Aetna Responses
To
Questions for the Record

U.S. Senate Committee on the Judiciary
Subcommittee on Antitrust, Competition Policy and Consumer Rights Hearing
"Consolidation in the Health Insurance Industry and its Impact on Consumers"
September 22, 2015

Senators with Submitted Questions:

- Dianne Feinstein (D-CA)
- Thom Tillis (R-NC)
- Orrin Hatch (R-UT)
- David Vitter (R-LA)
- Patrick Leahy (D-VT)
- Mike Lee (R-UT)

Questions for the Record from Senator Dianne Feinstein

1. **Medical loss ratio refers to the percentage of premium dollars that go toward medical care for patients versus administrative costs. Companies that are merging often tout increased administrative efficiencies.**

   a. **Do you expect that increased efficiencies would translate into increased medical loss ratio percentages for Aetna in comparison to the last two years?**

   Aetna's acquisition of Humana is about Medicare. The primary goal is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

   After the transaction, we expect to achieve over $1 billion in cost savings each year. We expect that a significant portion of these savings will flow back to consumers in the form of more cost-effective high quality product offerings in more areas across the country. Our goal is to remove waste and duplicative administrative costs and use some of the savings to develop products to keep people healthier.

   The Medical Loss Ratio (MLR) is clearly a part of the regulatory landscape in Medicare Advantage (as well as for many of our other segments). Most Aetna plans today already outperform the federal MLR requirements in terms of the balance of patient care to administrative expenses, and we expect this will continue following the transaction.

   It is also worth noting that Medicare Advantage plans, governed by the federal bidding process, are doing a good job keeping costs down. Monthly Medicare Advantage premiums are down 10 percent in 2016 from 2009 and this is a trend we think will continue.

2. **What impact do you expect Aetna's merger with Humana to have on consumers' choice of health plans?**

   Aetna's acquisition of Humana is about Medicare, a market that is robust and very competitive. In addition to having to compete with traditional Medicare, in the over 3,000 counties across the country, there are 143 health care companies offering Medicare Advantage plans, with an average of 18 Medicare Advantage private plan options available to each beneficiary. In California, Medicare beneficiaries have a choice of 21 plans on average in 2015. When combined, Aetna and Humana will be only about 8 percent of Medicare business nationwide, with 92 percent of Medicare beneficiaries having coverage other than Aetna or Humana.

   New entrants continue to enter Medicare Advantage. Twenty-eight new health plans have joined over the last 3 years, of which 15 are owned by providers. The trend of provider-based insurers in Medicare Advantage is continuing into the 2016 plan year. For example, Johns Hopkins recently announced it plans to offer a Medicare Advantage PPO featuring access to all of its providers, as well as thousands of others across Maryland.

Similarly, Cone Health, a two-hospital group based in Greensboro, NY, announced it will begin marketing a Medicare Advantage plan in 2016.

After the acquisition, the new Aetna will continue to face significant competition such as this from a large number of health plans and other new market entrants, including provider-based insurers — all of which will continue to offer consumers a robust selection of choices.

3. **What steps are you planning to take to ensure that it is easy for consumers to understand their exact provider network, especially if different plans offered by Aetna and Humana have different provider networks?**

   Both Aetna and Humana are committed to a consumer-centric model that includes offering health insurance products that are simple and easy to understand. This model includes providing simple tools that allow consumers to understand how to access the providers in their plan's network. At Aetna today, our DocFind web-based tool enables our members to locate and evaluate network providers and their services.

   Both Aetna and Humana are committed, pre- and-post transaction, to ensuring that consumers have all the information they need to choose health plans that best meet their needs — including clear and easy-to-use information about the providers in a plan's network.

4. **What impact do you expect Aetna's merger with Humana to have on the cost of premiums?**

   Aetna's acquisition of Humana is about Medicare. The primary goal is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

   After the transaction, we expect to achieve over $1 billion in cost savings each year. We expect that a significant portion of these savings will flow back to consumers in the form of more cost-effective high quality product offerings in more areas across the country. Our goal is to remove waste and duplicative administrative costs and use some of the savings to develop products to keep people healthier.

   It is worth pointing out that Medicare Advantage plans, governed by the federal bidding process, are already doing a very good job keeping costs down for their members. Monthly Medicare Advantage premiums are down 10 percent in 2016 from 2009, and this is a trend we think will continue.

5. **What specific benefits to the consumer do you expect to see from Aetna's merger with Humana?**

   Aetna decided to acquire Humana to enable it to offer better and more innovative products, simplify insurance, and improve the overall health care experience for more

consumers. Following this transaction, Aetna consumers will have access to better consumer engagement, as well as programs and services that utilize particular Humana expertise. Our goal is to increase our customers' number of "Healthy Days", as measured by the Centers for Disease Control (CDC) metric.

Toward this goal, Humana is already a noted leader in delivering:

- Wellness and prevention programs (e.g., Humana Vitality, 12 percent lower health care costs and 15 percent lower absenteeism); and
- Home health care (Humana at Home — 496,000 more member days at home in 2014).

Meanwhile, Aetna is a leader in designing strong and dynamic relationships with high-quality providers. Examples of this include:

- Memorial Herman (Texas), where through improved efficiencies, costs have been lowered for the self-insured population from 2013 to 2014 by, increasing the generic prescribing rate by 21.3 percent and reducing avoidable emergency room visits by 13.5 percent.
- Banner Health (Arizona) where medical costs for commercial membership were reduced by five percent, along with a nine percent decrease in avoidable admissions.

Together, we will continue to accelerate these types of successes that benefit consumers. We will compete for business based on our ability to improve quality and cost, but we also want to win on effectively engaging consumers and delivering best-in-class service. In short, more consumers will have a broader choice of products, and access to higher quality and more affordable care.

6. Are there any markets in which Anthem, Cigna, Aetna, and Humana each have more than 10% market share? If so, please identify them.

Aetna is not in a position to speculate on Anthem and Cigna's market share. As for Aetna and Humana, calculating market shares is a complex, fact-intensive exercise and is a process we will likely work through with the Department of Justice as part of its investigation of Aetna's proposed acquisition of Humana.

Calculating shares requires a proper determination of relevant geographic and product markets. There are many distinct insurance products and the relevant geographic areas may vary based upon the insurance products or consumers involved. In the case of most products and geographies, there is little or no overlap between Aetna and Humana. Where the parties offer the same products in the same geography there are often numerous competitors.

Even where the parties offer the same product, however, Aetna and Humana tend to have different focuses. For example, in commercial insurance offered to employer groups, Aetna's business focuses on large multi-site self-insured customers whereas

Humana's business is focused on small fully-insured local employers. The transaction between Aetna and Humana combines companies that are highly complementary.

We also note that a 10 percent market share is not typically a cause for alarm from a competition perspective, and in the insurance industry, market shares typically are not a reliable indicator of a firm's competitive significance. Given the ability of employers and individuals customers to switch plans on an annual basis as well as the ability of insurance providers to take on new members, insurance providers can experience significant changes in enrollment numbers from year to year. From the perspective of employers and individual customers, the number of plans available to them is of greater competitive significance than any one firm's market share, and employers and individual customers in fact have a growing number of choices.

a. What impact do you expect the proposed mergers (i.e. Anthem with Cigna and Aetna with Humana) to have on consumers' choice of health plans in the markets in which the companies each have more than 10% market share?

Our deal is primarily about Medicare, as Humana has only two percent of the commercial market. Aetna's proposed acquisition of Humana will not negatively impact consumers' choice of health plans.

For example, over the last 3 years, 28 new companies began offering Medicare Advantage products. Ninety-four percent of Medicare beneficiaries already choose from at least five Medicare Advantage plan options, in addition to traditional Medicare. After this combination, Aetna-Humana will still only account for about eight percent of the total Medicare market.

In the commercial segment, there are a number of significant competitors, including United, Anthem, HCSC, Cigna, Highmark, Centene, CareFirst, other local Blue Cross Blue Shield plans, Emblem Health, Kaiser, and provider-based plans. Some of the largest and most prestigious health systems are entering the insurance business. On the eight public exchanges where Aetna and Humana both participate, there are on average 10 other insurers (at least 5 other participating issuers in each state). A growing number of employers also are turning to new private health care exchanges offered by large benefits consultants such as Towers Watson and Mercer.

b. What impact do you expect the proposed mergers (i.e. Anthem with Cigna and Aetna with Humana) to have on the cost of premiums in the markets in which the companies each have more than 10% market share?

The combined company will continue to face significant competition from a large number of competitors. The primary goal of the Humana transaction is to enable the combined company to offer consumers a broader choice of products and access to higher-quality and more-affordable care. Also, bringing together Aetna and Humana is projected to realize over $1 billion of synergies in 2018 and each year thereafter —

which will enable us to drive costs out of the system and offer more affordable products to our consumers.

The combination will enhance our ability to work with providers and create value-based payment agreements that result in better care to consumers. Our combined organization will build a health services division that will offer consumers and providers digital solutions and services that will lower costs and improve care.

Given that our merger is primarily about Medicare, it is important to note that Medicare is tightly regulated to protect consumers. Most notably, in Medicare Advantage, companies bid against government determined benchmarks and operate within regulated profit limits.

Questions for the Record from Senator Thom Tillis for Mark T. Bertolini

1. **What can Congress do to ensure that the United States Department of Justice objectively examines these proposed mergers, free from undue influence from the Administration, and without predetermining the outcome of their analysis?**

   The July announcement of the Aetna acquisition of Humana is the first step in a process that is subject to both federal and state review. Over the next several months, we will cooperate with the appropriate regulators to answer their questions as they review the transaction. We are confident the Department of Justice will conduct a thorough and detailed review.

2. **Much has been said of the potential ability of larger health insurers to act as a check on larger provider networks. In short, the argument goes that larger insurers can better negotiate with larger provider chains, thus creating a balance that will ultimately benefit consumers. Do you agree with this justification?**

   Aetna's acquisition of Humana is about Medicare. The primary goal is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

   We do not view the transaction as a way to negotiate better rates. Rather, we think the combination will enhance our ability to work with providers and create value-based payment agreements that result in better care to consumers. In fact, as we move away from the rate negotiations of the old days to value-based care arrangements with providers, we find that by putting the right incentives in place, we and our provider partners end up sharing the same goal of improving health care at a reduced cost.

   Together with other like-minded private organizations, Aetna has made a pledge to have 75 percent of medical spend in value-based payment arrangements by 2020 — surpassing the goal set by CMS. Similarly, 54 percent of Humana beneficiaries are in accountable care relationships today (a total of 1.5 million Medicare Advantage members cared for by 33,000 primary care physicians in 43 states), and the company is on course to have more than 75 percent of beneficiaries in accountable care relationships by 2017.

   Further, do you believe that consolidation in the health insurance market is the inevitable result of consolidation in the provider market?

   There has been much research linking provider consolidation to increased healthcare spending.

   In our transaction, Aetna and Humana are combining to enhance our ability to work with providers to create value-based payment arrangements that result in better care to consumers.

One successful example of these arrangements is Innovation Health, an insurance product offered by Aetna and Inova in Virginia. Together we offer consumers premiums that are three to five percent lower than other network plans in the area. And we've improved health outcomes, including a 27 percent reduction in C-section admissions and 86 percent engagement in complex case management.

A combined Aetna and Humana will still occupy only eight percent of the Medicare marketplace.

Finally, please opine as to whether the Affordable Care Act has hastened consolidation in health care markets, and if so, identify the features of the Act that are most responsible for this result.

The Affordable Care Act has accelerated changes (some of which were already occurring) and has influenced all elements of the health care system over the past few years. That being said, the primary goal of the Humana transaction is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

Our decision to acquire Humana was based on what we believe is in the best interest of our customers, offering them more healthy days per year by building a consumer centric health care experience.

Questions for the Record from Senator David Vitter for Mark T. Bertolini

Background:

The ACA's medical loss ratio (MLR) requirement mandates that insurers spend at least 85 percent of premium revenues for large groups on claims or "activities that improve health care quality." In doing so, the MLR shields incumbents from competition. The need for sufficient scale to comply with MLRs is an impediment to start-up insurance providers while, at the same time, mergers of existing insurers is incentivized by the requirement to minimize administrative and operating costs as a percentage of revenue.

MLRs are also likely to limit the capacity of small insurers to invest in overhead needed to expand, serving as punishment for retaining funds unused for medical expenses, which, in turn, is likely to make external funding necessary.

Caps on operating expenses can also work to the advantage of hospital run health plans, where the cap is set at 20% of revenue. On the other hand, the cap on operating expenses for for-profit health insurers is set at 15%. This variance gives an advantage to hospital run health plans, which have an easier time staying under the cap because they can shift costs between medical care and administrative overhead. For-profit health insurers, since the provision on medical care is not an option, must spread their fixed operating costs over a larger base of members in order to sustain themselves while meeting the government imposed caps. They must grow larger through mergers and acquisitions.

Questions Addressed to Each of the Witnesses:

1. **What role do the ACA's medical loss ratio requirements play in calculations and decisions of health insurers to consolidate? Does the cap on operating expenses incentivize scale over competition, driving insurance industry consolidation?**

   Aetna's acquisition of Humana is about Medicare. Our decision to acquire Humana was not driven by the medical loss ratio (MLR). Rather, the goal of our transaction is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

2. **Do MLRs make market competition-driving high deductible health plans harder to provide, forcing insurers to avoid markets with greater moral hazard that may also have a greater need for higher administrative costs?**

   Current MLR rules can present challenges for issuers of high-deductible health plans (HDHPs), because of fixed expenses such as marketing and enrollment, that do not vary by how lean or rich the benefits are. So for a HDHP, those fixed expenses represent a higher percentage of claims and premiums than a lower-deductible plan.

Nevertheless, Aetna continues to offer HDHPs for our customers interested in health savings accounts (HSAs) and related savings vehicles, a market that continues to grow and to which Aetna remains committed.

3. Does this lack of competition result in higher health care costs for consumers? Will it do so in the future?

Aetna's acquisition of Humana is about Medicare, a market that is robust and very competitive. Aside from having to compete with traditional Medicare, in the over 3,000 counties across the country, there are 143 health care companies offering Medicare Advantage plans. New entrants continue to come into Medicare Advantage. Twenty-eight new health plans have joined over the last 3 years and beneficiaries have an average of 18 Medicare Advantage private plan options to choose from; even in non-metro (more rural) areas there is an average of 10 plan options to choose.

As noted above, the MLR is clearly a part of the regulatory landscape (including in Medicare Advantage) and it does bring associated compliance costs. And overall, the MLR also can also sometimes present a challenge to carriers seeking to reduce costs and innovate. However, in our experience, the MLR has not significantly compromised our ability to compete and to deliver savings to our customers through competitive pricing of quality products.

With respect to the Medicare Advantage program more broadly, Medicare Advantage plans, governed by the federal bidding process, are doing a good job keeping costs down. Monthly Medicare Advantage premiums are down 10 percent in 2016 from 2009.

Question for the Record from Senator Orrin Hatch for Mark T. Bertolini:

1. **The American Hospital Association has argued that the Aetna-Humana merger would increase the Herfindahl-Hirschman Index score for Medicare Advantage by over 200 points in 924 highly concentrated markets and by over 100 points in another 159 highly concentrated markets. Do you agree with those calculations? If not, why not? And if those calculations are correct, does that mean the merger will presumptively increase market power?**

   We recognize the provider trade associations in Washington, D.C. have expressed concerns about this deal. The AHA and AMA are large membership organizations that represent a diverse set of interests. But we have a different perspective, all health care is local. Aetna's acquisition of Humana is about Medicare, a market that is robust and full of competition. In fact, we believe these concerns are unfounded.

   Aetna has a track record of working in collaboration with dozens of forward-looking hospital systems and doctor groups to create better products for consumers based on value-based design. Many of these partners are likely members of the trade associations that have expressed concerns. In these partnerships, together, we align financial incentives to improve cost and quality for the population served.

   For example, Innovation Health in Virginia is an insurance plan offered by Aetna and Inova Health System. Our membership quadrupled in 2014 and we have been able to offer premiums that are three to five percent lower than other network plans in the area. We have improved health outcomes too, including a 27 percent reduction in C-section admissions and 86 percent engagement in complex case management.

   Similarly, Aetna's collaborations with the Memorial Herman Accountable Care Organization in Houston, Texas and Banner Health Network in Mesa, Arizona have also led to positive results including consistent membership growth — showing that this type of care model and health plan is resonating — and cost and quality improvements.

   As for the Herfindahl-Hirschman Index (HHI) scores estimated by the AHA, they require proper definition of geographic markets and product markets. This is a complicated process that we continue to work through with the Department of Justice. And even when HHIs are accurately calculated, they are a screening mechanism, and not determinative. The HHI screens create a safety zone, below which there are not likely to be any issues. If a transaction is above the screen, a more thorough analysis of documents, market facts, competitors, new entrants, products, geographies, costs, prices, innovation, and efficiencies, among other things, is necessary.

   Together, Aetna and Humana would have only 8 percent of all Medicare enrollment and 13 percent of all commercial enrollment once the transaction is complete. While I am confident competition will remain strong, even after our transaction, I would leave the detailed analysis and thorough review to the Department of Justice.

Question for Joseph R. Swedish, President & CEO, Anthem, Inc.

1. **The American Hospital Association has argued that the Anthem-Cigna merger would increase the Herfindahl-Hirschman Index score for commercial health insurance by over 200 points in 600 highly concentrated markets and by over 100 points in another 217 highly concentrated markets. Do you agree with those calculations? If not, why not? And if those calculations are correct, does that mean the merger will presumptively increase market power?**

   This question was not directed to Aetna.

Questions for the Record from Senator Patrick Leahy for Mark T. Bertolini

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

   Do you continue to support the permanent antitrust exemption for the health insurance industry? If so, what justification can you give this Committee for why it should continue to exist, and in particular, why it should exist on a permanent basis?

   While we understand the need to examine antitrust exemptions to see if they continue to serve the public interest, McCarran-Ferguson does not prevent the antitrust laws from being applied to our merger. Aetna does not believe that the McCarran-Ferguson Act, which provides an antitrust exemption for the "business of insurance," prevents or hinders the Department of Justice from investigating the antitrust implications of Aetna's proposed acquisition of Humana. The exemption under the Act is limited in many ways and the Department of Justice has investigated and brought many antitrust actions involving insurance providers in the past. We are complying with the Department of Justice's request for information regarding the Humana transaction.

Question for the Record for Joseph Swedish

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

   Do you continue to support the permanent antitrust exemption for the health insurance industry? If so, what justification can you give this Committee for why it should continue to exist, and in particular, why it should exist on a permanent basis?

   This question was not directed to Aetna.

Question for the Record for Paul Ginsburg

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the**

reauthorization process.

Is there any justification for leaving this permanent antitrust exemption in place in its current form?

This question was not directed to Aetna.

2. **Are there any concerns that you raised with respect to these particular mergers that could be exacerbated by leaving the permanent health insurance industry antitrust exemption in place?**

This question was not directed to Aetna.

Question for the Record for Leemore Danfy

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

Is there any justification for leaving this permanent antitrust exemption in place in its current form?

This question was not directed to Aetna.

2. **Are there any concerns that you raised with respect to these particular mergers that could be exacerbated by leaving the permanent health insurance industry antitrust exemption in place?**

This question was not directed to Aetna.

Question for the Record for Richard Pollack

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

Is there any justification for leaving this permanent antitrust exemption in place in its current form?

This question was not directed to Aetna.

2. **Are there any concerns that you raised with respect to these particular mergers that could be exacerbated by leaving the permanent health insurance industry antitrust exemption in place?**

   This question was not directed to Aetna.

Question for the Record for George Slover

1. **Since 1945, the insurance industry has enjoyed a permanent statutory exemption from the antitrust laws. I have long been skeptical of statutory exemptions from the antitrust laws because of the important role these laws play in protecting consumers and promoting competition. Permanent antitrust exemptions are particularly troublesome because they limit the Congressional oversight that comes as part of the reauthorization process.**

   Is there any justification for leaving this permanent antitrust exemption in place in its current form?

   This question was not directed to Aetna.

2. **In your view, what would be the impact on consumers if the permanent antitrust exemption for the health insurance industry is kept in place during a period of industry consolidation?**

   This question was not directed to Aetna.

Questions for the Record from Senator Mike Lee for Mark T. Bertolini

1. **Should your acquisition of Humana receive clearance from the Department of Justice and be consummated, will your customers see an increase or decrease in their premiums, deductibles, and/or co-pays?**

   Aetna's acquisition of Humana is about Medicare. The primary goal of the Humana transaction is to enable us to offer more consumers a broader choice of products and access to higher quality, more affordable care.

   After the transaction, we expect to achieve over $1 billion in cost savings each year. We expect that a significant portion of these savings will flow back to consumers in the form of more cost-effective high quality products offerings in more areas across the country. Our goal is to remove waste and duplicative administrative costs and use some of the savings to develop products to keep people healthier.

   We think it is worth noting that Medicare Advantage plans, governed by a federal bidding process, are already doing a good job keeping costs down. Monthly Medicare Advantage premiums are down 10 percent in 2016 from 2009 and this is a trend we think will continue.

2. **In your testimony, you mentioned pursuing greater affordability and higher quality for your health insurance products. What do you mean by "affordability," and what do you mean by "quality?"**

   Aetna decided to acquire Humana to enable us to offer better and more innovative products, simplify insurance, and improve the overall health care experience for more consumers. Consumers will have access to better consumer engagement, programs and services that utilize Humana expertise. Our goal is to increase our customers' number of "Healthy Days", as measured by the CDC metric. For example:

   Humana is a leader in delivering better care at a lower cost. For example:

   - Wellness and prevention programs (e.g., Humana Vitality, 12 percent lower health care costs and 15 percent lower absenteeism); and
   - Home health care (Humana at Home — 496,000 more member days at home in 2014)

   Meanwhile, Aetna is a leader in designing strong and dynamic relationships with high quality providers, including:

   - Memorial Herman (Texas), where through improved efficiencies, costs have been lowered for the self-insured population from 2013 to 2014 by, increasing the generic prescribing rate by 21.3 percent and reducing avoidable emergency room visits by 13.5 percent.

- Banner Health (Arizona) where medical costs for commercial membership were reduced by five percent, along with a nine percent decrease in avoidable admissions.

We will continue to compete on improved quality and cost but also want to win on consumer engagement. In short, more consumers will have a broader choice of products, access to higher quality and more affordable care.

3. In explaining why your merger with Humana is necessary to achieve the efficiencies and consumer benefits you expect, you identified the portability of health insurance plans and the need to enter new markets quickly and broadly in order to do so effectively. How does this square with your repeated assertion that "health care is local?"

Health care is local and what matters most to consumers are the plan options and providers available to them in their areas. Nowhere is this more evident than Medicare, where Medicare Advantage plans compete against traditional fee-for-service Medicare and each other in over 3,000 counties across the country. There are 143 health care companies offering Medicare Advantage plans, with new entrants coming into Medicare Advantage. Twenty-eight new health plans have joined over the last 3 years and beneficiaries have an average of 18 Medicare Advantage private plan options to choose from; even in non-metro (more rural) areas there is an average of 10 plan options to choose.

At the local level, providers are also starting their own health plans. For example, in Medicare Advantage of the 28 new entrants coming into the market over the last 3 years, 15 are owned by providers. This trend is continuing into the 2016 plan year — Johns Hopkins just announced it will offer a PPO with access to all of its providers, as well as thousands of others across Maryland. Similarly, Cone Health, a two-hospital system based in Greensboro, NY, recently announced that it will begin marketing a Medicare Advantage plan in 2016.

Our proposed transaction brings together Aetna and Humana's complementary capabilities in the highly competitive Medicare and commercial product segments, while diversifying Aetna's portfolio. Aetna's experience will make Humana's commercial business more effective and competitive. Similarly, Humana's capabilities will make Aetna's Medicare business more effective and competitive by allowing Aetna to offer Humana's award-winning care and service model to the rapidly growing Medicare population. In this way, the transaction will enable the combined company to enter new markets quicker and more effectively than either company could do separately.

Over the first three years of the transaction, we expect to achieve over $1 billion in cost savings each year that will help Aetna become more efficient and provide high quality affordable products. We expect that a significant portion of these savings will flow back to consumers through more cost-effective products. Our goal is to remove waste and duplicative administrative costs and use some of the savings to develop products to keep people healthier.

4. **In addition, does not this imply that there are significant barriers to entry in these markets?**

   We do not believe there are barriers to entry in the current environment. We think the combination of Aetna and Humana will actually enhance competition at the local level by giving consumers a strong alternative to Blue Cross Blue Shield plans and other competitors.

   In this way, this combination is actually strongly pro-competitive. Even after the acquisition, Aetna will continue to face significant competition from a large number of health plans and other new market entrants such as Accountable Care Organizations (ACOs) or start-up companies like Oscar. Oscar, which recently received additional investment from Google, has built a successful new model with a consumer-centric approach is focused on providing insurance through the exchanges in New York and New Jersey and plans to expand to other states.

   There has also been a rapid increase in provider-sponsored health plans, for example, in Medicare Advantage of the 28 new entrants coming into the market over the last 3 years, 15 are owned by providers. This trend is continuing into the 2016 plan year — Johns Hopkins just announced it will offer a PPO with access to all of its providers, as well as thousands of others across Maryland. Similarly, Cone Health, a two-hospital system based in Greensboro, NY, recently announced that it will begin marketing a Medicare Advantage plan in 2016. Further, Medicaid managed care plans, such as Centene, are expanding into Medicare Advantage and commercial business.

   Nationally, there are over 400 insurance companies in the commercial market. The most recent Government Accountability Office (GAO) report on state-level concentration in commercial health insurance indicates that, from 2010 – 2013, a Blue Cross Blue Shield insurer was the largest insurer in 44 states in the individual market, 38 states in the small group market, and 40 states in the large group market. Meanwhile, Aetna was the largest insurer in only one area (DC large group), and Humana was not the largest insurer in the commercial market in any area.

   We anticipate the transaction will enhance competition in the public exchanges as well, where options are increasing for eligible enrollees. On July 27, 2015, the Department of Health & Human Services (HHS) announced that 86 percent of individuals eligible to enroll in the exchanges had access to at least 3 issuers in 2015, up from 70 percent in 2014. Nearly 60 percent of counties experienced a net gain of at least one issuer, while only 8 percent of counties experienced a net loss of issuers.

5. **What are the product and geographic market overlaps between your business and Humana's, and what is your company willing to do to address them?**

   Identifying and measuring the extent of any product or geographic overlap between Aetna and Humana is a complex, fact-intensive exercise and is a process we will work

through with the Department of Justice as part of its investigation of Aetna's proposed acquisition of Humana. There are many distinct insurance products and the relevant geographic areas of overlap may vary based upon the insurance products or consumers involved.

In the case of most products and geographies, there is little or no overlap between Aetna and Humana. Where the parties offer the same products in the same geography there are often numerous competitors. Even where the parties offer the same product, Aetna and Humana tend to have different focuses. For example, in commercial insurance offered to employer groups, Aetna's business focuses on large multi-site self-insured customers whereas Humana's business is focused on small fully-insured local employers. The transaction between Aetna and Humana combines companies that are highly complementary.

The combined company will continue to face significant competition from a large number of competitors. Employers and individual customers have a growing number of choices. This deal is primarily about Medicare and in the Medicare Advantage market there 143 companies offering plans in 2015. And more companies are entering this market each year. In Medicare Advantage of the 28 new entrants coming into the market over the last 3 years, 15 are owned by providers. Ninety-four percent of Medicare beneficiaries already choose from at least five Medicare Advantage plan options, in addition to traditional Medicare. After this combination, Aetna-Humana will still only account for about eight percent of the total Medicare market.

Humana represents less than 2 percent of the commercial market and Aetna less than 12 percent. The commercial market will remain basically unchanged after the transaction. In the commercial segment, there are a number of significant competitors, including United, Anthem, HCSC, Cigna, Highmark, Centene, CareFirst, other local Blue Cross Blue Shield plans, Emblem Health, Kaiser, and provider-based plans. Some of the largest and most prestigious health systems are entering the insurance business. On the 8 public exchanges where Aetna and Humana both participate, there are on average 10 other insurers (at least five other participating issuers in each state). A growing number of employers also are turning to new private health care exchanges offered by large benefits consultants such as Towers Watson and Mercer.

This transaction is subject to a lengthy, careful and thorough investigation by the Department of Justice and State Attorneys General. As the analysis continues to develop, if necessary, we are amenable to discussing appropriate remedies to resolve potential competitive concerns.

6. **As I'm sure you're aware, federal regulations and legislation have imposed a complex set of restrictions and requirements upon your business. Between actuarial value measures, community rating, age bands, guaranteed issue, and medical loss ratios, how does your business set itself apart from the competition?**

   Whether it's the Affordable Care Act, the Medicare Prescription Drug benefit, or another government program, our job is to follow the law and provide affordable, high quality, health products to consumers.

   The health care industry is rapidly transforming amid a highly competitive environment where a number of new companies have entered the market, providing consumers with more choice than ever before. As a result of these industry-wide changes, a new economic model is emerging for health insurers.

   Competing on price alone is no longer enough. Instead, consumer engagement will be key, especially as more individuals move from employer-based insurance to the individual market, where the consumer will determine where and how to access the health care system. We believe that to be successful, insurers will need to compete on price, but will win on how effectively they engage consumers to help keep them healthy and make it easier to navigate the health care system.

   Our proposed transaction brings together Aetna and Humana's complementary capabilities in the highly competitive Medicare and commercial product segments while diversifying Aetna's portfolio. Aetna's experience will make Humana's commercial business more effective and competitive. Similarly, Humana's capabilities will make Aetna's Medicare business more effective and competitive by allowing Aetna to offer Humana's award-winning care and service model to the rapidly growing Medicare population.

   Together, we will be better positioned to deliver a consumer-centric experience and when it comes time to re-enroll customers decide to choose Aetna because they experienced superior best-in-class service.

Question for the Record for Joseph Swedish:

1. **Should your acquisition of Cigna receive clearance from the Department of Justice and be consummated, will your customers see an increase or decrease in their premiums, deductibles, and/or co-pays?**

   This question was not directed to Aetna.

2. **In your testimony, you mentioned pursuing greater affordability and higher quality for your health insurance products. What do you mean by "affordability," and what do you mean by "quality?"**

   This question was not directed to Aetna.

3. **In explaining why your merger with Cigna is necessary to achieve the efficiencies and consumer benefits you expect, you identified the length of time it would take to enter markets individually, as opposed to all-at-once through the acquisition, and constantly changing consumer demand as reasons for the deal. Are not these concerns significant barriers to entry for potential competitors?**

   This question was not directed to Aetna.

4. **What are the product and geographic market overlaps between your business and Cigna's, and what is your company willing to do to address them?**

   This question was not directed to Aetna.

5. **As I'm sure you're aware, federal regulations and legislation have imposed a complex set of restrictions and requirements upon your business. Between actuarial value measures, community rating, age bands, guaranteed issue, and medical loss ratios, how does your business set itself apart from the competition?**

   This question was not directed to Aetna.

6. **Do you believe there is a national market for commercial health insurance plans, ASO plans, or any other product? If so, how will Anthem and Cigna's merger effect competition in those markets?**

   This question was not directed to Aetna.

Question for the Record for Leemore Dafny:

1. **Defenders of the Aetna/Humana and Anthem/Cigna mergers have identified several new entrants in the health insurance industry as evidence of the ease and likelihood of entry. What is your view of these entrants? Do they actually compete with the merging parties? Are they likely to impose any competitive restraint on them? Are they likely to survive long-term?**

   This question was not directed to Aetna.

2. **Utah is home to strong regional competition in the health insurance space, especially from companies such as Intermountain Healthcare/SelectHealth. Do you believe the proposed mergers may result in lower payments to providers, which the providers may seek to cost-shift to such regional health plans?**

   This question was not directed to Aetna.

Question for the Record for Paul Ginsburg:

1. **Defenders of the Aetna/Humana and Anthem/Cigna mergers have identified several new entrants in the health insurance industry as evidence of the ease and likelihood of entry. What is your view of these entrants? Do they actually compete with the merging parties? Are they likely to impose any competitive restraint on them? Are they likely to survive long-term?**

   This question was not directed to Aetna.

2. **Utah is home to strong regional competition in the health insurance space, especially from companies such as Intermountain Healthcare/SelectHealth. Do you believe the proposed mergers may result in lower payments to providers, which the providers may seek to cost-shift to such regional health plans?**

   This question was not directed to Aetna.

Question for the Record for George Slover:

1. **What is your view of the necessity for the parties to merge in order to realize the benefits and efficiencies they claim will result from the transactions?**

   This question was not directed to Aetna.

2. **How do consumers view "affordability" and "quality" when shopping for health insurance? What do consumers value when selecting a health insurance plan?**

   This question was not directed to Aetna.