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-01494-JDB

HUMANA INC.'S ANSWER TO PLAINTIFFS' COMPLAINT

Defendant Humana Inc. ("Humana") responds to the allegations of the Complaint as set forth below. Any allegation not expressly and explicitly admitted is denied. Humana also states that, except to the extent indicated below, it lacks knowledge or information sufficient to form a belief about the truth or falsity of allegations that relate to the actions, statements, or intent of Aetna Inc. ("Aetna") or third parties, and therefore denies them. Humana reserves the right to amend this Answer.

I. GENERAL RESPONSE

Humana's proposed merger with Aetna is procompetitive and will provide significant benefits to consumers. The transaction will combine two complementary companies whose strengths lie in very different sectors of the health insurance business: Aetna focuses largely on the sale of employer sponsored health benefit plan products, while Humana focuses largely on the sale of individual Medicare products. The combined company will be better positioned to offer its customers a broad array of healthcare products and services that are more affordable, higher quality, more technology-driven, and the result of increased innovation. As the

Complaint confirms, "insurers 'are under continued competitive pressure to improve their benefits, reduce their premiums and cost sharing, and improve their networks and services.'" (¶13). This transaction seeks to—and will—achieve those goals.

Nonetheless, Plaintiffs have contested the merger, alleging that it would result in anticompetitive harm in alleged individual Medicare Advantage and public exchange markets in selected geographies. But Plaintiffs' legal theory and purported competitive assessments are grounded in—and depend entirely on—fundamental misconceptions of the marketplace realities.

By positing Medicare Advantage as its own relevant market, for example, Plaintiffs omit traditional Medicare and private insurers' supplemental and drug benefit products that compliment, despite alleging that "Medicare Advantage provides all the insurance coverage of traditional Medicare," and is a "market-based alternative to traditional Medicare." (¶¶ 2, 21). In fact, the undeniable market realities reveal the fallacy of Plaintiffs' contrived market definition. As the Complaint acknowledges, "Americans 65 or older and other Medicare-eligible individuals can enroll in traditional Medicare" or they may "instead choose Medicare Advantage." (¶¶ 20, 21). And the Centers for Medicare & Medicaid Services ("CMS"), the agency that administers the Medicare program, presents Medicare Advantage and traditional Medicare plans as equally available options for seniors aging into the program, and confirms that the two are functionally interchangeable substitutes. CMS states in its Medicare handbook that "[a] Medicare Advantage Plan (like an HMO or PPO) is another way to get your Medicare coverage." "If you join a Medicare Advantage Plan, *you'll still have Medicare* but you'll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not Original Medicare." In other words, the Medicare program is designed to deliver an array of benefits and options to seniors through two different channels. The products

available in each channel are highly substitutable and are in constant competition, as evidenced by the fact that participants can switch back and forth between the two.

These realities were recognized by certain state regulators in the context of reviewing the proposed transaction. For example, the state of Florida's insurance regulators found that "Medicare Advantage, the private market product, competes directly with traditional Medicare. Accordingly, when considering the impact of the acquisition, the private market is only a portion of the Medicare market." Similarly, when the Illinois Department of Insurance approved the transaction in June 2016, its order found that "Medicare Advantage insured are not confined to remain in a Medicare Advantage plan, and may choose to return to traditional Medicare if they were to become dissatisfied with their Medicare Advantage plan in the future."

Indeed, going back to the origins of the Medicare Advantage program's predecessor program under the TEFRA law passed in 1982, the Health Care Financing Administration (the predecessor to CMS) expressly affirmed that the new alternative to traditional Medicare would be in direct competition with the fee-for-service health care delivery and financing scheme under traditional Medicare and would put competitive pressure on health care providers operating under the traditional model:

> [T]the main effect of the new program will be on those particular Medicare beneficiaries who make a conscious decision to enroll in HMOs. The program, by removing a barrier to such choices, is pro-competitive in its effects, and is expected to increase consumer satisfaction. As a result of increased competition we expect that other Medicare beneficiaries will also benefit from increased responsiveness of the fee-for-service sector to their needs.

Medicare Program; Payment to Health Maintenance Organizations and Competitive Medical Plans, 49 Fed. Reg. 22,214 (May 25, 1984).

The Affordable Care Act expanded coverage for wellness and preventive care benefits offered under traditional Medicare (such as the Diabetes Prevention Program) with no

copayments or deductibles, mirroring additional coverage that has long been provided by many health plans under the Medicare Advantage program. And the creation of accountable care organizations and bundled payment care improvement initiatives within the traditional Medicare coverage option, also pursuant to the Affordable Care Act, are bringing coordinated and network-based care delivery to enrollees under traditional Medicare, further sharpening the direct competition among alternative coverage options for Medicare beneficiaries. This is the very definition of two products functioning in the same product market. Once the market is properly defined, the core of Plaintiffs' case crumbles.

There are other dispositive problems with Plaintiffs' allegations regarding Medicare Advantage products. For one, the proliferation of diverse organizations entering the Medicare market, and the ease with which they do, means that any attempt to impose above-market pricing would be defeated. For another, CMS regulates Medicare Advantage Organizations' ("MAOs") offerings, including the prices for the benefits they provide, the prices they charge, and the profit margins they realize. And, as a result of the regulatory bidding process, the competitive landscape has been locked-in for 2017. Plaintiffs' assertions about what might happen post-transaction in 2018 and beyond in this highly dynamic marketplace therefore become all the more speculative.

Plaintiffs' claims with respect to the public exchange segment are also highly speculative. The Complaint overstates both the current levels, and the sustainability, of competition among insurers. The public exchange segment is highly volatile, and current enrollment is not a valid predictor of future competitive significance or market success, making any projections of competitive harm theoretical at best. Uncertainties about the risk pool to be served, the government subsidies for coverage that can drive extreme shifts in enrollment across plans from

year to year, and regulatory limits on administrative costs and profits have made this business exceptionally risky for insurers. Humana has been losing and continues to lose enormous amounts of money in the business, and is now necessarily independently considering various options to mitigate these losses, including cutting back or discontinuing altogether its public exchange products. Based on publicly available information, other insurers are also losing money in the business and are considering similar options. For example, UnitedHealthcare ("United") has announced that it is discontinuing its public exchange business in a number of geographies. As a result, market shares—and the cast of participating insurers—will look very different year over year until the segment stabilizes, and current market shares provide no indication of future competition. Plaintiffs' reliance on the current market as a barometer for future competition is without merit, and will fail at trial.

Ultimately, Plaintiffs' claims are unsupportable, and Plaintiffs will be unable to carry their burden of proof at trial. In addition to the inherent shortcomings in Plaintiffs' allegations, the Defendants have agreed to divest their Medicare Advantage business to Molina Healthcare Inc. ("Molina") in each of the geographies where Plaintiffs have raised competitive concerns. Molina is a sophisticated insurer with billions of dollars in annual revenue and experience in administering Medicare Advantage plans. There simply is no basis for enjoining the transaction. Indeed, the market for health insurance is robust, and is continually evolving and expanding. As the Complaint acknowledges, companies are "under continued competitive pressure" to offer the best products at the most affordable prices. Through this transaction, the merged company seeks to do just that. The transaction is procompetitive and will provide consumers with the very benefits that Plaintiffs suggest that they are trying to protect.

II. INTRODUCTORY ALLEGATIONS

1. Humana denies the allegations in Paragraph 1.

2. Humana admits that Medicare Advantage is a market-based alternative to traditional Medicare. Humana admits that it competes with numerous other entities, including Aetna, in certain geographies to sell Medicare Advantage plans. Humana admits that it competes with numerous other entities, including Aetna, in certain geographies to sell health insurance on the public exchanges established by the Affordable Care Act. Humana admits that competition among Medicare Advantage plans and traditional Medicare coverage options, as well as competition for health insurance offered through public exchanges, benefits consumers, including those with low to moderate income levels. Humana states that the transaction would result in improved healthcare products and services, at more affordable prices. Humana denies the remaining allegations in Paragraph 2.

3. Humana lacks knowledge or information sufficient to form a belief about the truth of the allegations in Paragraph 3 regarding the purchasing habits of seniors and low- and moderate- income individuals and therefore denies those allegations. Humana admits that it seeks to provide lower premiums, improved benefits, an attractive network of doctors and hospitals, and effective care management. Humana denies the remaining allegations in Paragraph 3.

4. Humana admits that it, Aetna, Anthem, United and Cigna are at times called the "big five" and that Humana's CEO has referred to the group of insurers as "G-5." Humana admits that Aetna proposes to acquire Humana for $37 billion. Humana admits that Anthem, through public statements, has represented that it seeks to acquire Cigna for $54 billion. Humana admits that it seeks ways to lower healthcare costs to consumers, and confirms that this transaction seeks to create an entity capable of reducing healthcare costs while improving the quality of care. Humana lacks knowledge or information sufficient to form a belief about the

truth of the allegations in Paragraph 4 regarding what others in the industry are doing with health care costs and therefore denies those allegations. Humana admits that in the event that Humana merges with Aetna and Cigna merges with Anthem, the five separate companies that previously operated as Aetna, Anthem, Cigna, Humana, and United will numerically become three. Humana denies the remaining allegations in Paragraph 4.

5. Humana states that Plaintiffs' Complaint speaks for itself, and no response is required for the first two sentences of Paragraph 5. Humana denies the remaining allegations in Paragraph 5.

6. Humana admits that Congress created the Medicare Advantage program (then known as Medicare + Choice) in 1997, as a modified version of previously established private Medicare plan coverage options, for the stated purpose of offering seniors a market-based alternative to traditional Medicare. The Medicare Advantage program continues to serve as a market-based alternative to traditional Medicare. Humana admits that both it and Aetna offer Medicare Advantage plans in various geographies. Humana admits that it has been growing its Medicare Advantage offerings. Humana lacks knowledge or information sufficient to form a belief about the truth of the allegations in the last sentence of Paragraph 6 about Aetna and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 6.

7. Humana admits that it was one of the first insurers to enroll seniors in Medicare Advantage. Humana admits that it is the second-largest Medicare Advantage insurer in the country, as measured by the total number of enrollees. Humana admits that it continually has sought to grow and improve its Medicare Advantage business and that it projected continued enrollment in its Medicare Advantage business. Humana denies the remaining allegations in Paragraph 7.

8. Humana lacks knowledge or information sufficient to form a belief about the truth of the allegations in Paragraph 8 and therefore denies those allegations.

9. Humana admits the allegations in the second sentence of Paragraph 9. Humana admits that that it competes with numerous other health insurers, including Aetna, to enroll seniors in Medicare Advantage plans in various geographies. Humana admits that a Humana executive has described Aetna as a "formidable competitor" in certain geographies. Humana lacks information sufficient to form a belief about the truth of the allegations that Aetna has described Humana as a "formidable competitor" and therefore denies that allegation. Humana denies the remaining allegations in Paragraph 9.

10. Humana admits that individual Medicare Advantage products serve approximately 1.7 million seniors, nearly 980,000 of whom are enrolled with Aetna or Humana, in the 364 counties listed in the Appendix to the Complaint. Humana denies the remaining allegations in Paragraph 10.

11. Humana denies the allegations in Paragraph 11.

12. Humana denies the allegations in Paragraph 12.

13. Humana admits that CMS has stated in at least one document that insurers "are under continued competitive pressure to improve their benefits, reduce their premiums and cost sharing, and improve their networks." Humana denies the remaining allegations in Paragraph 13.

14. Humana states that the allegations in the third and fourth sentences of Paragraph 14 are conclusions of law to which no response is required. To the extent a response is required, Humana denies the allegations set forth in the third and fourth sentences of Paragraph 14. Humana denies the remaining allegations in Paragraph 14.

III. THE DEFENDANTS AND THE MERGER

15. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 15 regarding Aetna and therefore denies those allegations.

16. Humana admits that it is the nation's fifth-largest [for profit] health insurance company and the second-largest Medicare Advantage insurer, as measured by total number of enrollees. Humana admits that its revenue for the 2015 fiscal year was approximately $54.3 billion and that it operates in every state and the District of Columbia. Humana admits that its government-sponsored products account for over 75 percent of its revenue. Humana lacks information sufficient to form a belief about the truth of the allegations in the fourth sentence of Paragraph 16 regarding the number of enrollees added by other Medicare Advantage plans and therefore denies those allegations.

17. Humana admits that it had discussions with Aetna beginning in March 2015 regarding a potential transaction, and that Humana entered into an agreement with Aetna on July 2, 2015 through which Aetna would acquire Humana for approximately $37 billion in cash and stock. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations regarding Aetna in the second sentence of Paragraph 17 and therefore denies those allegations. Humana admits that Anthem has represented that on July 23, 2015, it agreed to acquire Cigna for $54 billion.

18. Humana admits that the terms of its Agreement and Plan of Merger with Aetna provide that Aetna will pay a $1 billion break-up fee to Humana if the merger is not consummated on or by December 31, 2016, but denies that such a provision in any way evidences any recognition by Humana that the merger is anticompetitive. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations relating to

Aetna in the second, third, and fourth sentences of Paragraph 18 and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 18.

IV. THE MERGER WILL NOT SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF MEDICARE ADVANTAGE PLANS

19. Humana admits that it currently offers Medicare Advantage in nearly 90 percent of the counties where Aetna represents that it offers Medicare Advantage. Humana denies the remaining allegations in Paragraph 19.

20. Humana admits the allegations in Paragraph 20 to the extent they generally describe some of the options available to Medicare-eligible individuals. Humana denies that the allegations describe all of the options available to such individuals.

21. Humana admits that some seniors choose to enroll in Medicare Advantage rather than traditional Medicare, and admits that Congress introduced the Medicare Advantage program (then known as Medicare + Choice) in 1997, as a continuation of predecessor private Medicare plan alternative programs, for the stated purpose that it would allow private plans offering Medicare Advantage products to compete with fee-for-service health care delivery and coverage under traditional Medicare. Humana admits that enrollment in Medicare Advantage has more than tripled since 2004. Humana admits that Medicare Advantage provides insurance coverage that seniors could otherwise obtain through traditional Medicare options. Humana admits that in some cases Medicare Advantage plans provide additional benefits which traditional Medicare itself does not, including those listed at the end of the fourth sentence of Paragraph 21. Humana admits that Medicare Advantage insurers contract with networks of doctors and hospitals. Humana denies the remaining allegations in Paragraph 21.

22. Humana admits the allegations in the second sentence of Paragraph 22. Humana admits that, among the Medicare-eligible population, some view Medicare Advantage plan as the

best option for their health insurance needs, while others see traditional Medicare, or traditional Medicare accompanied by a Medicare Supplement ("MedSupp") and/or Prescription Drug Plan ("PDP"), as the superior option. Indeed, beneficiaries choose between Medicare Advantage and traditional Medicare for the same purpose—to obtain Medicare benefits and access to health care services—so recipients view them as functionally-interchangeable substitutes. Humana denies the remaining allegations in Paragraph 22.

A. Medicare Advantage is not a relevant product market.

23. Humana states that the first, second, and third sentences in Paragraph 23 are conclusions of law to which no response is required. To the extent a response is required, Humana denies the allegations in the first, second, and third sentences in Paragraph 23. Humana states that Plaintiffs have the burden of establishing relevant product and geographic markets. Humana denies that the sale of Medicare Advantage plans is a relevant product market and line of commerce under Section 7 of the Clayton Act. With respect to the fourth sentence of Paragraph 23, Humana states that the Complaint speaks for itself, and therefore no response is required to the fourth sentence of Paragraph 23.

24. Humana admits that certain attributes of Medicare Advantage and traditional Medicare differ in that traditional Medicare is administered by the government. Humana admits that individuals enrolled only in traditional Medicare must pay certain annual deductibles and coinsurance payments for certain services, including physician and outpatient services. Humana admits that traditional Medicare itself does not include a limit on how much enrollees could pay out-of-pocket annually. Humana admits that enrollees in traditional Medicare can supplement the coverage it provides by purchasing MedSupp Plans, which cover out-of-pocket expenses, and/or PDPs, which provide coverage for prescription drugs. Humana admits that MedSupp and PDP plans are sold by private insurance companies, including Aetna and Humana. Despite some

differing attributes of each form of coverage, customers nonetheless view Medicare Advantage and traditional Medicare as substitutes for one another. Humana denies the remaining allegations in Paragraph 24.

25. Humana admits that a stated purpose of the Medicare Advantage program is to create competition between and among traditional Medicare, and fee-for-service health care providers operating within that program, and private firms selling Medicare Advantage plans that provide or arrange for health care services. Humana admits that MAOs receive funding from CMS and the amount of that funding is tied in part to the amount it would cost to cover a patient under traditional Medicare. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in the sixth sentence of Paragraph 25 regarding the purported ease with which seniors can navigate the various plans and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 25.

26. Humana denies the allegations in Paragraph 26.

27. Humana admits that the total number of Medicare Advantage enrollees and the percentage of Medicare-eligible individuals enrolled in Medicare Advantage plans both have grown in the last several years. Humana admits that there have been funding cuts to Medicare Advantage programs that will be fully phased in by 2017. Humana denies the remaining allegations in Paragraph 27.

28. Humana admits that it has different business units for its Medicare Advantage plans and its MedSupp plans. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 28 regarding the beliefs of Aetna and other insurers and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 28.

29. Humana states that the allegations in Paragraph 29 are conclusions of law to which no response is required. To the extent a response is required, Humana denies the allegations in Paragraph 29.

B. The merger will not harm seniors or other consumers in any geographic market.

30. Humana admits that it competes with various other health insurers, including Aetna, to enroll consumers in Medicare Advantage plans in various geographies in the United States. Humana admits that CMS allows individual beneficiaries to enroll only in those Medicare Advantage plans that have been approved for the county in which the enrollee lives. Humana states that the fourth sentence in Paragraph 30 is a conclusion of law to which no response is required. To the extent a response is required, Humana denies the allegations in the fourth sentence of Paragraph 30. Humana denies the remaining allegations in Paragraph 30.

C. The merger is not presumptively unlawful.

31. Humana states that the allegations in Paragraph 31 are conclusions of law to which no response is required. To the extent a response is required, Humana denies the allegations in Paragraph 31.

32. Humana denies the allegations in the first sentence of Paragraph 32. Humana denies the remaining allegations in Paragraph 32 on the basis that both Humana and Aetna have entered into an agreement to divest to Molina, Medicare Advantage assets in all 364 counties identified in the Appendix to the Complaint.

33. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegation in the third and fourth sentences of Paragraph 33 regarding Aetna's plans for 2017 and its expansion plans, and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 33.

D. The merger will not harm seniors or other consumers by eliminating competition to sell Medicare Advantage plans.

34. Humana admits that in certain geographies it competes with various other health insurers, including Aetna, and traditional Medicare options, to attract individuals to enroll in its Medicare Advantage plans in a variety of ways. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 34 regarding the specific manner in which Aetna competes and therefore denies those allegations. Humana states that the last sentence in Paragraph 34 is a conclusion of law to which no response is required. To the extent a response is required, Humana denies the allegations in the last sentence of Paragraph 34.

35. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 35 regarding statements made by Aetna and therefore denies those allegations. Plaintiffs' selective quotation of certain statements by Humana, offered without context, is misleading as framed in the Complaint and is therefore denied. Humana denies the remaining allegations in Paragraph 35.

36. Humana admits that in certain geographies it competes with other health insurers, including Aetna, and traditional Medicare options, by, among other things, seeking to keep premiums, maximum out-of-pocket costs, and the amounts of copayments and coinsurance low. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 36 regarding the specific manner in which Aetna competes and therefore denies those allegations. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations regarding Aetna in the second and third sentences of Paragraph 36 and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 36.

37. Humana admits that in certain geographies it competes with other health insurers, including Aetna, and traditional Medicare options, by, among other things, offering various wellness and care management programs. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 37 regarding the specific manner in which Aetna competes and therefore denies those allegations. Humana admits that it has invested in programs to keep seniors healthier and in their own homes longer. Humana admits that it works with doctors and hospitals to improve quality of care and to reduce costs by improving patients' health. Humana admits that its Transcend subsidiary provides doctors and hospitals with technology to share health data across various platforms, which helps healthcare providers to effectively coordinate care, identify health issues sooner, and reduce unnecessary treatment. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in the third and fourth sentences of Paragraph 37 regarding Aetna or its Healthagen subsidiary and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 37.

38. Humana admits that in certain geographies it competes with other health insurers, including Aetna, and traditional Medicare options, by, among other things, seeking to offer high quality plans. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 38 regarding the specific manner in which Aetna competes and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 38.

39. Humana admits that CMS provides certain financial benefits to plans that earn ratings of four stars or higher, but states that CMS also provides certain financial benefits to new plans and to plans that earn ratings of 3.5 stars or higher. Star ratings are one of many sources of information available to consumers regarding Medicare products, and seniors appear to give little

consideration to star ratings when choosing plans. Likewise, there is no direct correlation between star ratings and enrollment, and in some cases lower rated plans have more enrollment than higher rated plans and vice versa. Humana admits that insurers must apply part of any bonus payment to offer various benefits. Humana denies the remaining allegations in Paragraph 39.

40. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in the fourth and fifth sentences in Paragraph 40 and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 40.

41. Humana admits that, pursuant to 42 CFR 422 and subject to its terms, Humana receives certain bonus payments from CMS based on Humana's offering certain plans with at least a four star rating. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in the first and fourth sentences in Paragraph 41 regarding Aetna and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 41.

V. THE MERGER WILL NOT SUBSTANTIALLY LESSEN COMPETITION FOR THE SALE OF HEALTH INSURANCE ON THE PUBLIC EXCHANGES

42. Humana admits that it began selling insurance on public exchanges in 2014 and that it now sells insurance on such exchanges in 15 states. Humana admits that it currently sells insurance on exchanges in certain counties where Aetna represents that it also sells insurance on public exchanges, but states that Aetna has announced that beginning in 2017, it will no longer sell insurance on exchanges in any of those counties. Humana denies the remaining allegations in Paragraph 42.

43. Humana admits that the competitive landscape in the provision of health insurance on public exchanges is changing. Humana admits that United recently announced plans to exit most public exchanges next year. Humana admits that it recently decided to reduce

its public exchange offerings, including exiting a number of states and discontinuing plans in many counties. To the extent the Complaint is alleging that Humana's decisions were made in concert with Aetna or to affect any antitrust proceedings in connection with the merger, Humana denies the allegation. Humana admits that it currently plans to offer plans on public exchanges in certain states in 2017. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in the fifth and sixth sentences in Paragraph 43 regarding Aetna and therefore denies those allegations. Plaintiffs' selective quotation of certain statements by Humana's CEO in the seventh sentence of Paragraph 43, offered without context, is misleading as framed in the Complaint and is therefore denied. Humana denies the remaining allegations in Paragraph 43.

44. Humana states that the first sentence in Paragraph 44 is a conclusion of law to which no response is required. To the extent a response is required, Humana denies the allegations in the first sentence of Paragraph 44. Plaintiffs have the burden of establishing relevant product and geographic markets. Humana admits the allegations in the second, third, and fourth sentences of Paragraph 44.

45. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 45 regarding Aetna and other insurers and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 45.

46. Humana states that the first sentence in Paragraph 46 is a conclusion of law to which no response is required. To the extent a response is required, Humana denies the allegations in the first sentence of Paragraph 46. Humana admits that tax credits and cost-sharing reductions are available to some individuals who purchase insurance through public exchanges. Humana admits that 85 percent of consumers who purchase health insurance on

public exchanges receive some financial assistance. Humana denies the remaining allegations in Paragraph 46.

47. Humana admits that it currently competes with numerous other health insurers, including Aetna, to enroll customers in public exchange plans in certain counties in the United States, but states that Aetna has announced that beginning in 2017, it will no longer sell insurance on public exchanges in any of those counties. Humana admits the allegations in the second, third, and fourth sentences of Paragraph 47. Humana states that the allegations in the fifth sentence of Paragraph 47 (including its sub-parts) are conclusions of law to which no response is required. To the extent a response is required, Humana denies the allegations in the fifth sentence of Paragraph 47.

48. Humana admits that it recently decided to stop offering plans on public exchanges in certain counties. To the extent the Complaint is alleging that Humana's decisions were made in concert with Aetna or to affect any antitrust proceedings in connection with the merger, Humana denies the allegation. Humana states that the allegations in the third sentence of Paragraph 48 are conclusions of law to which no response is required. To the extent a response is required, Humana denies the allegations in the third sentence of Paragraph 48. Humana denies the remaining allegations in Paragraph 48.

49. Humana denies that United's recently announced exit from public exchanges in certain counties necessarily will reduce the number of competitors in those counties because the number of insurers offering plans in such counties in 2017 is not yet known. Humana denies the remaining allegations in Paragraph 49.

50. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 50 regarding statements and views of Aetna and therefore denies

those allegations. Plaintiffs' selective quotation of certain statements by Humana in Paragraph 50, offered without context, is misleading as framed in the Complaint and is therefore denied. Humana denies the remaining allegations in Paragraph 50.

51. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in the first and second sentences of Paragraph 51 regarding statements and views of Aetna and therefore denies those allegations. Humana admits that its CEO made the statements attributed to him in the second sentence of Paragraph 51. Humana denies the remaining allegations in Paragraph 51 as Aetna has announced that beginning in 2017, it will no longer offer insurance on public exchanges in Florida, Georgia, or Missouri.

52. Humana states that the allegations in the third sentence of Paragraph 52 are conclusions of law to which no response is required. To the extent a response is required, Humana denies the allegations in the third sentence of Paragraph 52. Humana denies the remaining allegations in Paragraph 52.

VI. LOW BARRIERS TO ENTRY INTO THE HEALTH INSURANCE BUSINESS WILL PERMIT OTHER HEALTH INSURERS TO COMPETE WITH THE MERGED COMPANY

53. Humana denies that the proposed merger will result in any anticompetitive effects. Competition among health insurers is robust, and dynamic and widespread entry by new firms and expansion by existing firms only serves to further enhance competition. Diverse firms—including healthcare systems, health insurers offering Medicare Advantage plans in other geographies, and health insurers that did not previously offer Medicare Advantage plans but offered other products in particular geographies—have entered geographic markets for Medicare Advantage in the past five years and have remained successful, including growing market share and winning business. Barriers to entry for potential entrants are low, especially for the numerous existing firms that already possess many or most of the assets required to enter. New

entry will be timely, likely, and sufficient in its magnitude, character and scope to deter or counteract any competitive effects of concern.

54. Humana denies the allegations in Paragraph 54.

VII. THE PROPOSED REMEDY ADDRESSES THE PLAINTIFFS' COMPETITIVE CONCERNS

55. Humana states that the allegations in Paragraph 55 are conclusions of law to which no response is required. To the extent a response is required, Humana denies the allegations in Paragraph 55.

56. Humana admits that Aetna and Humana proposed divesting portions of each's Medicare Advantage business in a good faith attempt to address concerns by Plaintiffs that the merger would have anticompetitive effects. Humana denies that the merger in fact would have any such anticompetitive effects and denies that its proposed divestiture was an express or implied admission of any such anticompetitive effects. Humana denies the remaining allegations in Paragraph 56 and confirms that, on August 2, 2016, Humana and Aetna entered into definitive agreements with Molina through which Humana or Aetna will divest certain Medicare Advantage assets (the "Divestiture Transactions"). Through the Divestiture Transactions, Molina will gain approximately 290,000 Medicare Advantage enrollees in all 21 states in which Plaintiffs have alleged anticompetitive effects relating to the merger. With the exception of two counties from which Aetna represents that it already had planned to withdraw, the Divestiture Transactions will cover all of the counties identified in the Appendix to the Complaint, as well as certain additional counties. Following the Divestiture Transactions, either Aetna or Humana will not have individual Medicare Advantage enrollees in each of the counties in the Appendix to the Complaint. The Divestiture Transactions are subject only to the successful completion of Aetna's acquisition of Humana, CMS approvals, and customary closing conditions.

57. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 57 regarding purported statements made by Aetna and therefore denies those allegations. Humana denies the remaining allegations in Paragraph 57. Medicare Advantage enrollees affected by the Divestiture Transactions will remain in the exact same plans they selected, with the same benefits and access to the same healthcare providers; only the owner of that plan will change. Moreover, those enrollees will not be able to "simply switch[] back to the Aetna or Humana plan they had originally chosen" because that exact plan will be owned by Molina pursuant to the Divestiture Transactions.

58. Humana denies that allegations in Paragraph 58.

59. Humana denies the allegations in Paragraph 59.

60. Humana denies the allegations in Paragraph 60.

61. Humana denies the allegations in Paragraph 61.

VIII. VIOLATION ALLEGED

62. Humana admits that the United States purports to bring this action under Section 15 of the Clayton Act and that the United States purports to seek to prevent and restrain Defendants from violating Section 7 of the Clayton Act. Humana denies that the merger violates the Clayton Act in any way and further denies the remaining allegations in Paragraph 62.

63. Humana admits that the Plaintiff states purport to bring this action as *parens patriae* pursuant to Section 16 of the Clayton Act and that the Plaintiff states purport to seek to prevent Defendants from violating Section 7 of the Clayton Act. Humana denies that the merger violates the Clayton Act in any way and further denies the remaining allegations in Paragraph 63.

64. Humana states that the allegations in the first sentence of Paragraph 64 are conclusions of law to which no response is required. Humana admits that it sells health insurance to customers located throughout the United States and that its insurance covers some

enrollees when they cross state lines. Humana lacks knowledge or information sufficient to form a belief as to the truth of the allegations relating to Aetna and therefore denies those allegations.

65. Humana states that the allegations in the first sentence of Paragraph 65 are conclusions of law to which no response is required. Humana admits that it transacts business in this district.

66. Humana states that the allegations in the first sentence of Paragraph 66 are conclusions of law to which no response is required. Humana admits that it transacts business in this district.

67. Humana denies the allegations in Paragraph 67.

68. Humana admits that, post-merger, Humana and Aetna would not offer separate Medicare products in the relevant geographies. Humana denies the remaining allegations in Paragraph 68.

IX. REQUEST FOR RELIEF

69. Humana denies that Plaintiffs are entitled the relief requested or any other relief in this action. Humana requests that it be awarded the costs incurred in defending this action and any other relief the Court may deem just and appropriate.

X. AFFIRMATIVE DEFENSES

Humana asserts the following affirmative defenses, without assuming the burden of proof on any such defense that would otherwise rest with Plaintiffs.

FIRST DEFENSE

The Complaint fails to state a claim upon which relief may be granted.

SECOND DEFENSE

Granting the relief sought is contrary to the public interest.

THIRD DEFENSE

The Complaint fails to adequately allege any relevant product markets or relevant geographic markets.

FOURTH DEFENSE

The proposed merger is procompetitive. The merger will result in substantial efficiencies and other procompetitive effects that will benefit consumers in providing greater access to quality, affordable healthcare. These benefits outweigh any alleged anticompetitive effects.

FIFTH DEFENSE

Aetna and Humana have proposed a remedy that addresses any alleged anticompetitive effects and ensures that there will be no harm to competition or consumers.

SIXTH DEFENSE

Humana reserves the right to assert other defenses as they become known to Humana.

Dated: August 19, 2016

Respectfully Submitted,

/s/ Kent A. Gardiner

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CERTIFICATE OF SERVICE

I hereby certify that on August 19, 2016, a true and correct copy of the foregoing was served via the Court's CM/ECF system or via electronic mail, pursuant to Rule 5.4(d) of the Local Civil Rules and Rule 5(b) of the Federal Rules of Civil Procedure, upon the following:

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