.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on November 23, 2016, a true and correct copy of the foregoing public version of Defendants' Pre-Trial Brief was served on counsel of record via the Court's CM/ECF system.

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