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 VERSION]**

PLAINTIFFS' PRETRIAL BRIEF

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I. INTRODUCTION

Aetna's proposed merger with Humana would harm two groups of consumers especially vulnerable to enhanced market power and reduced choice: (1) senior citizens seeking to lower their healthcare costs and increase their coverage through Medicare Advantage (MA) plans offered by private insurers; and (2) under-65 individuals seeking affordable coverage on the Patient Protection and Affordable Care Act (ACA) public exchanges. The merger violates Section 7 of the Clayton Act because it would eliminate competition between the largest individual MA insurer, Humana, and the rapidly growing fourth largest, Aetna, and greatly increase market concentration in hundreds of counties across the country. The merger also violates Section 7 because it would eliminate competition between Aetna and Humana for the sale of individual health insurance on the public exchanges and result in highly concentrated markets in several counties, affecting hundreds of thousands of consumers.

Aetna agreed to acquire Humana for $37 billion on July 2, 2015. Defendants realized at the outset that their combination would raise significant antitrust concerns.[1] To convince Humana to proceed in the face of those risks, Aetna agreed to pay Humana a $1 billion breakup fee if the merger is not consummated.[2] [redacted]

[1] *See, e.g.*, PX0003 [redacted]

[2] Aetna Answer ¶ 18.

[3] PX0001 (internal quotation marks omitted); PX0002 [redacted]

[redacted]

But Aetna cannot disguise the harm its merger with Humana would cause. The United States, eight states, and the District of Columbia sued to block the merger in the areas where its anticompetitive effects would be felt most acutely: (1) the markets for the sale of individual MA plans to seniors in 364 counties in 21 states; and (2) the markets for the sale of individual health insurance on the public exchanges in 17 counties in Florida, Georgia, and Missouri.

Medicare Advantage is a separate product from Original Medicare and the plans seniors purchase to supplement Original Medicare. Compared to other options, MA plans offer broad coverage at a lower overall cost, in return for seniors giving up some flexibility in their choice of healthcare providers. These and other differences matter to seniors who enroll in MA plans. MA enrollees are much more likely to switch to a different MA plan in response to a price increase or benefit reduction than to Original Medicare (with or without supplemental insurance). [redacted] Competition among MA insurers focuses on low premiums, low out-of-pocket costs, supplemental benefits, and other features that distinguish MA plans from one another. Plaintiffs' expert economist, Professor Aviv Nevo, will testify that the sale of individual MA plans in each of the 364 Complaint counties constitutes a distinct relevant antitrust market in which to assess the likely effects of the proposed merger.

MA relies on robust competition among private insurers to bring seniors high-value plans at affordable prices and reduce overall program costs to taxpayers. This merger would undermine those goals by eliminating all competition between Aetna and Humana. The combination of

[4] PX0001.

[5] PX0015 at HUM-DOJ-0007622879.

these two insurance giants is presumptively unlawful in each of the 364 relevant markets. In most, the merger would increase market concentration far beyond the thresholds for presumptive illegality. Indeed, the merger would create MA monopolies in 70 counties.[6]

[redacted] By eliminating this competition, the proposed merger likely would cause seniors to pay significantly higher premiums and receive significantly reduced benefits. Professor Nevo's analysis shows that seniors enrolled in MA plans in the relevant markets would pay hundreds of millions of dollars more per year in rebate-adjusted premiums post-merger than they would if Aetna and Humana remain independent competitors. Taxpayers also would be harmed because they would be forced to foot the bill for increased payments to insurers amounting to more than $100 million per year.[8]

Defendants argue that new entrants would prevent anticompetitive harm from the merger, but the evidence will show that new entry is infrequent and rarely successful. Defendants also argue that the merger should be allowed to proceed in view of their proposed divestiture to Molina—a Medicaid specialist with junk-bond-rated debt.[9] Molina's previous attempts to market individual MA plans have been utter failures, and, despite having entered 63 counties since 2008, it is now left with only 424 individuals enrolled in individual MA plans in six counties in the entire United States.[10] The bare-bones divestiture proposed here—[redacted]—is highly

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[6] Nevo Report ¶ 195.
[7] PX0007.
[8] Nevo Report ¶¶ 214-15.
[9] Burns Report ¶ 34.
[10] *Id.* ¶ 42.

unlikely to replace the competition that would be lost from the merger. Among other hurdles, Molina does not currently have an MA provider network in any of the divestiture counties, [redacted] At the next enrollment period, seniors enrolled in the divested plans would be free to switch back to an MA plan offered by the merged firm.

The public exchanges also rely on vigorous competition among insurers to promote affordable health coverage to individual consumers. Aetna sought to prevent this Court from even considering the effect of the merger on the exchange markets by announcing, soon after the Complaint was filed, that it would withdraw from the exchanges in Florida, Georgia, and Missouri—the very states that are the subject of Plaintiffs' claims. But the Court should not allow Aetna to avoid antitrust scrutiny by essentially shuttering its factory. [redacted] and Aetna has preserved its ability to re-enter those states' exchanges in a future competitive cycle. When competition is assessed without consideration of Aetna's tactical maneuvering, the proposed merger is presumptively illegal and likely would result in higher premiums for individual

[11] PX0102.
[12] PX0117.
[13] PX0125.

insurance plans on the exchanges in the 17 counties identified in the Complaint.

Defendants attempt to rebut the presumption of illegality by arguing that merger-related efficiencies would prevent anticompetitive harm. But the evidence will show that the claimed efficiencies are not verifiable, merger-specific, related to the markets at issue, or likely to benefit consumers. There is no consumer-oriented reason why two of the largest health insurers in the country need to merge. Rather, the record suggests the merger was driven by an industry-wide rush to consolidate—[redacted] not by any need to merge to bring benefits to consumers that the firms could not achieve independently. In fact, Mr. Bertolini testified before the Senate that Aetna could accomplish the benefits of the acquisition on its own within 3 to 4 years.[16]

The merger violates Section 7 of the Clayton Act and should be permanently enjoined.

II. BACKGROUND

A. Competition Is Important to Medicare Advantage

Congress created the Medicare program in 1965 to provide senior citizens with health insurance coverage. Medicare is administered by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS). Medicare Part A generally covers inpatient hospital care, and Part B generally covers physician care. Parts A and B together are referred to as Original Medicare. Original Medicare enrollees can go to any doctor or hospital in the United States that accepts Medicare rates, which almost all do.[17]

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[14] Bertolini Dep. 130:14-16, Oct. 11, 2016.

[15] *See* Bertolini Dep. 45:14–46:7, May 11, 2016; PX0566 at AET-P001-0000074105 [redacted]

[16] PX0005 at p.21.

[17] *See* http://kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot/ (93% of non-pediatric primary care physicians report that they accept Medicare).

Original Medicare imposes large cost-sharing requirements on enrollees, does not cap their total out-of-pocket expense, and does not cover prescription drug costs.[18] Thus, seniors with only Original Medicare may incur significant medical and drug costs. Seniors can buy supplemental plans (known as Medigap or MedSupp) from private insurers to cover some of these deductible and out-of-pocket costs, and Part D plans to cover prescription drugs.

In 1997, Congress created Medicare Part C, now known as Medicare Advantage, to allow seniors to opt out of Original Medicare and obtain government-subsidized health insurance through private insurers.[19] MA is designed as 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."[20] All MA plans include Parts A and B coverage, and most include prescription drug coverage and other additional benefits not available under Original Medicare.[21] CMS pays the MA insurer a fixed fee (known as the capitation payment) for each MA enrollee regardless of the enrollee's actual medical costs. This creates an incentive for the insurer to work with providers to reduce medical expenses. As a result, MA plans are normally managed care programs, either HMOs or PPOs, which allow insurers more control over medical costs.

The capitation payment is determined by the relationship between the "benchmark" for the plan's payment area and the "bid" that the insurer enters with CMS for the plan. The benchmark is the maximum that CMS will pay the insurer for an MA enrollee in the plan. If the

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[18] *See* https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html.
[19] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 276 (1997).
[20] H.R. Rep. No. 108-391, at 525 (2003) (Conf. Rep.).
[21] Nevo Report ¶¶ 53-56; *see also* https://www.medicare.gov/what-medicare-covers/medicare-health-plans/medicare-advantage-plans-cover-all-medicare-services.html.

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 difference. If the bid is below the benchmark, CMS pays the insurer the bid plus a "rebate" that is some portion of the difference between the bid and the benchmark.[22]

Since 2012, the amount of the capitation payment has depended on the MA plan's "star rating." CMS assigns star ratings to collections of plans based on factors such as clinical outcomes and customer satisfaction. Ratings vary in half point increments from one (the lowest) to five (the highest). Plans rated 4 stars or higher receive a bonus that effectively raises the benchmark 5% for those plans. 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 and 4 stars and 70% for 4.5 or 5 stars.[23]

Because CMS pays more per enrollee to higher rated plans, those with higher star ratings can offer seniors better benefits at a lower premium. Plans receiving CMS rebates must use them to pay down the standard Part B premium, reduce the plan's cost sharing requirements, or provide additional benefits such as prescription drug or dental coverage.[24] Most insurers use the rebate to pay for additional benefits. Bidding below the benchmark allows insurers to increase plan benefits without increasing the premium, making the plan more attractive to enrollees. In 2016, 94% of MA enrollees were in plans that bid below the benchmark.[25]

This regulatory structure is designed to harness competitive forces for the benefit of MA enrollees and taxpayers. Plaintiffs' expert Professor Frank will explain that robust competition

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[22] *See generally* Frank Report ¶¶ 27-29; Burns Report ¶¶ 110-11.
[23] *See generally* PX0028 at AET-P003-0003641073–093.
[24] Nevo Report ¶ 31 n.28; Frank Report ¶ 30.
[25] Nevo Report ¶ 67.

pushes insurers to bid aggressively and offer better plans to attract enrollees. Conversely, reduced competition leads to higher bids and, therefore, higher premiums and reduced benefits. For example, CMS mandates that MA plans limit an enrollee's out-of-pocket costs to an annual maximum of $6,700[26]—but competition spurs many insurers to set a lower maximum.[27]

Humana is the largest provider of individual MA coverage in United States.[28] Aetna is the fourth largest individual MA insurer, and has been expanding rapidly.[29] 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.[30] The merger would eliminate this competition.

B. Competition Is Important to the Public Exchanges

The public exchanges rely on vigorous competition among insurers to promote attractive and affordable health insurance options for individual consumers, as well as sustainable program costs for taxpayers.[31] The ACA requires that individuals with household income at or above the poverty level who do not have health insurance from another source buy health insurance through public exchanges established by the ACA (on-exchange) or directly from an insurer or through a broker (off-exchange). It also provides financial assistance to aid lower-income

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[26] 42 C.F.R. § 422.100(f)(4)-(5), 422.101(d)(2)-(3).

[redacted]

[28] Nevo Report ¶ 40.

[29] *Id.* ¶¶ 41, 217-18 & Ex. 18.

[30] *Id.* ¶¶ 220-21 & Ex. 20.

[31] 155 Cong. Rec. S13,891 (daily ed. Dec. 24, 2009) (Statement of Senator Reid) (ACA enacted with a goal of creating a marketplace to "ensure consumers will have more choices and insurance companies face more competition").

individuals who purchase health insurance. Only on-exchange plans qualify for these subsidies.[32] Professor Frank will explain that, because the amount of the subsidy is tied to the price of on-exchange plans, higher rates increase the subsidy that must be funded by taxpayers.[33]

Insurers first began selling individual health plans on ACA exchanges in 2013, with plans taking effect in 2014. 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.[34] In 2016, Aetna and Humana each offered on-exchange plans in 15 states. The merger would eliminate all competition between Aetna and Humana on the public exchanges.

III. ARGUMENT

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 Co. v. United States*, 370 U.S. 294, 323 (1962). Plaintiffs' burden is not to show that the proposed merger *will cause* competitive harm, but rather that it "is *reasonably likely to cause* anticompetitive effects." *United States v. H&R Block, Inc.*, 833 F. Supp. 2d 36, 49 (D.D.C. 2011) (emphasis added) (citation omitted); *accord FTC v. H.J. Heinz Co.*, 246 F.3d 708, 719 (D.C. Cir. 2001).

Merger analysis often begins with defining relevant markets. *See, e.g.*, *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 24 (D.D.C. 2015). If the government proves that the transaction would "produce 'a firm controlling an undue percentage share of the relevant market, and [would]

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[32] *See* https://www.healthcare.gov/lower-costs/save-on-monthly-premiums/; https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/.

[33] Frank Report ¶ 87.

[34] Nevo Report ¶ 272.

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 (quoting *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 363 (1963)). Once the government shows that the merger is presumptively unlawful, "[t]he burden then 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.'" *Sysco*, 113 F. Supp. 3d at 23 (quoting *Heinz*, 246 F.3d at 715). "The more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully." *United States v. Baker Hughes Inc.*, 908 F.2d 981, 991 (D.C. Cir. 1990).

A. The Proposed Merger Likely Would Substantially Lessen Competition for the Sale of Individual Medicare Advantage Plans in Hundreds of Counties

1. The Sale of Individual Medicare Advantage Plans in Each of the Complaint Counties Constitutes a Separate Relevant Market

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.'" *FTC v. Arch Coal*, 329 F. Supp. 2d 109, 119 (D.D.C. 2004) (citation omitted).

Relevant markets have two dimensions: product and geographic area. *Id.*; U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines (2010), *available at* https://www.justice.gov/atr/file/810276/download (Merger Guidelines). The parties' experts agree that individual counties are the relevant geographic markets.[35] Seniors may enroll only in

[35] Nevo Report ¶¶ 86-89; Orszag Report ¶ 112.

MA plans offered in their county of residence,[36] and insurers monitor their competitors' activities on a county-by-county basis and set pricing and other plan attributes accordingly.[37]

Plaintiffs will prove at trial that the sale of MA to individuals constitutes the appropriate relevant product market, and will show that Defendants' attempts to include Original Medicare, MedSupp, and Part D plans are mistaken. Courts look to two types of evidence in defining the product market: "the 'practical indicia' set forth in *Brown Shoe* and testimony from experts in the field of economics." *Sysco*, 113 F. Supp. 3d at 27. In *Brown Shoe*, the Supreme Court explained that the contours of a product market can be determined by examining such factors as "[1] industry or public recognition of the [relevant market] as a separate economic entity, [2] the product's peculiar characteristics and uses, [3] unique production facilities, [4] distinct customers, [5] distinct prices, [6] sensitivity to price changes, and [7] specialized vendors." 370 U.S. at 325. Courts in this circuit routinely consider these factors in defining the product market. *See, e.g., FTC v. Staples, Inc.*, 2016 WL 2899222, at *9-*12 (D.D.C. May 17, 2016) (*Staples II*).

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 nontransitory increase in price" (known as a SSNIP) on at least one product sold by the merging firms. *See* Merger Guidelines § 4.1; *FTC v. Advocate Health Care Network*, No. 16-2492, 2016 WL 6407247, at *5-6, *9, -- F.3d -- (7th Cir. Oct. 31, 2016).

MA and Original Medicare are separate product markets even though both offer seniors

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[36] Nevo Report ¶ 88.

[37] *See* PX0219; Nevo Report ¶¶ 93-94 & n.133.

access to government-subsidized health care. 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 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). 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 "all methods of tax preparation are, to some degree, in competition." 833 F. Supp. 2d at 54.

a. The *Brown Shoe* Factors Show That Individual Medicare Advantage Is a Relevant Product Market

Market definition is a matter of business reality. *See, e.g.*, *Sysco*, 113 F. Supp. 3d at 37. One court already has observed that "Medicare Advantage is a product independent of Medicare." *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) (denying motion for summary judgment).[38] This conclusion 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.

First, Defendants recognize MA as a distinct product. Aetna and Humana both report MA results separately in their annual reports.[39] [redacted]

[38] *See also* PX0076 at p.32 (Missouri Dep't of Insurance finding that "Medicare Advantage constitutes a relevant antitrust product market.")

[39] PX0303 (Humana 2015 Annual Report); PX0503 (Aetna 2015 Annual Report).

[40] *See, e.g.*, PX0007; PX0009; PX0255; [redacted]

[redacted]

Second, MA plans are structured differently than Original Medicare, MedSupp, and Part D plans. Most MA plans allow seniors to obtain Parts A and B coverage, prescription drug coverage, and often other benefits, all within a single plan.[42] MA plans are usually managed care programs, whereas Original Medicare and MedSupp enrollees can choose their own providers from among almost every doctor and hospital in the United States.[43] Seniors choosing MA plans give up some flexibility in the selection of providers, but having a single managed care plan simplifies their health insurance and allows for greater coordination among providers.[44] [redacted]

Third, [redacted]

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[41] *See, e.g.*, PX0494 [redacted] PX0070 [redacted] PX0369 [redacted]

[42] *See, e.g.*, PX0006 at AET-LIT001-0000225985, 991, 003; PX0444 at HUM-DOJ-0000224262 [redacted]

[43] *See, e.g.*, [redacted]

[44] *See, e.g.*, [redacted]

[45] PX0021 at AET-P002-0001662017; [redacted]

[46] [redacted]

[47] *Id.*; *see also* [redacted]

[redacted]

Fourth, MA appeals to different customers than Original Medicare, MedSupp, and Part D plans. [redacted] Seniors enrolled in Original Medicare are more likely to value provider choice; those who supplement Original Medicare with MedSupp and Part D plans are likely to have higher incomes.[49] [redacted]

Fifth, premiums and out-of-pocket costs for MA plans are different from those for Original Medicare or Original Medicare supplemented with MedSupp and Part D plans. MA plans typically offer very low (often zero) premiums, and cost-sharing is minimized.[52] Original Medicare provides less comprehensive coverage and does not cap out-of-pocket costs. Seniors who opt to enroll in Part D and MedSupp plans typically pay more in monthly premiums and may receive fewer benefits than through an MA plan.[53] For many seniors on fixed incomes,

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[48] [redacted]

[49] *See, e.g.*, PX0033 at HUM-DOJ-0003171304 [redacted] PX0045 at HUM-DOJ-0002345196 [redacted]

[50] *See, e.g.*, PX0033 at HUM-DOJ-0003171306; PX0021 at AET-P002-0001662017.

[51] [redacted]

[52] *See, e.g.*, [redacted]

[53] *See, e.g.*, PX0072 at HUM-DOJ-00006737798 [redacted]

MedSupp and Part D plans are simply unaffordable,[54] and [redacted]

Sixth, [redacted]

[54] [redacted]

[55] [redacted]

[56] PX0015 at HUM-DOJ-0007622879. Professor Ford found this study provides reliable information regarding MA customer switching behavior. *See generally* Ford Report.

[57] *See* [redacted]

[58] *See* [redacted]

[59] *See* [redacted]

b. Economic Analysis Establishes That Individual Medicare Advantage Is a Relevant Product Market

Professor Nevo will explain that economic evidence leads to the conclusion that MA is a relevant product market in which to analyze the effects of the proposed merger in the Complaint counties. He studied CMS switching data for 2014 and 2015 and found that seniors switching away from an Aetna or Humana MA plan in the relevant counties chose another MA plan more than 87% of the time.[60] He also conducted an econometric analysis that found that 70% of seniors in the relevant counties leaving an Aetna or Humana MA plan in response to a price increase would switch to another MA plan.[61] Professor Nevo then applied two formulations of the hypothetical monopolist test and found that in all 364 relevant counties a hypothetical monopolist of MA plans would impose a SSNIP.[62]

2. The Merger Is Presumptively Illegal in the Complaint Counties

Once the government has properly defined the relevant markets, it establishes a prima facie violation of Section 7 by showing that the transaction would result in "'undue concentration in the market.'" *Arch Coal*, 329 F. Supp. 2d at 123 (citation omitted). 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 Sysco*, 113 F. Supp. 3d at 55; *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 166 (D.D.C. 2000). Courts also routinely apply the Herfindahl-Hirschmann Index (HHI) thresholds in the Merger Guidelines to determine whether

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[60] Nevo Report ¶ 136 & Ex. 8.
[61] *Id.* ¶ 166.
[62] *Id.* ¶ 171.

the government has established the presumption of anticompetitiveness. *See, e.g.*, *Arch Coal*, 329 F. Supp. 2d at 124. HHI figures are calculated by summing the squares of the individual firms' market shares. "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." Merger Guidelines § 5.3; *see also Staples II*, 2016 WL 2899222, at *17.

Under these standards, the proposed merger is presumptively unlawful in all 364 relevant markets. Professor Nevo will testify that, post-merger, the merged firm would control 80% or more of the MA market in 150 of those counties. In 70 of those counties, the merged firm would control 100% of the MA market. In every Complaint county, Defendants' combined market share would be at least 35%.[63] The proposed transaction also would significantly increase concentration in already concentrated markets. 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. 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.[64] In short, 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").

3. The Elimination of Head-to-Head Competition Between Aetna and Humana Is Likely to Harm Consumers

The market shares and concentration levels that would result from this merger establish Plaintiffs' prima facie case. This evidence shifts the burden to Defendants to rebut the

[63] Nevo Report App. I.

[64] Nevo Report ¶ 196.

presumption of illegality. But Plaintiffs' case is not based solely on market concentration data.

"Mergers that eliminate head-to-head competition between close competitors often result in a lessening of competition." *Staples II*, 2016 WL 2899222, at *20. In particular, such mergers can 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.

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[65] *See, e.g.*, PX0037

[66] *See* PX0354 at AET-P002-0001634440 to -444); PX0075 at AET-P001-0001219358. *See* PX0014 at HUM-DOJ-000074210

[67] *See, e.g.*, PX0390 at AET-P001-0000484745 PX0008 at AET-LIT002-0000438329 PX0019 at HUM-LIT-0002031401

[68] *See* PX0019 at HUM-LIT-0002031402; PX0464 at HUM-DOJ-0006452401; PX0503 (Aetna Inc. 2015 Annual Report at p.5). Orszag Report ¶ 186 n.353.

That Aetna is a rapidly growing competitor in the MA market underscores the likely harm to competition from the merger. "[A]n important consideration when analyzing possible anticompetitive effects" is whether the merger "would result in the elimination of a particularly aggressive competitor in a highly concentrated market." *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1083 (D.D.C. 1997) (*Staples I*). Aetna has entered 640 new counties in just the last four years—more than twice as many as any other insurer.[73] The number of counties in which Aetna and Humana compete head-to-head has grown dramatically, from 79 in 2011 to 675 to

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[69] PX0007.

[70] PX0216; *see also* PX0480 at HUM-DOJ-0024753344

[71] *See, e.g.*, PX0587 at AET-P003-0003376642 PX0588 at HUM-DOJ-0008342485

[72] PX0397 at AET-P001-0000699651. PX0038 at HUM-DOJ-0006455804. PX0352 at HUM-LIT-0000021884.

[73] Nevo Report ¶ 218.

[74] PX0075 at AET-P001-0001219358.

2016.[75]

The merger likely would harm consumers in counties where Defendants currently compete by eliminating a strong competitor that has been offering attractive plans to expand its market share.[76] It also would harm consumers in counties where the two firms would compete against each other in the near future.

Professor Nevo's economic analysis confirms that the merger likely would lead to harmful unilateral effects. He conducted a merger simulation and found that the proposed transaction would cause the merged firm and other insurers in the relevant markets to bid higher and charge higher premiums (net of rebates).[79] As a result, seniors in the relevant markets would pay an estimated $340 million more in rebate-adjusted premiums each year. The merger also would cost taxpayers an additional estimated $135 million per year in the form of higher

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[75] Nevo Report ¶ 220 & Ex. 19 Nevo Report ¶ 222.

[76] *See, e.g.*, PX0078 at AET-LIT002-0000537659 PX0038 at HUM-DOJ-0006455804

[77] PX0354 at AET-P002-0001634444; *see also*

[78] PX0225 PX0020; *see also* PX0056

[79] 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; *H&R Block*, 833 F. Supp. 2d at 88.

payments by CMS to insurers as a result of higher bids by insurers.[80]

4. Defendants' Cannot Rebut Plaintiffs' Prima Facie Case

To rebut Plaintiffs' case, Defendants have the burden of showing that, even though their merger would "bl[o]w through" the presumption thresholds "in spectacular fashion," *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 568 (6th Cir. 2014), the market concentration data "are not an accurate indicator of the merger's probable effect on competition," *Sysco*, 113 F. Supp. 3d at 72. None of Defendants' arguments alters the conclusion that the merger likely would harm competition for the sale of individual MA plans in the Complaint counties.

a. New Entry Will Not Replace Lost Competition

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 (citation omitted). The entry must be (1) timely, (2) likely, and (3) sufficient to replace the lost competition. *FTC v. Cardinal Health*, 12 F. Supp. 2d 34, 55 (D.D.C. 1998). Defendants cannot meet these criteria.

Barriers to entry in the MA market make successful and timely entry unlikely. [redacted] Barriers include

[80] Nevo Report ¶¶ 214-15.

[81] PX0062 at p. 4.

the need for a competitive provider network,[82] high star ratings,[83] strong brand,[84] and MA-related operational expertise and infrastructure.[85]

Professor Nevo's analysis of MA entry and exit from 2012 through 2016 shows that entry would not be timely, likely, or sufficient to offset the anticompetitive effects of the proposed merger. More than half of the relevant markets did not experience any new entry during that time period. And what entry did occur was rarely successful. Of the 66 new entrants in the Complaint counties in 2012, only 27% still operated in the county in 2016. Those new entrants that did stay in the market rarely captured enough share to replace the smaller of either Aetna's or Humana's

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[82] *See* PX0007 at AET-P001-000419847 PX0022 at HUM-LIT-0000097612, 617, 632)

[83] *See supra* note 67.

[84] *See, e.g.*,

[85] *See, e.g.*, PX0007 at AET-P001-000419848)

[86] ; *see also*

[87] PX0603.

[88]

share in those counties.[89]

b. Defendants Cannot Rebut the Presumption by Divesting Certain Limited Assets to Molina

In an attempt to address competitive concerns with the proposed merger, Aetna and Humana have agreed to divest some of their MA enrollees in the Complaint counties to Molina Healthcare. A divestiture cannot save an otherwise unlawful merger unless it would "'replac[e] the *competitive intensity* lost as a result of the merger.'" *Sysco*, 113 F. Supp. 3d at 72 (citation omitted). The divestiture "must effectively preserve competition in the relevant market." *Id.* at 73 (quoting U.S. Dep't of Justice, Policy Guide to Merger Remedies 1 (2011), *available at* https://www.justice.gov/sites/default/files/atr/legacy/2011/06/17/272350.pdf (Remedies 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. Remedies Guide at 8.

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, e.g.*, *Sysco*, 113 F. Supp. 3d at 73-78. Where the record shows that the divestiture would not create an effective competitor, or that the divestiture may not occur at all, courts analyze the likely effects of the transaction absent the divestiture. *See, e.g.*, *FTC v. Libbey, Inc.*, 211 F. Supp. 2d 34, 50 (D.D.C. 2002) (granting preliminary injunction where FTC offered no statistics regarding post-divestiture concentration because shares without divestiture were "best evidence" of impact of merger); *see also FTC v. CCC Holdings Inc.*, 605 F. Supp. 2d 26, 44-46, 56-59 (D.D.C. 2009) (analyzing market concentration data without

[89] Nevo Report ¶ 253 & Ex. 25; ¶ 254 & Ex. 26; ¶ 255 & Ex. 27.

adjusting for growth in share of firm benefiting from divestiture); *United States v. Franklin Elec. Co.*, 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 . . . ."). [redacted] *See* Remedy Guide at 7 ("[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."). [redacted]. But, as Professor Nevo will explain, merger divestitures can and do fail to replace lost competition, and the proposed divestiture to Molina suffers from features associated with unsuccessful

[90] PX0095 [redacted]

[91] *Id.*

divestitures.[92] Indeed, a failed divestiture is especially likely here.

i. Molina Lacks the Capabilities to Maintain Competition in the Relevant Markets

Even if the divestiture were to occur, it would not give Molina the resources it needs to preserve competition in the relevant markets. [redacted] Professors Nevo and Burns will testify that this type of limited-scope divestiture is much less likely to succeed than a divestiture of an entire ongoing business.

Running a successful MA business requires competencies in many areas: [redacted] Molina's lack of individual MA expertise, [redacted] make it very unlikely that Molina would "maintain the intensity that characterizes the present competition." *See Sysco*, 113 F. Supp. 3d at 78.

Replicating Aetna's and Humana's provider networks would be critical to Molina's success. [redacted]

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[92] Nevo Report ¶ 245.

[93] *See, e.g.*, [redacted]

[94] Burns Report ¶¶ 106-116.

[95] *Id.* ¶¶ 139-142.

[96] *Id.* ¶¶ 132, 147.

[97] *See, e.g.*, [redacted]; Burns Report ¶ 154.

[98] PX0102 [redacted]

[redacted]

[redacted]

[99] Burns Rebuttal Report ¶ 12.

[100] Burns Rebuttal Report ¶ 67. Medicaid plans usually have limited networks built around low-cost providers, and they are not geared towards the older and relatively more affluent individuals enrolled in MA plans. Burns Report ¶ 87.

[101] [redacted]

[102] [redacted] *See* [redacted] Burns Report ¶ 80.

[103] Burns Report ¶¶ 89–90 & Ex. 7 (Chicago MSA), Ex. 8 (Dallas MSA), Ex. 9 (St. Louis MSA), Ex. 10 (Philadelphia MSA).

[104] [redacted]

[redacted]

Star ratings stand as another barrier to Molina replacing the competition lost through the merger. As discussed above, high star ratings allow insurers to offer low premiums and attractive benefits to MA enrollees. [redacted]

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[105] PX0278 at AET-P004-0005961219 [redacted]

[106] Burns Report ¶ 103.

[107] [redacted] PX0606 (AET-LIT012-0001801730 [redacted]

[109] *See generally* PX0095 [redacted] PX0096 [redacted] Burns Report ¶ 79.

[110] PX0102.

[redacted]

[redacted]—to maintain high star ratings for the divested plans.

Molina would need to make investments to acquire the ability to match Aetna's and Humana's star ratings. [redacted]

Molina also lacks experience marketing MA plans to seniors. Brand is an important factor in an MA plan's success,[115] and Molina lacks the strong brand of Aetna and Humana.

[redacted]

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[111] [redacted] Burns Report ¶ 118.

[112] Aetna, "Aetna's Medicare Advantage plans receive high Star ratings," https://news.aetna.com/2016/10/aetnas-medicare-advantage-plans-receive-high-star-ratings/.

[113] [redacted] *See* PX0505 .

[114] [redacted]

[115] Burns Rebuttal Report ¶¶ 24-29.

[116] PX0082 at MOL0008265.

[117] PX0503 (Aetna 2015 Annual Report at p.72).

[118] PX0101 at MOL0426087; *see also* [redacted]

[redacted] Courts recognize a "problem" if a proposed divestiture allows "continuing relationships between the seller and buyer of divested assets after divestiture, such as a supply arrangement or technical assistance requirement, which may increase the buyer's vulnerability to the seller's behavior." *Sysco*, 113 F. Supp. 3d at 77 (internal quotation omitted). [redacted]

ii. Molina's Lack of Experience and Past Failures Confirm That It is Not Likely to Maintain Current Competition

Molina's acknowledged lack of experience and past failures in individual MA—[redacted]—provide perhaps the most compelling evidence of the ineffectiveness of Defendants' proposed remedy. [redacted] Molina first began selling individual MA plans in 2008. Over time, it has sold individual MA plans in 63 counties.[120] [redacted] Molina has since quit the MA

[redacted]

[119] Burns Report ¶ 30.

[redacted] PX0585; PX0529 [redacted]

[120] Burns Report ¶ 42.

[121] PX0234 at MOL0763772; *see also* PX0242 [redacted]; PX0107 [redacted]

business with the exception of two small plans offered in Utah and California that enroll a mere 424 members in 2016.[122] [redacted] Seniors should not be forced to bear the risk that this "experiment" will fail as well.

Molina's recent failures show that seniors cannot count on it to operate and compete successfully in the relevant markets. [redacted]

[redacted] PX0091.

[122] Burns Report ¶ 42.

[123] *Id.* ¶ 84.

[124] PX0081 at MOL0003327.

[125] PX0083 [redacted] *Id.*

[126] PX0052; PX0271.

[redacted] In sum, Molina's lack of experience and failures in individual MA demonstrate that the divestiture would not forestall harm from the proposed merger.

[redacted] 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). [redacted]

This transaction may be a good deal for Molina, but it is not a good deal for consumers because it would not restore the competition that would be lost due to the merger. [redacted] The experience from Humana's 2012 acquisition of Arcadian shows that concerns

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[127] PX0433 at AET-LIT005-0001365052–053.

[128] [redacted]

[129] [redacted]

[130] PX0081 at MOL0003329; PX0284 at MOL4844393.

[131] PX0075 at AET-P001-0001219358.

[132] [redacted]; PX0090 [redacted]; PX0233.

about Molina losing a large portion of the divested enrollees are warranted. As a condition for that merger to close, Humana and Arcadian were required to divest MA plans in 45 counties. Professor Nevo found that three years after the divestitures, the average divestiture buyer had lost more than half of the market share it started with; in 21 of the 45 divestiture counties, the buyer had exited the market altogether. Among buyers with no prior MA presence in the counties for which they purchased divested plans—like Molina here—the buyers lost an average of 68% of their original enrollees, and in most cases failed outright. If Molina were to lose a similar percentage of enrollees post-divestiture, the merger would be presumptively illegal in 90% of the Complaint counties.[133]

iii. The Divestiture Faces Uncertainty

Even if permitted to proceed, the divestiture to Molina would still require a number of state and federal regulatory approvals. [redacted]

[133] Nevo Report ¶ 249.

[134] PX0095 (APA, § 6.02(e)); PX0096 (APA § 6.02(e)). CMS assigns the new contracts the average star rating of their new owner. Medicare Advantage Call Letter, 2017 at 12, https://www.cms.gov/Medicare/ Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2017.pdf. [redacted] *Id.*

[135] PX0095 (APA § 6.01(c)); PX0096 (APA § 6.01(c)).

[redacted] Finally, regulators in the states where the divested assets are located may need to approve the transaction, including the Missouri Department of Insurance, which already issued a preliminary order blocking the Aetna and Humana merger,[138] and Florida's Office of Insurance Regulation, which expressed skepticism about the efficacy of divestitures.[139]

c. Regulatory Changes Will Not Prevent Anticompetitive Effects

Defendants contend that regulatory changes ushered in with the ACA will make MA and Original Medicare closer options for many consumers and prevent the merged firm from exercising market power. They argue that, due to reductions in MA benchmarks under the ACA, MA plans will no longer cost less than other health insurance options for seniors. But, as Professor Frank will explain, reductions in MA benchmarks have not led to decreases in MA enrollees. Indeed, MA enrollment has continued to grow after the ACA's adoption.[140]

Defendants also contend that Accountable Care Organizations (ACOs) are making Original Medicare a closer substitute for MA. An ACO is a network of providers that may coordinate patient care. ACOs are paid on the Original Medicare fee-for-service model, and

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[136] Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program, 75 Fed. Reg. 19678, 19782 (Aug. 15, 2010) (describing the limit on novations in Part D, which like "the Part C regulations only permit novations that include the entire MA line of business (that is, all MA contracts held by a single legal entity)"; "allowing the spin-off of just one contract . . . or pieces of a single contract can have a negative impact on beneficiary election rights").

[137] 42 C.F.R. § 422.122.

[138] *See* PX0076.

[139] *See* PX0476 ¶ 22 ("The OFFICE finds 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.").

[140] Frank Rebuttal Report ¶ 40.

CMS may pay them limited bonuses for keeping costs low. But ACOs do not eliminate the previously discussed differences that make Original Medicare and MA separate products. For example, if an ACO lowers its costs of providing care and earns a bonus, there is no mechanism for sharing that bonus with enrollees, as occurs with MA rebates.[141] And unlike MA plans, ACOs do not offer enrollees benefits beyond Original Medicare.

Defendants further argue that CMS regulation of MA plans would prevent harm from the proposed merger. This misapprehends the nature of CMS's oversight and ability to protect consumers. As Professor Frank will explain, MA is structured to rely on competition among insurers—not regulation—to ensure that seniors have access to the best plans at a reasonable cost. Professor Nevo found, for example, that CMS's review of MA bids did not prevent premium increases following the Humana and Arcadian merger.[142] Moreover, regulation is not a substitute for competition. *See, e.g.*, *Phila. Nat'l Bank*, 374 U.S. at 372 ("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.").

B. The Merger Likely Would Substantially Lessen Competition for the Sale of Individual Insurance on the Public Exchanges in the Complaint Counties

1. The Court Should Disregard Aetna's Withdrawal from the Exchanges in the 17 Complaint Counties

Aetna maintains that its post-Complaint announcement that it will withdraw from the public exchanges in Florida, Georgia, and Missouri in 2017 nullifies Plaintiffs' claim. [redacted]

[141] *Id.* ¶¶ 42-44.

[142] Nevo Rebuttal Report ¶¶ 126-27; Nevo Report ¶ 233 & Ex. 21; *see also* [redacted]

effort to defeat judicial review, and should assess the likely effects of the merger based on competition on the exchanges in 2016, prior to Aetna's strategic withdrawal.

Up until the eve of litigation, Aetna viewed the public exchanges as, in the words of its CEO Mr. Bertolini, a "big opportunity for the Company" with "long-term market potential."[143] In April 2016, Mr. Bertolini told investors that, while he recognized that there were short-term losses, the exchanges were a "good investment," and Aetna was "encouraged by [its] year-to-date performance."[144]

[143] PX0162 at p.6 (Third Quarter 2015 Earnings Conference Call).
[144] PX0112 at pp.4, 13 (First Quarter 2016 Earnings Conference Call).
[145] PX0116 at AET-LIT009-0001769198.
[146] *See, e.g.*, PX0264 at AET-LIT001-0000129121.
[147] PX0134 (Aetna's Response to Third Set of Aetna Interrogatories (No. 1) at p.7).
[148] PX0117 at p.2.

The Department of Justice nevertheless sued on July 21 to stop Aetna's anticompetitive merger with Humana, alleging loss of competition on the public exchanges in 17 counties in Florida, Georgia, and Missouri. Aetna then announced on August 15, that it would withdraw from the exchanges in those three states and eight others. But it confirmed that it would "continue to offer an off-exchange individual product option for 2017 to consumers in the vast majority of the counties where [it] offered individual public exchange products in 2016."[152]

The probative value of merging parties' 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." *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 504-05 (1974). 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, Inc.*, No. 13-cv-00133-WHO, 2014 WL 203966, at *73 (N.D. Cal. Jan. 8, 2014) (probative value of post-acquisition evidence

[149] *Id.*
[150] *Id.*
[151] PX0118.
[152] PX0133 at p.2.

especially limited "when the parties are aware of the government's scrutiny and the potential for a court challenge").

Applying this rule, when a merging party takes an action plausibly intended to affect the outcome of an ongoing merger challenge, the Court properly can disregard the resulting change. *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1384 (7th Cir. 1986) ("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, 1243 (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").

[redacted]

[153] PX0121.

[154] PX0124 (emphasis added).

The Court therefore should evaluate the state of competition in the relevant public exchange markets under conditions existing prior to Aetna's post-Complaint maneuvering, which show a presumptively illegal elimination of competition. This conclusion is supported by the fact that Aetna has not withdrawn from the product market entirely. It will sell on-exchange in four states in 2017. Moreover, Aetna withdrew from Florida, Georgia, and Missouri in a way that allows it to reverse course and re-enter those exchanges in 2018 or after. Like most states, Florida, Georgia, and Missouri prohibit an insurer from selling in the state for five years if the insurer stops selling individual commercial insurance in the state altogether.[158] But Aetna will continue to sell off-exchange policies in Florida, Georgia, and Missouri for the 2017 policy year,

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[155] PX0125 (emphasis added).

[156] PX0127. *See, e.g.*, PX0122 *See, e.g.*, PX0001 PX0576 ; PX002 ; PX0575 .

[157] PX0129.

[158]

which means that it will be able to re-enter the public exchanges in those states as soon as 2018.[159] [redacted] Aetna's "future ability to compete," which is what matters for Section 7 purposes, *Gen. Dynamics*, 415 U.S. at 501, is not jeopardized by its temporary decision to stop selling on the public exchanges in the Complaint counties in 2017.

Important public policy considerations undergird the conclusion that this Court should not credit Aetna's announced withdrawal in assessing the likely effects of the merger on the public exchange markets. 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. Libbey*, 211 F. Supp. 2d at 46 & n.27 (contrasting parties' legitimate effort to address FTC's concerns through divestiture with an "unscrupulous[] attempt to avoid judicial and FTC review of an agreement by continuously amending it"). [redacted]

2. The Sale of Individual Insurance on the Public Exchanges in Each of the Complaint Counties Constitutes a Separate Relevant Market

Health plans offered to individuals on public exchanges constitute a relevant product. A critical distinction between individual health insurance sold on-exchange and that sold off-exchange is that on-exchange plans are significantly cheaper for many consumers. In 2016, 85% of all on-exchange enrollees receive a subsidy, and for almost all of them, the subsidy covers at

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[159] *Id.*

[160] [redacted] PX0215.

[161] PX0125.

least 10% of the premium.[162] For many, the amount of the subsidy is substantially greater. The average monthly premium for on-exchange plans in 2016 is $386, but it is only $102 net of subsidies.[163] Individuals qualifying for a subsidy must buy on-exchange to receive the subsidy.

The fact that most on-exchange enrollees receive a subsidy of 10% or more makes it highly likely that a hypothetical monopolist of all on-exchange plans would apply a SSNIP. Professor Nevo's analysis confirms that a hypothetical monopolist would apply a SSNIP in all of the 17 Complaint counties.[164]

Individual counties are appropriate relevant markets in which to assess the effect of the proposed merger on the sale of individual insurance on public exchanges. Insurers make decisions about which plans to offer, how to price them, and what benefits to include at the county level in Florida, Georgia, and Missouri,[165] and consumers may enroll only in plans offered in their county of residence.[166] There are approximately 700,000 consumers purchasing health insurance on the public exchanges in the 17 Complaint counties, and more than 400,000 of them have an Aetna or a Humana plan.[167]

3. The Merger Is Presumptively Illegal in the Complaint Counties

Using 2016 data, Professor Nevo will show that the average increase in HHI in the relevant markets due to the merger is 1,037 and the average post-merger HHI is 4,871.[168] The

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[162] Nevo Report ¶ 281 n.358.
[163] Frank Report ¶ 84.
[164] Nevo Report ¶ 310 & Ex. 32.
[165] *See, e.g.*, PX0300 at HUM-VOL-00001193, 205, 217, 224 [redacted]
[166] Nevo Report ¶¶ 288-89.
[167] *Id.* App. L-2.
[168] *Id.* ¶ 3131 & App. M.

minimum increase in HHI is 690 and the minimum post-merger HHI is 3,408. Aetna and Humana's combined market share in the complaint counties exceeds 40%.[169] These concentration measures greatly exceed the thresholds under which a transaction presumptively violates Section 7.

4. The Merger Will Eliminate Beneficial Head-to-Head Competition Between Aetna and Humana

Aetna and Humana are close competitors on the public exchanges in Florida, Georgia, and Missouri.[170] [redacted] Professor Nevo's economic analysis shows that Aetna's and Humana's on-exchange plans are close competitors and that the elimination of competition between them is likely to increase prices substantially in each of the Complaint counties.[173] Moreover, even if the exchanges are changed or replaced in the future, competition among private insurers will remain vital to consumers purchasing individual health insurance.

5. Defendants Cannot Rebut the Government's Case

Defendants cannot rebut the presumption that the proposed merger likely will have anticompetitive effects in the markets for the sale of on-exchange plans in the Complaint counties. Entry by other insurers is unlikely to fill the competitive void given the substantial

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[169] *Id.* App. M.

[170] *See, e.g.*, PX0108; PX0263 [redacted]; PX0351 at AET-P003-0004209977 [redacted]

[171] *See, e.g.*, PX0266 at HUM-DOJ-0000984341 [redacted] PX0263 [redacted]

[172] Nevo Report ¶¶ 314-16 & n.411.

[173] *Id.* ¶ 323 & Ex. 34.

barriers to entry, including the need to assemble a low-cost provider network, build IT infrastructure, and learn the regulatory environment.[174]

C. The Parties' Claimed Efficiencies Cannot Offset the Likely Harm to Consumers in the Relevant Markets

"The Supreme Court has never expressly approved an efficiencies defense to a § 7 claim," *Saint Alphonsus Med. Center-Nampa Inc. v. St. Luke's Health System, 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; *Sysco*, 113 F. Supp. 3d at 82 (finding no such case). 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. The hurdle for Defendants is especially high here, as "high market concentration levels" require "proof of extraordinary efficiencies." *Heinz*, 246 F.3d at 720; *Sysco*, 113 F. Supp. 3d at 81.

Given the high concentration levels, "the court must undertake a rigorous analysis of the kinds of efficiencies being urged by the parties." *Heinz*, 246 F.3d at 721. Cognizable 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" absent the merger, *id.* at 722; and (iii) likely to benefit consumers, *CCC Holdings*, 605 F. Supp. 2d at 74; *Sysco*, 113 F. Supp. 3d at 82.

Defendants' proffered efficiencies do not meet these tests. *First,* the claimed efficiencies have not been verified. Defendants' expert, Mr. Gokhale, uses Aetna's internal efficiencies

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[174] *See, e.g.*, [redacted]

estimates, [redacted] as the foundation for all of his claims.[175] [redacted] and Mr. Gokhale performed only the most perfunctory review of the estimates provided to him, without testing the underlying assumptions or conducting other independent analysis. As a result, it is impossible to conclude that Mr. Gokhale has adequately substantiated any of the claimed efficiencies. *See Sysco*, 113 F. Supp. 3d at 83-84 (rejecting claimed efficiencies where testifying expert relied extensively on work done by third-party consultants and conducted little or no "independent analysis"). The "lack of a verifiable method of factual analysis" by Mr. Gokhale renders his claimed efficiencies "not cognizable." *H&R Block*, 833 F. Supp. 2d at 91.

Second, two examples illustrate that the claimed efficiencies are not merger-specific and are not likely to benefit consumers, in addition to being unverifiable. [redacted] *See, e.g.*, *Heinz*, 246 F.3d at 721 n.19 (firm being acquired could have made its distribution system more efficient without merger). And, [redacted], Defendants offer no basis for concluding that consumers would benefit from these so-called efficiencies—[redacted]

[175] *See, e.g.*, Gokhale Report ¶ 49 & Ex. 1.

[176] Gokhale Rebuttal Report Ex. 6-1; Hammer Rebuttal Report ¶¶ 168, 171, 181; Hammer Report ¶¶ 38-39.

[redacted]

Third, Defendants' claimed efficiencies do not benefit consumers in the relevant 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. The law does not allow "anticompetitive effects in one market [to] be justified by procompetitive consequences in another." *Phila. Nat'l Bank,*

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[177] *See* Gokhale Report ¶¶ 173-74 [redacted]

[178] Gokhale Rebuttal Report Ex. 5-1 & ¶¶ 79-81; Hammer Rebuttal Report ¶¶ 113-16; *see also id.* ¶ 100 [redacted]

[179] *See* Hammer Rebuttal Report ¶¶ 121-22 (Mr. Gokhale has not sufficiently addressed the quality of the consultants' underlying data, [redacted]

[180] Hammer Rebuttal Report ¶¶ 138-39.

374 U.S. at 370. Mr. Gokhale has provided no detailed analysis attributing the efficiency claims to the relevant markets, and has not even attempted to attribute efficiencies to the challenged MA markets on a post-divestiture basis.[181]

Defendants contend that Aetna's experience with its 2013 acquisition of Coventry bolsters their efficiencies defense, but the opposite is true. Even if the Aetna–Coventry transaction were sufficiently analogous to provide a reasonable benchmark for this case, which Mr. Gokhale has not established,[182] the transaction would, if anything, cut against a finding of cognizability here. 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.[183] Thus, even if that merger generated efficiencies—a possibility Mr. Gokhale has not established— Aetna did not pass them on to consumers.[184]

IV. CONCLUSION

The evidence at trial will show 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.

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[181] Hammer Rebuttal Report ¶ 32; *see also* Gokhale Rebuttal Report Ex. 15.

[182] [redacted] *See* Gokhale Rebuttal Report ¶ 13. *Compare* [redacted]

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on November 22, 2016, a true and correct copy of the foregoing was served on all counsel of record via email.

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